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Doctoral Thesis

Doctor in Philosophy (Ph.D.)

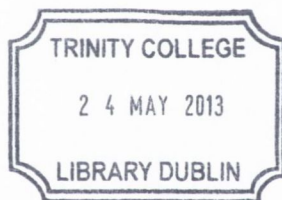
Pathways to Mental Health Care of People with
Mental Health Problems within the Irish Criminal
Justice System

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Student ID Number 01166026

Doctoral thesis submitted to the University of Dublin Trinity
College in part fulfilment of the requirements for a degree of
Doctor in Philosophy

April 2012



Thesis 9798

DECLARATION

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DEDICATION

I would like to dedicate this thesis to all those who agreed to participate in this study, without your contribution this research would be meaningless.

I would also like to acknowledge any people who may have been excluded from this study. This may have been for several reasons for example limitations of the recruitment process or in some cases people expressed an interest in the study but were too unwell to get involved during the data collection phase.

It will now become my mission to disseminate the findings from this study to all the relevant stakeholders. This is to ensure that these hidden voices from behind the institutional walls of prisons are heard.

EPIGRAPH

'I never want to end up in prison again I just need a chance I know I could do it with the right help all I need is that chance.'

(Participant Ten)

ABSTRACT

Pathways to Mental Health Care of People with Mental Health Problems within the Irish Criminal Justice System CJS

This research identifies the many barriers that Irish prisoners encountered when accessing and maintaining links with mental health services prior to incarceration. These are: lack of recognition of mental illness by participants and health professionals, limited referral options, over-reliance on pharmacological interventions to manage mental health problems, stigma, lack of or breakdown of social supports, and limited professional supports within the community. Combinations of these barriers with individual circumstances are shown to be important predisposing factors for future involvement with the criminal justice system. This research makes several assertions. Firstly, the CJS is increasingly becoming a pathway to accessing mental health care. This claim is strongly supported by participants' level of disengagement with mental health services prior to incarceration revealed by this study. Secondly, mentally disordered offenders are gradually becoming re-institutionalised within the Irish criminal justice system. This finding demonstrates that the WHO's prediction within the Trencin statement that prisons 'will' become twenty-first century asylums (WHO 2007, p. 5) has in fact happened. Thirdly a noteworthy contention of this research involves the process of re-integration with the community following a period of incarceration. This research reveals that the process of re-integration is complicated by participants' lack of confidence in mental health services in the community as well as their conviction that they feel extremely stigmatised by society and health professionals following previous involvement with the CJS.

This dissertation utilised a pragmatic exploratory sequential mixed methods design. The study was conducted in two phases. The first used a qualitative design. This phase involved conducting fifteen interviews with prisoners with mental health problems. This provided a platform for participants to tell their stories of accessing and maintaining links with mental health services prior to incarceration as they experienced it. This was followed by a quantitative phase which used an adapted version of the Pathways

Encounter Form. This phase received a response rate of 78% (n=117). This facilitated the construction of a socio-demographic profile of a larger sample of prisoners with mental health problems. It also provided information regarding delay in seeking help for mental health problems, as well as referral pathways, the range of contacts made, the types of treatment provided at each of these stages, if contact with community mental health services was established prior to imprisonment and if that contact was maintained.

Recent Irish studies (Duffy *et al.* 2003, Linehan *et al.* 2006, and Wright *et al.* 2006) have shown a significant prevalence of mental illness among prisoners. This is consistent with Penrose's theory that deinstitutionalisation is a major factor leading to an increase of mentally ill people in prison. This is particularly noteworthy because prisons are considered grossly inappropriate environments for prisoners with mental health problems (Irish Penal Reform Trust 2001, WHO 2001, Coyle 2005, O'Neill 2006, Corston 2007, WHO 2007, Durcan 2008, Bradley 2009, Knight & Stephens 2009). Gater *et al.* (2005) profess that understanding the ways in which people seek care for mental health problems is an important factor when planning mental health services. Goldberg & Huxley (1980) described different levels of engagement with health care in the community, primary care and in-patient services. This model is useful not only in understanding the pathways to mental health care, but also as the starting point for evaluating the needs of people with mental health problems. The aim of this research is to understand the experiences people with mental health problems of accessing or maintaining links with mental health services prior to incarceration. Currently there is no Irish research that explores this issue from the prisoners' perspective. Uniquely, the central tenet of this research involves getting the actual stories of how these people experienced accessing and maintaining links with mental health services prior to incarceration. The process of gaining access to prisoners' to conduct research is fraught with many challenges for a researcher (Lofland *et al.* 2006, Dickson-Swift *et al.* 2007). Therefore ethical issues were meticulously addressed within this research. Ethical approval for this study was granted by the Faculty of Health Sciences Trinity College Dublin and the Prisoner Based Research Ethics Committee (PBREC).

The key themes which emerged from this study are: social circumstances, barriers to accessing community mental health services, re-institutionalisation, experiences with mental health services in prison compared with that in the community, and experiences of those who had been in prison upon re-entering the community.

This research provides a comprehensive account of the experiences of this group on the issue of accessing and maintaining links with mental health services prior to incarceration.

Its unique approach generates evidence that contributes to the extant body of knowledge on this topic. It will contribute to Irish policy development on the quality, resources and structure of community mental health services into the future.

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CHAPTER ONE - INTRODUCTION

“Without urgent and comprehensive action, prisons will move closer to becoming twenty-first century asylums for the mentally ill, full of those who most require treatment and care but who are held in unsuitable places with limited help and treatment available.”

(The Trecín Statement, WHO 2007)

1.1 Introduction

The Trecín Statement sets out a new agenda for the urgent need to focus on mental health and prisons (WHO 2007). However, as far back as 1995 the World Health Organisation raised concerns and stressed the need for a collaborative approach to improving mental healthcare in prisons across Europe (WHO 1995). The Trecín Statement (2007) suggested a number of reasons for the increased prevalence of mental illness among prisoners. One of these suggestions is that a number of prisoners already have mental health problems before entering prison (WHO 2007, p.5). This suggestion raises the question about the type and quality of mental healthcare received by people with mental health problems before their involvement with the Criminal Justice System CJS. This fact, coupled with the process of de-institutionalisation of mental healthcare which commenced in Ireland in the late 1970s and the consequences of that, set the agenda for this research. The primary focus of this research is to gain an understanding of people with mental health problems experiences of accessing and maintaining links with mental health services prior to incarceration. To date no research exploring this issue has been conducted in Ireland. This research is unique because it extracts these experiences from the actual stories of the people who experienced it. This will provide a conceptual understanding of these experiences which will lay the foundation for future pertinent research on this topic. In addition the knowledge gathered through this research process, will make a tangible contribution to how and what mental health services are provided for people who experience difficulties in gaining access and maintaining links with mental health services in the community. Such developments would impact considerably on the problem of mentally ill entering the CJS.

1.2 Background

Mental health problems among prisoners are world-wide (WHO 2007, 2011). WHO (2011) estimates that in Europe alone, at least 400,000 prisoners suffer from a significant mental disorder. However, this does not take in account those who suffer from common mental health problems such as depression and anxiety (WHO 2011). Furthermore, co-morbidity is common with conditions such as personality disorder, alcoholism and drug dependence (WHO 2007). It has been well documented that the prevalence of mental illness amongst the prison population is significantly higher than that found among the general population (Belcher 1988, Aderibigbe 1996, Singleton *et al.* 1998, Reed & Lyne 2000, Fazel & Danesh 2002, Linehan *et al.* 2005).

On the 30 November 2010 the total number of persons in custody in Irish prisons stood at 4,440. This figure has increased by almost 9.9% since 2009 (Irish Prison Service [IPS] 2010, p. 5). The average number of female offenders in custody in Irish prisons was 157, compared to 132 in 2009 (IPS 2010, p. 13). An Irish study of the extent of mental illness in prisoners revealed an incidence of psychosis among men on remand of 7.6%. Among those on a sentence this was 2.6%. The findings also revealed 70% of prisoners were excessively using or dependent on drugs or alcohol (Duffy *et al.* 2003).

The Trencín Statement (WHO 2007), referred to above, suggests several reasons for the growth of mental health problems among prisoners. These are:

- A number of prisoners already have mental health problems before entering prison.
- Prison environments are, by their nature, normally detrimental to protecting or maintaining the mental health of those admitted and held there.
- Many vulnerable prisoners have a drug problem prior to entering prisons, and a large proportion had their first drug experience in a prison.
- Diversion schemes, prior to and at the point of sentencing, are often poorly developed, under-resourced and badly managed.
- Prisons have too often become the place used to hold individuals who have a wide range of mental and emotional disorders (WHO 2007, p. 5).

Penrose's law (1939), showed an inverse relationship between the number of psychiatric hospital beds and the number of prisoners in any given society, suggesting that a reduction in psychiatric hospital beds leads to an increase of mentally ill people in the criminal justice system. Ireland, like many other countries around the world, has introduced a policy of de-institutionalisation (Government Commission of Enquiry on Mental Illness 1966, Department of Health 1984, Department of Health and Children [DoHC] 2006, Brennan 2006, Kelly 2007). The overarching principle for the delivery of mental health services in Ireland is now dependent on a primary care approach (DoHC 2006). The Declaration of Alma-Ata outlined the importance of the concept of primary healthcare in the promotion of quality healthcare (WHO 1978). Primary care is regarded as the first point of contact that people have with a healthcare provider (DoHC 2001, 2006). This level of access to healthcare should be available to all people regardless of who they are, where they live, what their income is or what health and social problems they have (DoHC 2001). The model of primary care promoted in Ireland is intended to ensure that services are coordinated and integrated across the boundaries of health and personal social care to the benefit of the consumer in terms of better quality, better outcomes, better cost-effectiveness and better health status (DoHC 2001). The key role of primary care in the recognition, assessment and treatment of Mental Health issues is clearly articulated in the national policy document *Vision for Change* (2006). The WHO again reiterated the importance of primary care in mental health in its report *Mental Health: New Understanding New Hope* (2001). This report recommended that treatment for people with mental disorders should be provided in primary care as this enables the largest number of people to get easier and faster access to services (WHO 2001).

The process of de-institutionalisation in Ireland which began in the late 1970s witnessed a substantial reduction in psychiatric bed numbers (WHO 2005, p. 3). De-institutionalisation within the mental healthcare system has significantly, if not radically, improved the care for and the lives of mentally ill people in countries that have conducted psychiatric reforms (Salize *et al* 2008, p. 527, European Commission, 2005). According to the DoHC (2006), the aim of Ireland's newly constructed mental health system is to deliver a range of activities to promote positive mental health in the community. It should intervene early when problems develop and it should enhance the inclusion and optimal

functioning of people who have severe mental health problems (p.14). However, Munk-Jorgenson (1999) argued that the process of de-institutionalisation in mental healthcare has actually contributed to the development of many other problems. Examples of such problems are the increased suicide rate among psychotic patients, the increase in coercive activities in psychiatric hospital wards, the increasing rate of occupancy of psychiatric beds, the increase in the rates of acute or emergency admissions, and the increase in the number of criminal offenders among the mentally ill. The latter problem is particularly relevant in the context of Penrose's Law (1939). Furthermore, Murphy (1992) contested that the process of de-institutionalisation and the reluctance among general psychiatrists to accept high-risk prisoners from the criminal justice system had contributed to an increase in mental health problems being dealt with in the prison system. This, accompanied by inadequate funding for community-based programmes and legislative changes, has created a pathway for some mentally ill people to enter the Criminal Justice System. In turn, this raises many issues such as human rights violation, treatment and access to care for people with mental health problems within the Criminal Justice System.

In 2001 Ireland introduced its Health Strategy (DoHC, 2001) where it set "better health for everyone" as its primary goal. This document highlighted the need for an expanded range of health and personal social services over the following years. It promised increased investment to address unmet needs and to deliver the kind of person-centred, holistic and locally accessible range of services that are required if the health strategy is to make a real difference. However the United Nations Committee on Economic, Cultural and Social Rights (CECSR 2002) stated that the principles of non-discrimination and equal access to health facilities and services were not embodied in this health strategy.

In 2001 the Government of Ireland introduced the *Primary Care: A New Direction* document which stressed the commitment of the Government and the DoHC to primary care as the first and on-going point of contact with the health and personal social services. This meant dealing with health problems at the lowest level of complexity. It acknowledged the critical nature of a primary care system in the future development of a first class mental health service which would meet the growing needs of an expanding population in terms of its size and diversity.

In 2006 the report of the Expert Group on Mental Health Policy *A Vision for Change* was launched. This report sets out the direction for mental health services in Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness. One of the key recommendations of this report is that links between specialist mental health services and primary care should be enhanced and formalised. It proposed the strengthening of this relationship and is in agreement with the WHO Report *New Mental Health: New Understanding New Hope* (2001) which endorses the provision of treatment within primary care services. These recommendations are also in line with the *Primary Care: A New Direction* (2001) and *Quality and Fairness: A Health System for You* (2001) reports discussed earlier. To date, the links between primary and secondary care within the Irish health system have been markedly underdeveloped (Wright 2007). A study by Tedstone Doherty *et al.* in 2007 showed that the interface between primary care and secondary mental health services in Ireland remain undeveloped.

“The interface between primary care and secondary mental health services needs to be developed so there is a continuity of care for those who require specialised mental health services”. (Tedstone Doherty *et al.* 2007, p. 15)

There may be several reasons to explain the lack of this vital development such as lack of expert knowledge of healthcare providers (DoHC 2006) or insufficient Government funding (O’Shea and Kennelly 2008). GPs are considered the ‘gatekeepers’ of the mental health services (DoHC 2006). Tedstone Doherty *et al.* (2007) remarks that this requires these health professionals to be competent in accessing, diagnosing and treating mental health problems in the primary care setting or, if required, making appropriate referrals to secondary mental health services. However, it is estimated that one in four patients visiting a health service has at least one mental, neurological or behavioural disorder. Most of these disorders are neither diagnosed nor treated (WHO 2011). There is also evidence of a lack of the availability of psychological therapies (Tedstone Doherty *et al.* 2007), a fact which was also highlighted within the recent mental health policy document – *A Vision for Change* (DoHC 2006). The primary care system is fragmented from the user perspective and is difficult to access out-of-hours (DoH 2001). WHO (2003) asserts that many countries have not gone far enough and need to develop more community services,

with better infrastructure and support systems. WHO (2005) asserts that many people suffering from severe mental health problems, particularly vulnerable and marginalized people, experience difficulties gaining access to and remaining in contact with services (p. 99). Service structures and processes should offer evidence-based care which as far as possible keeps the patient in the community.

In 2005, the Republic of Ireland spent 8.2% of GDP on healthcare. O'Shea and Kennelly (2008) note a 50% decline in the GDP spent on mental health services between 1984 and 2005, from just under 14% in 1984 to 7% in 2005. In 2010 spending on mental health services fell to 5.3% of the health budget. This is almost 3% less than the recommended expenditure of 8.24% on mental health (DoHC 2006). The Dept of Health & Children (2006) in their report *A Vision for Change* noted that it would be inequitable if the total health funding devoted to mental health were to decline progressively.

Consequently, mental health services may not be able to provide the level of assessment and treatment for people with mental illness which they deserve. O'Shea and Kennelly (2008) outline some of the consequences of poor mental health as affecting emotional and physical health, personal relationships, access to employment and housing, ability to participate in society, and a higher risk of being incarcerated in prison.

1.3 Research Problem

Prison may not always be the suitable or appropriate environment for people with severe mental illness (O'Neill 2006, WHO 2007). In fact prison can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide (Birmingham 2003, Bradley Report 2009, WHO 1995, 2007, Coyle, 2005). Knight and Stephens (2009) are of the opinion that prisons by their very nature are clearly associated with punishment, deprivation and poor conditions. This remark is confirmed with regard to Ireland when the European Committee for the Prevention of Torture, Amnesty International Irish Section report (2007) noted its serious concerns about how Ireland's criminal justice system provides for the needs of prisoners with mental health problems.

Several suggestions were put forward by the WHO for the increased prevalence of mental illness among prisoners. One of these suggestions is that a number of prisoners already

have mental health problems before entering prison (WHO 2007, p.5). This suggestion is of particular significance in light of the many policy directives discussed earlier to ensure a more equitable and easier to access mental health services for Ireland (DoH 1966, 1984, 2001, 2001, DoHC 2006). As yet there is limited Irish research on the effectiveness of these directives in terms of equity and access to mental health services. However, much evidence exists within international literature to indicate that for many people access to mental healthcare is complex, challenging and sometimes inequitable (Lincoln & McGorry 1995, Boydell *et al.* 2006, Crowley 2003, Duffy *et al.* 2003, Bhugra *et al.* 2004, Shaw 2007, Hayward & Moran 2007, Howerton *et al.* 2007). Some examples of these studies are from UK literature which is in many ways similar to Ireland in terms of their policy on contemporary mental healthcare provision. Boydell *et al.* (2006) remark that for many people the pathway to mental healthcare is non-linear, complex and dynamic as described in a study on of how children with mental health problems access care. A study on ethnic minority groups showed that black patients were less likely to come through primary care services and were also most likely to be dissatisfied with primary care compared with white people (Bhugra *et al.* 2004). Lincoln & McGorry. (1995) explored pathways to care for young people experiencing a first episode of psychosis. Shaw (2007) concentrated her research on adolescent offenders with mental health problems and their pathways to care. Hayward & Moran (2007) studied personality disorder and pathways to inpatient psychiatric care. Other studies focused on mentally disordered offenders' socioeconomic characteristics (Howerton *et al.* 2007, Crowley 2003, Duffy *et al.* 2003), illness and behavioural characteristics (Duffy *et al.* 2003) and how these can impact on help-seeking behaviours. A critique of these studies is conducted in the following chapters.

1.4 Research Purpose

The purpose of this research is to conduct a pathways' study of how people with mental illness become involved with the Irish criminal justice system. This research is concerned with gaining an understanding of the experiences of prisoners with mental health problems while accessing and maintaining links with mental health services prior to involvement with the CJS. Currently no research similar to this has been conducted from

an Irish perspective. It is envisaged that this new knowledge generated from this study will help to improve the accessibility, efficacy and responsiveness of mental health services for this population.

1.5 Research Question

What are the pathways to care of people with mental health problems within the Irish criminal justice system?

1.6 Research Aims and Objectives

1.6.1 Aims

This research aims to identify the factors which influence how people with mental illnesses become involved with the Irish Criminal Justice System CJS. It is also concerned with understanding the experiences of this group of people in trying to access and maintain a link with mainstream mental health services prior to incarceration.

1.6.2 Objectives

- To explore the process through which people with mental health problems encounter the criminal justice system and
- To identify the current strengths and weaknesses in policy, protocols and service delivery for people with mental health problems within the criminal justice system.

1.7 Challenges of Doing Prison-Based Research

1.7.1 A personal reflection on accessing prison

Patenaude (2004) posits that prison research needs to be pragmatic and policy-oriented, if it is to be useful. Therefore, issues regarding the protection of participants, while remaining true to the research aims and objectives, require a researcher to be cognisant of the study environment and how it relates to its inhabitants (Schlosser 2008). These issues raise major challenges for a researcher particularly when a study involves the recruitment of prison inmates. Access to research sites may be complex, particularly

when the site is a prison and the target population is its inmates. Indeed a researcher must take account of the possible political, legal, and bureaucratic barriers that may arise during the process of gaining access to a study site (Lofland *et al.* 2006) and to participants (Dickson-Swift *et al.* 2007). In this section I will describe the challenges encountered in trying to undertake research within the Irish prison system. This will deal with the emotional, cultural, practical, dilemmas experienced by me in gaining access to prisons in order to conduct this research. In my professional career so far I have gained extensive experience and knowledge while working in various roles with people who have mental health problems within the National Forensic Mental Health Service and in prisons around Ireland. I have practiced as a psychiatric nurse, counsellor and, more recently, as an educator. My initial assumption as I broached this research topic was that my professional history would be an advantage in terms of understanding the prison culture and gaining access to prisons. However this process was more challenging than I expected. Gaining access to prison to carry out research is fraught with challenges even if you are, so as to speak, 'in the know'. At the outset I believed that I really understood the environment in which this study was located, namely, the prison. However, as I reflected on the finer details of this study I realised that I didn't truly understand this environment from the perspective of the potential participant.

I had to acknowledge that, while trying to truly understand this culture, I could be perceived by potential participants as being a member of the very group which controls them. Personally my dilemma was twofold. On the one hand I have made a good career and continue to do so from involvement in this field. On the other hand I wondered was there more involved than the promotion of my career. The dilemma raised the issue of whether I was the best person to conduct this study or not. I needed to acknowledge that I was in a privileged position in terms of gaining access to potential study sites and participants because I had many links established within the CJS. This privileged position could be perceived as a form of power and could be viewed negatively by the potential participants of this study. To address this issue considerable attention needed to be given to the methodological design for this study in order to ensure, as far as possible, that there was trustworthiness, inclusiveness, non-coerciveness, autonomy and confidentiality for potential participants within prison environments. My decision to proceed with this

study was finally reached by deliberating over two questions that have lingered in my mind throughout my professional career. Firstly, if the right interventions were available initially could some people with mental health problems be averted away from the Criminal Justice System? Secondly, why shouldn't people with mental health problems in prisons have the same access to the specialist care and skills as people using community psychiatric services do? Through deep and thoughtful discussion of these questions with my supervisors and members of the service users' advocacy network I reached the conclusion that this study could potentially hold many advantages for people who have not as yet been asked their opinion on this matter within an Irish context. It is true, as Brett (2003) has shown that this group is an extremely discriminated and marginalised one. This study provides an opportunity for this group of people to have their voices heard. In order to ensure that their stories are heard, a strategic plan for the dissemination of the findings of this study will be adopted. This will involve targeting key services and stakeholders. The key stakeholders and services in this research are service users (prisoners), the service user advocacy networks, mental health professionals, prison authorities, professional bodies from both the voluntary and public sectors, relevant Irish Government bodies such as the Department of Health and Children and the Department of Justice and Law Reform.

Many of these challenges were embraced and eventually overcome by acknowledging my personal limitations in understanding the experiences of potential participants from their perspective. Another important factor was having an understanding of and a respect for the prison environment and those working in it. Also there was the need for extensive perseverance and strategic planning by me and by my research supervisors.

The following sections provide a comprehensive account of how these issues were managed, particularly with regard to gaining access to prisons, establishing rapport from both the participants' perspective and that of the prison as an institution, and understanding prison culture.

1.7.2 Understanding prison culture from a personal perspective

"Access to research participants was, simply by the nature of the institution, constrained." (Stevenson 2009, p.5)

My experience of doing research within a prison environment was similar to that of Jacqueline Stevenson's when carrying out research among inmates in two prisons in the United Kingdom. It was constrained. Prison and academic cultures are poles apart. Understanding prison culture is twofold. Firstly, it is important to be aware of the prison culture from an institutional perspective and secondly, in so far as is possible, from that of the inmate within such an institution. Prisons are institutions which emphasise the need for punishment, security and control in order to protect society (Knight and Stevens 2009). They represent the power of the state to coerce (Morgan & Liebling cited in Maguire *et al.* 2007) and a need to be 'macho' (Nurse *et al.* 2003) in approach. My experiences within the Irish prisons which I attended were for the most part positive ones. However I did experience some challenges and restrictions. Prisons are institutions of power (Foucault 1977) and health professionals are part of a network (Perron, Fluet & Holmes 2005) who are responsible for enforcing that power. The approval of prison staff is crucial if research is to be carried out within a prison environment. As a researcher entering the prison environment I did sense this power imbalance both from the formal and informal perspectives of prison staff. One particular example occurred upon arrival at a prison while I was being searched and questioned about the nature of my business and my reason for attending that prison. I informed the prison officer that I had an appointment with the Governor to discuss my research and he responded by saying: "You're what? There's not much point in doing that with them (prisoners with mental health problems)."

Reflecting on this I remembered a situation some years ago when I started to provide an addiction counselling service for patients at the Central Mental Hospital. The culture within this service was similar to prison at that time. The reaction of some staff members to the provision of a counselling service was similar to that of the prison officer referred to above: "What's the point in doing that? They're not going to stop anyway."

So when I related this experience to the one I had above when entering the prison, I could understand what was happening and how to manage it. I also needed to acknowledge that this time I was entering the prison as a researcher in an academic capacity and not as a clinician. I didn't find the prison environment intimidating in terms of the security, searches and restrictions on what I could bring into prison. However, I did find the air of

suspicion challenging. I felt that I was being 'sussed out'. I experienced occasions of being left waiting outside the main gate of the prison for long periods of time and officers refusing to escort me to or from landings to meet potential participants or to exit the prison. There were several occasions when I attended prison on prearranged dates yet was not allowed to access prisoners. One particular morning, due to a Prison Officers' Association union meeting no healthcare consultations were facilitated. On that particular day I was one of a number of people who could not access prisoners. Among these there were two visiting psychiatrists, three visiting psychiatric nurses and three prison nurses. There were also many occasions when an interview was abruptly terminated due to staff routines for example, to facilitate meal breaks.

It was necessary to explore and attempt to understand the concept of prison culture from an inmates' perspective. Clemmer (1940) described the process of 'prisonization' as one by which inmates become socialised to prison culture. Consistent with Goffman's theory (1961) 'prisonization' is a gradually damaging process where prisoners adapt to the norms of prison life and come to accept crime as a way of life even after they are released. Morgan & Liebling (2007) are highly critical of this concept referring to it as an oversimplification of how prisoners adapt to a prison environment. Prisons have been described as 'toxic environments' (O'Neill et al. 2006). Factors such as overcrowding, violence, enforced solitude or lack of privacy, lack of meaningful activity, isolation from social networks, loss of hope about their future and inadequate or non-existent health services, especially mental health services, in prisons (WHO 2001) contribute to this toxicity. The Irish Penal Reform Trust (2001) report *Out of Sight, Out of Mind*, highlighted the fact that 78% of mentally-ill prisoners had been held in solitary confinement (p. 9). Anecdotally, it has also been reported that prisoners with mental health problems request to be segregated from other inmates to avoid social activity or being bullied due to their vulnerability in order to manage an environment which is inappropriate for their current needs. On several occasions I was unable to see a prisoner who was identified by my gatekeeper as suitable because it was reported by prison officers that they were segregated and therefore not available to meet me.

1.7.3 'Getting In'

A key starting point for this study was to ensure that access to the proposed sites was possible. Consultation was established with the relevant personnel within the Criminal Justice System (Appendix 1). Ethical approval was granted by the Prisoner-Based Research Ethics Committee (Appendix 13). This ethical approval gave permission to conduct research in the relevant prisons around Ireland. Nevertheless, permission to access a prison had to be negotiated with the prison governor of each individual prison.

According to Reeves (2010) gaining access to the required study site or sites is vital to accessing the population for carrying out a research project. An important factor in terms of gaining access to prisons occurs when the researcher is viewed as an 'outsider' by those within. Waldram (2009) notes that being an 'outsider' in prison is an asset particularly with regard to establishing trust and how one is viewed by inmates. This is particularly relevant when planning to access participants who may view the researcher as being 'one of them' i.e. one of the people who are keeping them in prison. Specific tactics, strategies and negotiation skills are critical during the process of gaining access to prisons. Lofland and Lofland (1984) suggested that researchers may need to use contacts which they have already established to improve the likelihood of gaining access. For this research project a deliberate strategy was implemented in order to secure access. Ethical approval was obtained from the relevant Prisoner-Based Research Ethics Committee and the Faculty of Health Sciences Ethics Committee Trinity College Dublin (Appendix 12). Following this, the process of gaining access to each individual prison was initiated. The final decision to enter each prison still had to be negotiated with the Prison Governor for each prison and it was at their discretion whether access was granted to the prison or not. Before meeting each prison Governor this researcher asked the visiting consultant psychiatrist, already known in that prison as being from the National Forensic Mental Health Service, to make a formal introduction. These psychiatrists had generally established good working relationships with the prisons and were also providing a very valuable service to the prison community. Once this introduction was made it was up to the researcher to explain this study and identify any requirements, such as office space, to carry out the study. Governors also clearly set out their rules if access was granted.

For example, supervision by prison staff was required at all times, as was the use of an identification card and adherence to various other security matters.

It was an asset that the supervisors of this research had a proven track record both academically and clinically. Dr. Damien Brennan, one of the supervisors, has an established academic background relevant to this area of study. The co-supervisor for this study is Professor Harry Kennedy Executive Director of the National Forensic Mental Health Service. These factors, along with the researcher's own knowledge and experience of the prison environment, were crucial to successfully gaining access to prisons. Access to all Irish prisons was successfully negotiated in spite of the fact that they are traditionally difficult places to access.

Gatekeepers in the sense of individuals capable of facilitating contact with potential participants are required particularly when accessing a vulnerable population. One of the primary reasons why a gatekeeper was used in this study was to protect the interest of potential participants and to ensure their voluntary participation. Ramazanoglu and Holland (2002) argue that if a research study is viewed with suspicion by the gatekeepers, this can lead to non-cooperation. Quina *et al.* (2007) reported that access to their population was to a greater extent controlled by prison staff. For example, they might discourage us from speaking to those they perceived as emotionally unstable or hostile. Therefore for this study the gatekeepers selected were not employed by the prison system. The gatekeepers were forensic community mental health nurses who provide an in-reach mental health clinic on a visiting basis. These personnel are employed by the Health Service Executive (HSE), predominantly the National Forensic Mental Health Service. Their role involved identifying potential participants in terms of their mental capacity to give informed consent and to distribute information about the study. This process reduced the possibility of prison staff controlling access to potential participants.

Highlighting the importance of how one dressed for the occasion may sound strange but it is a major issue when accessing an environment such as a prison. Prisons have strict rules with regards to dress code. Irish prisons are 'militarized' in terms of the uniforms, male domination and strict routines. They are similar to many prisons around the world. Therefore, this researcher attended prison appointments in semi-formal attire i.e. open-necked shirt and slacks. This ensured that the researcher appeared respectable to prison

staff and yet not too formal to potential participants. Furthermore, appearance may be the first factor in establishing rapport (Russell *et al.* 2002). It may be argued that a strategic approach to establishing rapport is in fact disingenuous (Funder 2005). This researcher believes that such a strategic approach was necessary in the early stages of gaining access and developing trust and respect. A good and genuine rapport with staff developed over the data-collection period for both phases of this study. As a result, a better understanding was gained of the challenging environment in which these people had to perform their duties. It became clear that overcrowding caused major problems and dealing with incidents of violence and aggression was common place. On a more humane note, many prison officers expressed real concerns at the number of prisoners with mental health problems and that prison was a totally inappropriate environment for many of them. One prison officer, for example, commented that: "I have seen over the last few years more and more prisoners coming in here with mental health problems." And in another prison in rural Ireland a prison officer commented that: "It's not right they should not be here. This place is not suitable for them... its wrong."

A final factor to be considered in gaining access is how the gender of the researcher may have an impact on access to a study site. Being a female researcher in a male-dominated environment may aid formal and informal access because women are perceived as 'warmer' and less threatening than men (Gurney, 1991: 379). However Genders and Players (1995), and Morris *et al.* (1963) claim that women report more personally difficult experiences when carrying out research in a prison environment. As a researcher entering the prison system the gender issue was not an influencing factor in this research. This may be due to several factors such as having established contacts within the prison system, the present researcher's credentials in terms of academic supervision, his extensive experience in this field and, finally and importantly, demonstrating respect for the culture of the environment which he was given permission to enter. Woods & Byrne (2005) recommend that researchers must take into account the various restrictions, rules and regulations which are in place when accessing a prison. Items such as beepers, cell phones, memory sticks and, in some prisons, audio recorders are prohibited. The only item really needed for phase one of this study was an audio recorder. On one occasion a prison officer expressed concern with regard to bringing it past the security check. It was

explained that permission had been obtained from the Governor and that only the in-reach clinic, and not the prison landings, was being used to carry out interviews. This was accepted. However, if the prison officer insisted on prohibiting the use of a recorder, notes would have to have been taken manually instead.

1.8 Projected Benefits of this Study

This is the first Irish study which explores the experiences of mentally disordered offenders accessing and maintaining links with mental health services prior to incarceration. A central component of this research is its unique design which specifically focuses on mentally disordered offenders' experiences and provides an opportunity for them to tell their stories. It is envisaged that the new and specific knowledge, provided by this research, will make a contribution to improving the accessibility, efficacy and responsiveness of mental health services for this population. The specific areas to which the findings of this study will make a contribution are:

- A greater understanding of the factors leading to recognition of mental health problems in this population;
- The identification of individual, social and service characteristics that influence the service pathways at the time of the index allegation or offence, thus providing information for future policy and service developments;
- By mapping the care pathways for this population this research will establish the strengths and weaknesses of present service provision.
- A greater understanding of how and what services are provided for this population.
- The provision of more appropriate services for this population resulting in fewer people ending up in the criminal justice system.
- A reduction in the number of people being inappropriately placed within the Criminal Justice System and having the stigma of a criminal record.

1.9 Thesis Structure

This thesis is presented in a manner structured to demonstrate clearly the evolution of the research. At each critical point from its earliest stage to the final write-up, crucial decisions and research dilemmas are explained and rationales given for them, particularly with regard to issues such as, the development of the research question, methodological issues and the integration of the findings.

This thesis is divided into eight chapters.

Chapter one introduces the area of study and provides a background to the research problem. It sets out a clear rationale for this study. It pays particular attention to key issues which need close consideration in order for this research to be conducted. One such key issue is the understanding of prison culture from the perspective of the prisoner as well as from that of the institution itself.

Chapter two presents an exploratory review of the literature on the topic of pathways to mental healthcare for people with mental health problems who have offended. The literature review develops the core research topic. Its purpose is to outline issues such as the sociological perspective on mental illness as it has developed over the generations. In turn, this provides an opportunity to gain a clear understanding of the manner in which society's perception of mental illness impacts on how mental health matters are addressed. This chapter then goes on to relate how mentally disordered offenders are viewed and treated by society. As a consequence this provides an opportunity to examine the changes which have taken place with regard to access to mental healthcare and to how the care and treatment needs of mentally disordered offenders are currently provided.

Chapter three creates a forum for an in-depth examination of the philosophical foundations of scientific enquiry and how this impacts on the research process. This research study adopts a pragmatic approach as its philosophical foundation. The establishment of this approach involves conducting an exploration of various research approaches and providing a rationale for the philosophical and methodological considerations pertinent to this research. These considerations are made in the context of the possible challenges faced when conducting such a study, challenges such as accessing prisons, vulnerable populations and matters relating to the recruitment of

potential participants. For this reason the methodological considerations for this study are inextricably aligned with its aims and objectives.

Chapter four presents the most appropriate research design for this particular study. This study utilises an exploratory sequential mixed-methods design. This design provides an opportunity to gain an in-depth understanding of the experiences of people with mental health problems within the Irish CJS when accessing and maintaining a link with community mental health services prior to incarceration. This exploratory sequential mixed-methods design ensures that the aims and objectives of the study are achieved. There are two parts to this study. Phase one develops an in-depth understanding of the experiences of this group of people in trying to access and maintain a link with mental health services prior to incarceration. Phase two deals with the collection of data from a larger sample of prisoners with mental health problems within the Irish CJS. This chapter discusses and explains the rationale for the research process required for this mixed-methods study. It provides a detailed account of, as well as the rationale for the methodological choices for this type of research. In particular, it discusses research methods, recruitment approach and approach to sampling, the procedures for data collection and the approach taken in the analysis of both data sets. Particular issues requiring explicit explanation due to the nature of this study are: the negotiation process to access study sites, the development and adaptation of the data collection instruments, and ethical issues. Since potential participants for this study are perceived as doubly vulnerable, ethical issues needed extremely close scrutiny. This chapter also discusses some of the limiting factors of this research study in areas of methodology, the researcher's competence in applying two approaches in one project and the reliability of recall when self-reporting. Finally, this chapter presents any methodological limitations associated with this design as far as this type of research is concerned.

Chapter five provides a detailed account of the application of a thematic framework to systematically analyse the data gathered from phase one. As this is a descriptive study the emphasis is on describing thoroughly the results to the research question. Colaizzi's (1978) framework for data analysis is applied to the qualitative data gathered during phase one of this research. The use of the NVivo software package was key to dealing with the data gathered. According to Jones (2007) the use of the NVivo software package

allows for a more thorough and rigorous coding and interpretation, and provides researchers with enhanced data management. Therefore a detailed rationale for using a Computer Assisted Qualitative Data Software Analysis (CAQDAS) NVivo for the qualitative phase of this study is provided.

Chapter six presents the results of participants' experiences accessing community mental health services before being imprisoned. An adapted version of the Pathways Encounter Form (Appendix 11) is utilised to document quantitatively these experiences. The primary aims of this phase of the study are to provide a more comprehensive demographic profile of a larger sample of prisoners with mental health problems and to corroborate, strengthen or refute the findings from phase one. A detailed description of the data analysis using the Statistical Package of the Social Sciences (Version 18) is provided. The type of data gathered in this phase of the study is predominantly non-parametric. Chi-Square is used to test differences in prevalence and the Mann Whitney U Test to measure differences between groups. Some data are also presented in diagrammatic form as pie charts, bar charts or histograms.

Chapter seven provides an extensive discussion of the study findings. The integration of the study findings enhances the credibility of the results from both data sets. This chapter elaborates on how a process of thorough interpretation of the results assists in establishing relationships and patterns hidden within the data. A key issue for mixed-methods studies concerns integration. In this study integration occurs at several points. It occurs in the formation of the research question, in the development of the data collection instrument for phase two and at the stage of the interpretation of study finding. For this study the main process of integration occurs in chapter seven through the interpretation of the findings.

Chapter eight provides a summary of the salient points of this study. Recommendations are drawn following the interpretation of the findings of both the qualitative and quantitative data sets. It is envisaged that these recommendations will be beneficial in gaining a better understanding of the experiences of people with mental health problems as they try to access and maintain a link with community mental health services prior to incarceration. The final section presents a reference list, appendices, and any other relevant material to demonstrate a rigorous methodological approach to this research.

CHAPTER TWO - LITERATURE REVIEW

“A *Vision for Change* proposes a framework for promoting mental health at all levels of society and for delivering specialist care to everyone who needs it”. (DoHC 2006, p.5)

2.1 Introduction

In 2006 the Department of Health and Children launched a comprehensive policy for Ireland’s mental health services for the following seven to ten years - *A Vision for Change*. This report describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness (DoHC 2006, p. 8). However, it is now known that there are a significant number of people with mental health problems within the Irish prison system (Duffy *et al.* 2003, Linehan *et al.* 2005, Duffy *et al.* 2006, Wright *et al.* 2006, Brennan 2006, Kelly 2007, Curtin *et al.* 2009). As stated previously, one of the reasons contributing to this occurrence is that a number of prisoners already have mental health problems before entering prison (WHO 2007, p.5). This suggests that difficulties may be encountered by some with regard to access, or with the nature of mental health care provided before being imprisoned. There is a vast amount of literature from various perspectives to indicate that the process of gaining access and maintaining a link with mental health services can be both complex and challenging (Bhugra *et al.* 1996, Boydell *et al.* 2006, Bhugra *et al.* 2004, Sayal 2006, Sayal *et al.* 2006, Cratsley *et al.* 2008, Shaw 2007, Mezey 2007, Howerton *et al.* 2007, Dressing & Salize 2009, Bookle & Webber 2011, Sayal *et al.* 2010, Tsakanikos *et al.* 2010). Ireland has made considerable advances in terms of equity, accessibility and standards of mental health service provision particularly in recent years (DoH 1966, 1984, 2001, 2001, DoHC 2006, MHA 2001, CL (I) A 2006). However, as yet there is limited Irish research on the effectiveness of these advances in policy and legislation, particularly in terms of equity and easier access to mental health services.

The main purpose of this literature review is to clarify a theoretical basis of the research undertaken and to locate this study within the relevant body of knowledge. A literature

review is a vital step in helping to lay the foundation (Boote & Beile 2005) for a study and in finetuning the research question. LoBiondo-Wood & Haber (2006) assert that a literature review should provide an overview of the relevant issues and concepts in relation to a research topic. Hence this should conceptually define the variables to be studied (LoBiondo-Wood & Haber 2006, p 319). It also identifies key factors that inform the methodological decisions pertinent to this type of research.

This chapter exposes the relevant literature, theories, policy documents and legislation to close scrutiny. The first stage of this review involved conducting a comprehensive examination of the contemporary published and unpublished literature. This necessitated carrying out searches of electronic databases such as CINAHL (Cumulative Index of Nursing and Allied Health literature), Pubmed, Psych Info, and the Cochrane Library. Internet searches to further enhance the validity of the literature review were also conducted. A range of key words were used to focus this review of the literature. The literature retrieved from this search ranges from early seminal writings to the most pertinent contemporary publications on the topic. This chapter presents the three major themes emerging from this review. Each of these themes has a range of sub-themes. The first major theme concerns the sociological perspective on mental illness. This theme provides an exploration of the discourse on mental illness and offending from ancient to modern times. Secondly, the theme of mentally disordered offenders, mental health and crime is considered. The third theme deals with pathways to mental healthcare. This theme examines the literature documenting the experiences of accessing and maintaining links with mental health services. Also considered within this theme are the experiences of ex-prisoners in accessing or re-engaging with mental health services upon release from prison.

2.2 Mental Illness - A Sociological Perspective

Mental illness and its association with prison systems have a long history (Dangerous Lunatics (Ireland) Act 1838, Central Criminal Lunatic Asylum (Ireland) Act 1845, Finnane 1981, Robins 1986, WHO 1995, Brennan 2006, Kelly 2007, WHO 2007). More specifically, punishment and its association with being mentally ill is well documented (Tuarascáil Report 1966, p. 11, Foucault 1977, Seddon 2007, Knight and Stevens 2009). Over

generations a transformation has occurred with regard to the discourse on mental illness. This in turn influences how and where people with mental illnesses are treated. Ancient beliefs led to the demonisation of the mentally ill (Tuarascáil Report 1966, WHO 2003, pp. 17-19, WHO 2001, p. 49, Stein and Santos 1998, pp. 6-7), resulting in their being considered criminals and punishable. In Ireland this era was followed by the establishment of the asylum system during the 1800s leading to a process of institutionalisation. The process of institutionalisation facilitated the extraction of people from society often for long periods of time because they were deemed to be mentally ill. Such actions were considered by society at the time to be a more humane approach to the care and treatment of the mentally ill (Stein and Santos 1998, p. 8). However this approach to the care and treatment of the mentally ill is heavily criticised (Foucault 1967, Porter 2002, Szasz 2003, DoHC 1966, 1984, 2006, Whitaker 2010, Szasz 2011). The asylum system was followed by a more contemporary view of mental illness which includes the notion of self-determination and autonomy (DoHC 2006). This shift was facilitated by a policy of de-institutionalisation (Tuarascáil Report 1966, DoH 1984, DoHC 2006). De-institutionalisation promotes care and treatment being located in and among communities (DoH 2001, DoHC 2006, WHO 1978, 2001). In Ireland this process commenced by the mid 1970s. However it was an extremely slow process (DoH 1984, DoHC 2006), particularly considering that Ireland's policy on de-institutionalisation was first introduced in 1966 (Government Commission of Enquiry on Mental Illness 1966).

Foucault's seminal work *Madness and Civilisation* (1967) traced the evolution of the concept of madness through three phases: the renaissance, the classical age and modern times. This review also draws from the writing of other discourse theorists such as Habermas and Derrida.

Discourse may be defined as

“...a body of ideas, concepts and beliefs which become established as knowledge or as an accepted world view. These ideas become a powerful framework for understanding and action in social life.” (Bilton *et al.* 1996, p. 657)

Foucault (1967) referred to discourse as a system of power and knowledge situated in a specific time and place. For example, Foucault's early writings on madness contrasted the social construction of madness from the divine inspiration of the Middle Ages with that of

the late twentieth century when it was viewed as a disease which could be treated by various therapies (Foucault 1967). During these two periods each discourse considers madness from two completely different perspectives. One period proposes that mental illness is the result of being possessed by supernatural powers and the other considers it a disease. Hence it would have been impossible or unimaginable for either perspective to understand or manage madness from the perspective of the other period. This illustrates the impact differing views can have on how madness is perceived and reacted to by society (Bilton *et al.* 1996). For many centuries in Ireland, religious, spiritual or cultural beliefs dominated the way in which individuals with mental illness were treated and regarded by society (Tuarascáil Report 1966). Hence the response to mental illness was often mixed. In some instances the mentally ill were treated with great respect because they were feared by society (Tuarascáil Report 1966, p. 11). However, more often they were regarded as persons to be punished for their sinful or criminal acts, and were subject to great cruelty, or were harried from place to place, often abused and tormented (Tuarascáil Report 1966, p. 11). Similarly, in Europe, during this period the dominant belief was that mental illness was caused by the presence of supernatural powers and that its sufferers were possessed (Foucault 1967, Aneshensel & Phelan 1999). Interestingly, the stigma associated with mental illness can be traced back to the cultural values of ancient Greece (Prince 2003, p. 58). Many of the responses to mental illness were often barbaric involving physical restraints, brutality and sometimes death (Foucault 1967, 1977). The mentally ill were frequently subjected to torture by means of being burned at the stake, hanged or decapitated to liberate their souls from demonic possession (WHO 2003 pp. 17-19, WHO 2001 p. 49, Foucault 1977 p. 11, Stein and Santos 1998, pp. 6-7). Stein and Santos (1998) report that over five thousand years ago in Eastern Mediterranean and North African countries, an act of trephination was performed as a form of treatment for madness. This treatment involved penetrating the skulls of mentally ill people in order to allow the evil spirits within to be released (Stein and Santos 1998, p. 6).

In Ireland, as far back as the seventh century, Brehon Laws made provisions for the insane. In fact, these laws were one of the first documents to distinguish the lunatic from the fool or imbecile. It was believed that the latter were able to work and be self-

sufficient. These laws placed the responsibility of the poor, aged and the insane onto the kin group (*derfhine*). Hence, the insane were cared for in their community and were supported and cared for by their families. These laws also provided for the provision of sick maintenance for the insane, which meant that they imposed responsibility on society to provide support for persons who were incapacitated. McClelland (1988) noted that during this period there appeared little evidence to indicate that the mentally ill were deliberately persecuted. This was contrary to what happened elsewhere in the British Isles (McClelland, p. 102).

However the proclamation of King James I in 1603 resulted in major changes in how the mentally ill were provided for in Ireland (Beckett 1966). The proclamation of King James I resulted in the authority and the social powers of the Brehon Laws gradually disappearing (Beckett 1966, p. 24). According to McClelland (1988) the emphasis was now shifting to one of conformity and social control. Madness was seen as a matter of deliberate and perverse choice rather than the inescapable consequence of a sick mind (McClelland 1988, p. 102). This resulted in there being little or no provision for the insane during this period in Ireland (Tuarascáil Report 1966, p. 3, McClelland 1988, p. 102). In 1699 a petition was made to the Assembly to provide a hospital to care for the insane in Dublin. By 1701 Ireland had its first public provision for the separation of the insane in workhouses and gaols (prisons). Kirkpatrick (1931) observed that in 1703 the Irish Parliament passed an Act for the erection of a workhouse in the city of Dublin for employing and maintaining the poor. In 1787 Ireland, under British rule, was influenced by the British practice of separating the insane from the other inmates of the Irish houses of industry. According to Finnane (1981) this reflected a social norm. This is not surprising considering that McClelland (1988) is of the opinion that Ireland's provision for its lunatics was greatly influenced by British social and political norms.

The Irish Workhouses Act of 1772 provided for the separation of classes of poor such as the separation of vagrants from beggars. The utilization of the Prisons Act (1787) empowered grand juries to establish lunatic wards in houses of industry in order to separate lunatics from other inmates (Finnane 1981, p. 21). However, Finnane (1981, p. 22) remarks that little changed administratively for this group because they were still considered part of the wider class of destitute poor and criminals.

The Newport committee was established in 1804 to reconsider provisions already made for the “aged and infirm poor of Ireland”, the punishment of vagrants and the future care of lunatics and idiots. However, the only recommendation made was in relation to the insane. Finnane (1981) noted that the “attention and care” required for the relief of the lunatic and idiot could not be given to them whilst they were in the workhouse. It was now recognised that these lunatics needed specific care in a separate environment even if the intentions were not solely for the benefit of the inmates. He goes on to suggest that lunatics and idiots might affect the orderly running of the workhouses (Finnane 1981 p. 23). As a result the Newport committee recommended that four provincial lunatic asylums be established in Ireland. However, these never materialised. In fact, it was not until 1817, when another Select Committee of the House of Commons was established, that the need for district asylums in Ireland was reiterated. These asylums were to provide exclusively for the reception of the insane. It was this report which led to the passing of the Lunacy (Ireland) Act 1821, which gave rise to Ireland’s asylum system. One of the reasons for the establishment of the asylum system so early in Ireland could possibly be due to the fact that Ireland had no poor law until 1838. This resulted in there being little or no provision for the poor in Ireland, in workhouses or houses of industry, as there was in Britain.

On the surface it would appear that the establishment of purpose-built facilities for the mentally ill was good. However these early asylums were considered places of incarceration for lunatics and the poor because a cure was not envisaged (Finnane 1981, p. 22). They resembled prisons and the patients were regarded as criminals (Tuarascáil Report 1966, p. 11). Severe forms of punishment were frequently applied, such as the use of chains and fetters, to control inmates (Tuarascáil Report 1966, p. 11). This is worthy of note considering that the expansion of Ireland's asylum system continued regardless of its inhumane culture. Indeed, as Kelly (2007) observed, the conception of the asylum system in Ireland in this period had little or no legislative provisions for the mentally ill. In 1838 the Dangerous Lunatics Act was passed. It empowered two justices of the peace to commit a person to gaol (jail) on his/her being found to be a dangerous lunatic or a dangerous idiot (Kelly 2008, p. 51). Brennan (2006, p. 178) identified the Dangerous Lunatics Act 1838 itself as a central factor in the enormous and continual

increase of the mentally ill in the Irish asylum system. According to Prior (2003) this was a direct result of the extremely loose criteria of this Act upon which a person was committed to an asylum. Indeed as Prior (2003) pointed out, this provided the potential for gross misuse of this Act. Interestingly with regard to this issue, Brennan (2006) also draws attention to the fact that the Dangerous Lunatics Act 1938 established a legal link between insanity and criminality (p. 179).

During the 1800s a change in attitude towards the mentally ill was developing across Western Europe. This gradual change resulted in the establishment of a humanitarian approach towards the mentally ill. Tuke in the Great Britain and Pinel in France pioneered this movement. William Tuke held the belief that those who behaved in strange and unexplainable ways did so because they were mentally ill. Based on this philosophy he founded the York Retreat, where individuals with mental illness were provided with decent living conditions and were treated in a dignified manner (Stein and Santos 1998, p. 8). Similarly in France in the late eighteenth century, Philippe Pinel oversaw the reform of the Bicêtre and Salpêtrière. Here the philosophy was one of respect, where the inmates were unchained. The approach developed by Pinel and Tuke became known as 'moral treatment'. These changes can be set in the context of a Europe which was experiencing enormous social and economic change. The 1700s and 1800s marked the beginning of the industrial revolution in countries such as Britain, Germany and France. However, this was not the case in Ireland. During this period Ireland was poverty-stricken and affected by the famine and emigration. Modernity, which began intellectually with the Enlightenment, attempted to describe the world in rational, empirical and objective terms (Harvey 1990). It assumed that there was a truth to be uncovered, and that answers could be found to explain human conditions. Enlightenment led to the conception of insanity as a form of illness (Turner 1969). Considering that Porter (2002) noted this period was preceded by one which treated the insane as "wild beasts" who only responded to brutal interventions, the moral treatment approach must have been an enormous improvement in how the mentally ill were provided for. However, Foucault (1967) was highly sceptical of these developments with regard to the mentally ill. In fact he regarded it a form of "social control". Regardless of such criticism, this period saw the field of psychiatry burgeoning as a medical discipline (Stein and Santos

1998, pp. 6-8, WHO 2001, p. 49, Porter 2002). Porter (2002) was of the opinion that this period created a “forcing-house” which led to the establishment of the practice of psychiatry. Indeed, it was considered that “the asylum was not instituted for the practice of psychiatry. Psychiatry rather was a practice developed to manage its inmates.” (Porter 2002, p. 100).

Interestingly, such developments did not occur at the same pace in Ireland. The Irish Health Research Board (2004) noted in its report *The Great Confinement up to 1900* that even up to the eighteenth century the response to the mentally ill in Ireland was “sporadic and uncoordinated” (p. 14). In fact in the 1800s, Ireland was one of the first countries to establish laws for the control of the insane by implementation of such Acts as the Lunacy (Ireland) Act 1821, the Dangerous Lunatics (Ireland) Act 1838 and the Private Lunatic Asylums (Amendment) Act 1842. However as previously discussed, because of the abuse of the Dangerous Lunatics (Ireland) Act 1838, which based committals on information provided not under oath, the Central Criminal Lunatics Asylum Act 1845 was subsequently passed. This act required that evidence be given under oath prior to committing an individual to an asylum (O’Neill, 2005). Even allowing for such a substantial amendment to the Act it could still be considered coercive. According to Mercer *et al.* (2001) the idea of the “criminal lunatic asylum” is a result of British philosophical discourse in the nineteenth century. John Stuart Mill (1859) wrote:

“The sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others.” (Mill 1859, *Essay on Liberty*, p. 13)

This development allowed for the creation of an institutional environment for people who were deemed by society, to be both sick and dangerous. Broadmoor’s criminal lunatic asylum was established in Britain in 1863. This is important, considering that Ireland preceded Britain by some thirteen years in this development. In Ireland the Central Lunatic Asylum was established in 1850 to contain criminal lunatics. This development was a direct result of the murder of a respected businessman in Ireland by a ‘lunatic’. In 1845 a parliamentary committee was set up under Sir Edward Sugden, the Lord

Chancellor. It evaluated Irish lunacy provisions by examining specifically the need for prison-standard security for some of the patients in district asylums.

“Solid objections exist to criminals being received into district asylums which were never intended for prisoners. The advantage of bringing together all the criminal lunatics...are obvious. Their security could be easily provided for, and strangers could be prohibited from visiting that department from curiosity.” (Robins 1986, p. 149)

The Parliament passed an Act known as the Central Criminal Lunatics Asylum Act 1845. This Act made provisions for the committal of insane persons who had committed a crime. There were two main issues which resulted from this Act. Firstly, medical evidence was required to make a committal. Secondly, a person should be sent to a gaol (prison) initially and possibly later sent to an asylum. This was contrary to how similar matters were addressed in Britain. This led the opening of Dundrum Criminal Asylum 1850 (Central Mental Hospital, Dublin as it is known today). All criminal lunatics were to be confined here and not released until sanctioned by the Lord Lieutenant. The responsibility for the inspection of this asylum was transferred from the inspector general of prisons to the newly appointed ‘inspector of lunatics’, Francis White, giving him quite an amount of power. Some forty years later, in 1890, these roles were provided by medical practitioners. Within these institutions treatment was not the priority. It is particularly important to note that the approach to the mentally ill in these institutions conflicted with the general discourse across Western Europe which was influenced by the notion of “moral treatment” as discussed above.

During the nineteenth and twentieth century’s in Europe and the USA, there was a very different discourse regarding mental illness developing. This period, led the way to the birth of a ‘scientific approach’ in the treatment of mental illness. The Canadian Mental Health Association (1963, p. 2) attempted to explain mental illness as a result of disease and/or damage to the brain, or as the outcome of congenital and hereditary defects. Jacob (2008) asserted that the management of the mentally ill person did not arise from a need for care, but rather as a response to social revulsion and terror.

The work of Foucault has had an enormous influence on the development of the debate on modern psychiatry. Foucault’s work *Discipline and Punish: The Birth of the Prison* was first published in French in 1975 as *Surveiller et punir: Naissance de la prison*. It was

translated into English in 1977 (Foucault 1977). Foucault (1977) began to focus on the link between knowledge and power. By the mid-twentieth century Foucault (1977) was inquiring into the relationship between language and power. He revealed that part of the way the powerful stay in power is through a monopoly on 'truth' or 'knowledge'. Walker (2006) claimed that, with the emergence of democracy, politicians understood the need to manipulate public opinion. An example of this is the situation where the mental health profession defines what is 'normal' and what is 'pathological'.

Conrad (1992, p. 209) noted that the process of medicalisation of mental illness was a means by which a non-medical problem could be redefined as a medical one thus suggesting that it could be treated similar to any other illness. This process involved the use of medical language in its subsequent treatments. However, Foucault (1965) argued that this process also ensured a form of social control. Foucault (1973, 1977) suggested that this form of medical social control was perceived through a "medical gaze". Consequently, it has been noted that the medicalisation of mental illness also contributed to the notion of over-medicalisation (Conrad 2007, p. 146) followed by the concept of untreatability (Rabin 1993, Barkley 2000, Mason & Mercer 2000, Cohen & Morley 2009, Whitaker 2010, Szasz 2003, 2010) and the "amelioration of stigma" (Payton & Thoits 2011). Furthermore, Coid & Maden (2003) are of the opinion that the process of medicalisation of crime has contributed to the development of the discourse between mental illness and criminality. Mercer *et al.* (2001) claim that the medicalisation process applied to mentally ill offenders is a gradual process of psychopathologising in order to medically explain and understand specific behaviours. The consequence of this, as Mercer *et al.* (2001) assert, is the systemic movement of mentally disordered offenders from the social domain into institutional provision. These institutions function as instruments of social order and act as agents of social control (Foucault, 1965, Szasz, 1997).

Society's attitude towards mentally ill offenders can have major implications on how they are treated by the public (Lamb & Weinberger, 1998) and cared for by health professionals (Lyall, Holland, and Collins, 1995). Society's attitude towards mentally ill offenders can be influenced by many factors such as fear or sources of perceived danger. Indeed, Mitchell (2003) asserts that mentally disordered offenders are viewed by society

as offenders rather than mentally ill (p. 92). This may be influenced by how the mentally ill are portrayed in the media. Indeed Rogers as cited in Soothill *et. al.* (2008) comments on the impact of media coverage following a stranger-homicide committed by a 'madman' yet these are often rare occurrences (p.8). Media coverage of mental health issues has a negative effect on how people view those with mental health problems (Diefenbach & West 2007, Huntington 2008). This is often fuelled by sometimes inaccurate media attention to certain high profile cases. Diefenbach & West (2007) observe that people with mental health problems are more likely to be cast as violent criminals than non-mentally disordered television characters. The issue of public protection has led to the development of many policies which directly impact on conditions for mentally disordered offenders. However as Rueve & Welton (2008) assert, the mentally ill are no more likely to commit violent offences than any other member of society. The response to this issue is usually concerned with 'dangerousness' of the potential offender. According to Habermas (1987) risk assessment can be considered an instrument of social control to ensure that those whom society views as dangerous are directed towards institutions of social control such as prisons or secure hospitals. Consequently, in some cases this may lead to longer periods of incarceration for them than for the non-mentally disordered offender (Maguire *et al.* 2007). Being incarcerated for longer than necessary based solely on a prediction of dangerousness seriously impacts a person's human right.

More recently society is experiencing another shift in attitude toward mental illness. In Ireland, the introduction of the Mental Health Act 2001 (fully launched in 2006) and the Criminal Law (Insanity) 2006 paved a path which changes the focus of mental health service provision. The contemporary emphasis is now on providing mental health services which are rights-based. This transition in society's attitude is aptly described by O'Neill as follows:

"...the philosophy of the law has progressed significantly from the days of incarceration and control of 'lunatics' as a matter of public order when the issue of rights was considered anathema in the light of the 'problem' to be solved. It has moved from this stage to a welfare philosophy where the state's intervention was perceived as benign and as in the interests of the welfare of the person with mental illness so that the issue of rights was considered irrelevant. Now it is faced with a new challenge: that of

acknowledging that the recognition of the rights of the person with mental illness is an essential ingredient of the ethical carer/patient relationship". (O'Neill 2005, p. 32)

This perspective on mental illness moves away from a pathological focus to a social construct perspective. The social perspective of mental illness considers it in association with life events, cultural factors and personal characteristics. Foucault (1967) began to explore the way that knowledge and the increase of the power of the state over the individual have developed in the modern era. He deconstructed the concepts of illness and disorder and linked them to the development and maintenance of medical power discourse. Rolfe (2001), referring to Foucault's knowledge/power theory, looked at research within the world of healthcare and noted that randomised controlled trials (RCT) were of gold standard compared to qualitative approaches often used within mental health research. However the postmodernists' stance rejects this assumption. Postmodernists claim that in this situation those in positions of authority in healthcare research say what counts as knowledge and what does not.

Forensic psychiatry straddles two very powerful institutions within a society, psychiatry and the law. Foucault (1978) identified that courts began to accept psychiatric interpretations as a rationale for mitigation and leniency in certain cases, to as far back as the late 1700s. Mercer *et al.* (2001) show how professional power and knowledge converge and permeate institutions and structures. These institutions and structures are often frequented by mentally disordered offenders. So the mentally disordered offender can only be dealt with by one of two powerful institutions to which they are directed by instruments of social control (Habermas, 1987). One such instrument is the prediction of 'risk' by risk assessments. It is noteworthy that this notion of risk is a perpetuation of a modernist era practice.

Foucault (1977) asserts that "knowledge produces power". In order to examine the hidden meanings embedded within this particular knowledge/power relationship, it is necessary to deconstruct the relationship between them. Derrida (1976) referred to this as deconstruction by unveiling the contradictions within the text. Harper (1999) deconstructed mental health text as a means of challenging opposing terms implied within clinical categories. Harper's technique of deconstruction with regard to mentally disordered offenders revealed several challenges. The key challenging oppositions

identified with regard to mentally disordered offenders are: therapy/security, social control/individualism, deinstitutionalisation/reinstitutionalisation and patient/inmate.

2.3 Mentally Disordered Offenders, Mental Health, and Crime

Brett (2003) noted that the mentally ill in the criminal justice system are an extremely marginalised and discriminated group. This section provides a critique of the literature, legislation and policy documents in relation to mentally disordered offenders, mental illness and crime. Webb & Harris (1999, p. 2) note that mentally disordered offenders are a quite complex group because they do not fit exclusively into 'ill' or 'bad' categories. Hence discourses may not be compatible as cited by Maguire *et al.* (2007, p.496). Therefore, when conducting research involving mentally disordered offenders it is necessary to draw from several theoretical perspectives. Wessely & Taylor (1991) attest that over-reliance on any one theoretical perspective may impose limits on the various components of a study. It follows then that, due to the complex nature of people targeted by this research and in order to ensure a more objective approach, several theoretical perspectives were used to inform this part of the research. These are: socialisation theory, conflict theory and labelling theory.

2.3.1 Irish Mental Health Legislation

The law in Ireland regarding mental disorder and criminal insanity changed dramatically in 2006 with the implementation of the entire Mental Health Act 2001 and the enactment of the Criminal Law (Insanity) Act 2006. The Mental Health Act 2001 was formally enacted by the Irish Houses of the Oireachtas (Parliament) on 8 July 2001 and implemented in full on 1 November 2006. The reform of mental health legislation in Ireland was long overdue. Prior to the Mental Health Act 2001, the legislative framework was outdated and failed to address the rights of mental health service users. Furthermore, it failed to comply with international obligations and standards provided for by the European Convention on Human Rights and the United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care (1991).

The Mental Health Act 2001 replaces the majority of the provisions of The Mental Treatment Act 1945¹. It also replaces the Mental Treatment Act 1953, the Mental Treatment Act (Detention in Approved Institutions) Act 1961, the Mental Treatment Act 1961 and the Health (Mental Services) Act 1981 (Bulbulbia 2005). Kelly explains that the term 'mental disorder' is used throughout the Mental Health Act (2001) which includes "mental illness, severe dementia or significant intellectual disability". Mental illness is defined by the Act as "a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons". Severe dementia is defined by this Act as "a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression". Intellectual disability is defined as "a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person." (Kelly 2007, p.21) Mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's (2008) definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders."

Shortly after the enactment of the Mental Health Act (2001), the Criminal Law (Insanity) Bill was presented in the Seanad. This bill had its origins in the 1978 Third Interim Report of the Henchy Committee on Mentally Ill and Maladjusted Persons entitled 'Treatment and Care of Persons Suffering from Mental Disorder who appear before the Courts on Criminal Charges'.

¹ Part VIII (Superannuation of officers and servants of mental hospital authorities) and sections 241 and 276, 283 and 284 of the Mental Treatment Act 1945 are not replaced and are still in force.

The Criminal Law (Insanity) Act was enacted on 1 June 2006. The purpose of this Act was to clarify, modernise and reform the law on criminal insanity and fitness to be tried. Also it was intended to bring the Act into line with the jurisprudence of the European Convention on Human Rights. The enactment of the MHA 2001 and the CL(I)A 2006 has resulted in a change in focus that emphasises the need to deliver rights-based mental health services.

Kennedy (2007) notes that The CL (I) A 2006 appears to accept that principles are inherent and implicit. However, no formal statement of principles is given. The Mental Health Act 2001 clearly outlines its principles (section 4) which are derived from authoritative legal sources. Article 5(1)(e) of the European Convention on Human Rights says that no one may be confined as a person of unsound mind in the absence of medical evidence establishing that his mental state is such as to justify his compulsory hospitalisation. The Convention requires that the mental disorder "must be of a kind or degree warranting compulsory confinement".

2.3.2 *Human Rights Issues*

“Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.” (UN CESCR Article 12, 2000)

Every human being has the right to the highest attainable standard of physical and mental health, without discrimination of any kind. Enjoyment of the human right to health is vital to all aspects of a person's life and well-being, and is crucial to the realisation of many other fundamental human rights and freedoms. The reform of the legislation with regard to mental disorder serves the purpose of bringing Irish law into line with international standards. Indeed, the Mental Health Commission describes the Mental Health Act (2001) as bringing “Irish mental health law into line with the European Convention for the Protection of Human Rights and Fundamental Freedoms”. Similarly embedded within the Criminal Law (Insanity) Act 2006 is the establishment of an independent Mental Health (Criminal Law) Review Board. The main function of the Board is the regular review of all cases of detention in designated centres of persons found not

guilty by reason of insanity or unfit to be tried, as well as persons who have been transferred to the Central Mental Hospital from prison.

Section 33(3) of the Mental Health Act (2001) provides for the appointment of a Mental Health Tribunal for people who are involuntarily detained. Furthermore, Section (17) of this Act ensures that a person has the right to be represented at the Mental Health Tribunal by a legal representative appointed by the Mental Health Commission. Also contained within this section, is the stipulation that the Mental Health Commission must arrange for an independent medical examination of the patient to be carried out by a consultant psychiatrist. Prior to the introduction of the Tribunals by the MHA (2001), if an involuntary patient challenged the legality of their detention the only option was to make a *habeas corpus* application under Article 40 of the Constitution. The establishment of the Tribunals is critical to the introduction of a human rights approach to mental health services. In *X v. United Kingdom*², The European Court of Human Rights found that persons involuntarily detained in psychiatric institutions must have access to a speedy procedure for reviewing the legality of their detention, under Article 5 of the Convention. Consequently, in *Croke v. Ireland*³, the applicant brought *habeas corpus* proceedings challenging the legality of his detention in a psychiatric institution. However, The Supreme Court rejected that this person's detention under the Mental Treatment Act (1945) was unconstitutional. The applicant then applied to the European Court of Human Rights, alleging a breach of his rights under Article 5 of the Convention. The applicant succeeded in this case due to the absence of an independent and automatic review procedure prior to or immediately after his initial detention in a psychiatric institution (ECHR 2000).

The International Covenant on Economic, Social and Cultural Rights [ICESCR] (1976) did not embed the WHO's definition of health when drafting article 12. The Constitution of WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" WHO 1946, p. 100). However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical

² ECHR, *X v. the United Kingdom*, judgment of 5 November 1981, Series A, No. 46, p. 19, Para. 43.

³ ECHR, *Croke v Ireland* 33267/96(2000) 671/680.

and mental health” is not confined to the right to health care (Özden 2006, p. 40). In fact, it embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, conditions such as housing, nutrition and environmental factors (Özden 2006, p. 40). The ICESCR (2000) outlines the obligations of the member states involved in providing health care under article 12. These should include the following components: availability, accessibility, acceptability, and quality healthcare facilities. In 1991 the United Nations General Assembly adopted four texts specifically devoted to the rights of handicapped persons. Amongst these are the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. Principle 1 *Fundamental freedoms and basic rights* of the United Nations Principles states that:

“All persons have the right to the best available mental health care, which shall be part of the health and social care system.” (United Nations, Principle 1, 1991)

These principles are intended to ensure that all citizens have acceptable levels of access to appropriate mental health services and that such services be suited to their needs. Services provided must respect people’s fundamental human rights and dignity. Moreover, citizens with disabilities should enjoy equality of service access and provision (National Disability Authority [NDA], 2003). This is particularly interesting as Knight and Stephens (2009) draws particular attention to the fact that prisons are now linked to the treatment and human rights violations of mentally disordered prisoners.

Therefore in order to adhere to Article 3 of the ECHR, the principle of equivalence of care as enunciated in the United Nations Principles regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) must underpin the provision of mental health services to prisoners.

2.3.3 *Mentally Disordered Offenders*

Birmingham (2004) draws comparisons between forensic patients and prison inmates with mental health problems. According to Birmingham (2004) as cited by the Mental Health Commission (2006, p. 34) discussion paper on forensic mental health services in Ireland:

“persons detained in secure psychiatric hospitals and prison inmates have much in common. Both are particularly vulnerable to developing mental health problems. Histories of abuse, deprivation, homelessness, unemployment, substance abuse and previous contact with mental health services are commonly encountered.” (Birmingham 2004, p. 393)

Mentally disordered offenders can be described as individuals who have, or are alleged to have, broken the law and to have a mental disorder. It may also include those exhibiting challenging behaviour or deemed difficult to place (MHC 2011). Webb & Harris (1999) allude to a sense of confusion with regard to this group stating that “they are not exclusively ill or uncomplicatedly bad” (p. 2). James *et al.* (2002) suggested that this group may be more aptly described as “offending mentally disordered”. This may be due to the fact that many of these people are known to psychiatric services prior to their involvement with the criminal justice system (O’Neill 2006, WHO 2007). This factor is of major significance according to Peay (2003) because it has implications for how and by whom this group of people should be treated and cared for. Consequently Rogers as cited by Soothill *et al.* (2008) draws attention to the fact that people who offend and have mental health problems can be found in many different services which is a shift from the earlier belief that they may be associated with the forensic services solely.

The Criminal Law (Insanity) Act (CL(I)A) 2006 defines ‘Mental Disorder’ as mental illness, mental disability, dementia or any disease of the mind but does not include intoxication. Kennedy (2007) notes that the definition for a mental disorder provided in the Mental Health Act (2001) is different to that provided within the in the CL (I) A (2006). The Mental Health Act (2001) specifically excludes personality disorder, addiction to drugs and intoxicants and social deviance (sections 3 and 8 of the MHA 2001).

The CL (I) A has been criticised by Mills (2003) for its use of the term insanity. However McAuley and McCutcheon note that:

“..legal and medical evaluations of the conditions that might properly attract the label of ‘insanity’ can differ profoundly. The law regards several conditions, such as epilepsy and hypoglycaemia that medical professionals do not classify as mental disorders, as a basis for the insanity defence. This highlights the different perspectives of the relevant disciplines and it should be realised the defence raises a legal question of responsibility, not an issue of medical diagnosis and classification. Nevertheless, it is invariably the case

that medical evidence is adduced at trial and, it can be assumed, it is taken into account in the determination of the defendant's sanity. Thus, while a degree of congruence between the medical and legal evaluations can be expected, the ultimate resolution of the issue is one of law, not medicine." (2000, Pp 638-644)

Criminal responsibility is based on the principle that an individual possesses the capacity to make a rational choice with regard to committing a crime or not. Where a person, while understanding the significance of the act, performs it voluntarily and intentionally, he or she will be held responsible. In order to be guilty of an offence, it is necessary for the prosecution to prove all the required elements of the charge to the required standard of proof. This standard of proof must be 'beyond all reasonable doubt', which means that the evidence is so strong against the defendant as to leave only the remotest of possibilities that he or she is not guilty. It must be proven not only that the accused committed the act described (the *actus reus*), but also had the required 'state of mind' or *mens rea* (literally 'guilty mind') for the offence in question.

Bronnit & McSherry (2001) contend that there are some mental states that impair an individual's ability to meet these requirements. So, where a person behaves in a state of automatism, involuntariness may exculpate him or her from liability. Where, due to a 'disease of the mind', an individual is incapable of knowing that what they do is wrong, that person may be excused on the grounds of insanity. Similarly, a 'disease of the mind', short of insanity, may preclude an individual from forming the requisite intention for a particular crime. The M'Naghten rules form the basis for the test of insanity that the jury should be instructed to apply in each case of alleged insanity in this country.

The two rules are:

- (a) Presumption of sanity attaches to everyone that is everybody is presumed to be sane and to possess a sufficient degree of reason to be responsible for his/her actions, until proven otherwise.
- (b) To establish an insanity defence, it must be clearly proved that the accused was insane at the time of committing the act, that the accused was labouring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act or so as not to know that what s/he was doing was wrong.

A mentally disordered offender, who is convicted of a criminal offence and detained in a mental institution, will be detained under both the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006. Despite the ECHR's ambiguity over what constitutes a justifiable detention in relation to the mentally disordered, the European Court of Human Rights has interpreted and imposed a reasonably strict criterion. In the 1979 case, *Winterwerp v The Netherlands*, the European Court of Human Rights decided that the lawful detention of persons of unsound mind requires the observance of certain minimal conditions. *Winterwerp*⁴, the ECHR established three minimal standards that the government must adhere to, except in circumstances of an emergency, for the lawful detention of a person of 'unsound mind'. Firstly, a person must be shown to be reliably of 'unsound mind'. Therefore the government must establish "a true mental disorder before a competent authority on the basis of objective expertise" (*X v UK*, para. 40). Secondly, the mental illness must be of a 'kind and degree' that warrants confinement for care and treatment. Thirdly and finally, the legitimacy of detention is subject to the 'persistence' of a mental disorder.

However, a Court's interpretation of Article 5(4) has had a considerable impact on the detention of the mentally ill within the criminal justice system. In *E v. Norway* (1990)⁵, it was held that the review body must be legally empowered to conduct a review of a sufficient scope to bear on all of the conditions which are essential to the lawfulness of the detention. In *X. v. United Kingdom* (1981), a mental health review tribunal was held. This did not qualify as a 'court' for Article 5(4) purposes because it was limited to making advisory recommendations to the Home Secretary, and had no actual power of release. Further, it was held that habeas corpus proceedings were not sufficient to fulfil Article 5(4) requirements (Ní Raifeartaigh 2007, p. 22).

2.3.4 *Crime and Mental Illness*

The association between mental illness and crime has long been the focus of much debate and controversy (Gunn 1977, Monaghan & Steadman 1983, Prins 1990, Blackburn

⁴ ECHR, *Winterwerp v Netherlands* (6301/73 (1979) 4, para.38

⁵ ECHR, *E v Norway* (1990) 17 E.H.R.R. 30.

2001, Taylor 2004, Sirotich, 2008). According to Taylor (2004) the association between mental disorder and violence is only a modest one. A study by Brennan *et al.* (2000) and Asenault *et al.* (2000) suggest that there is a weak but definite association between schizophrenia and violence. However, Blackburn (2001) notes that the association between mental disorder and crime is not a straightforward one and that all research in this field suffers from major methodological problems which preclude more than tentative conclusions. Factors which are specifically highlighted include the clinical orientation of the researcher and the target population of the mentally ill being disproportionately represented (e.g. Taylor & Gunn 1984). Wessely & Taylor (1991) state that studies in the area have typically relied on samples whose representativeness is questionable.

Menezes *et al.* (1996) provide evidence of high levels of co-morbidity between serious mental illness and substance misuse. Soyka (2000) carried out an analysis of the literature on this topic and linked substance misuse in schizophrenia with male gender, high incidence of homelessness, more pronounced psychotic symptoms, non-adherence to medication, poor prognosis, violence and aggression. Soyka (2000) assert that substance misuse has been shown consistently to be a major risk factor for violence and disturbed behaviour among those diagnosed with schizophrenia.

2.3.5 Prevalence of Mental Illness in Prison Populations

A report by the National Economic and Social Forum (NESF) on Mental Health and Social Inclusion noted that prisoners were more susceptible to suffer from mental ill health and discrimination (NESF 2007). There are approximately nine million prisoners world-wide. At least one million suffer from a significant mental disorder, and even more suffer from common mental health problems such as depression and anxiety (WHO 2008). There is often co-morbidity with conditions such as personality disorder, alcoholism and drug dependence (Duffy *et al.* 2003, Linehan *et al.* 2006, and Wright *et al.* 2006). Duffy *et al.*'s study (2003) found that drugs and alcohol dependence and their harmful use were by far the most common problems, present in between 61% and 79% of prisoners. Additionally, homeless mentally ill persons are much more likely to be incarcerated than non-homeless (Crowley 2003, Duffy *et al.* 2003). For the more severe mental illnesses, rates of

psychosis were 3.9% amongst men committed to prison, 7.6% amongst men on remand and 2.0% amongst sentenced men. Women prisoners had psychosis in 5.4% of cases. Many of these findings are consistent with international studies which indicate that the prevalence of mental health problems amongst prisoners is significantly higher than that found in the rest of the population (Belcher 1988, Aderibigbe 1996, Singleton *et al.* 1998, Reed & Lyne 2000, Fazel & Danesh 2002). However the rate of psychosis in remand prisoners in Ireland is much higher than in comparable samples from abroad. This is most likely due to the fact the Republic of Ireland had no system of court diversion until 2005.

Ogloff (2007) reports that a number of contributing factors have been identified to help explain the high numbers of people with mental illnesses within the criminal justice system. Among these are deinstitutionalisation of mentally ill people, an increase in the use of drugs and alcohol by people with mental illnesses, and the limited capacity of community-based mental health services to address the needs of mentally ill offenders (Ogloff 2007). These factors agree with Penrose's law (1939), which showed an inverse relationship between the number of mental hospital beds and the number of prisoners in any given society. This suggests that a reduction in psychiatric hospital beds leads to an increase of mentally ill people in the criminal justice system. Indeed, Penrose's theory remains remarkably robust worldwide in countries which have adapted a community approach to mental health service provision (Biles & Mulligan 1973, Teplin 1990, Teplin & Abram 1996, Singleton *et al.* 1998, WHO 2007, p. 5). Ireland is not unique. Evidence from Irish studies confirms a strong association with Penrose's theory (Duffy *et al.* 2003, Linehan *et al.* 2006, and Wright *et al.* 2006). These studies indicate a steady decline in psychiatric inpatients alongside a steady increase in the number of prisoners (Brennan 2006, Kelly 2007). Kelly (2007) found that between 1963 and 2003, the number of psychiatric inpatients decreased by 81.5% (a five-fold decrease) and the average number of prisoners increased by 494.8% (a five-fold increase). However, according to Kelly (2007) Ireland's growth of prisoners with mental disorders markedly exceeds that of Great Britain. This may be due to several differences between these two countries, such as differing capacity limitations in prison systems, differences in criminal and mental health law, differences in mental health provision, or the emergence of different forms of re-institutionalisation (Kelly 2007, p. 374).

2.3.6 *Mentally Disordered Offenders, Prison and Social Control*

Knight and Stevens (2009) assert that the prison culture is based on the principles of punishment, security and control. Seddon (2006) argues that, as part of the shift from modernity to late modernity, by the end of the 1980s, prison was seen “less as a place for treating offenders and more as a place for containing them” (p. 55). However the Bradley Report (2009) highlighted that, while public protection remains the priority, there is a growing consensus that prison may not always be an appropriate environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide. WHO (2001) report that there are factors in many prisons that have negative effects on mental health, including: overcrowding, various forms of violence, enforced solitude or conversely, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects and inadequate health services, especially mental health services. Foucault (1977) described a prison as the “apex of a carceral archipelago” that in modern society spread downwards to encompass orphanages, charitable societies, and a wide variety of other organisations and institutions employing disciplinary and surveillance mechanisms. Prisons have historically had three functions: custodial, coercive and punitive (Morgan & Liebling 2007) as cited by Maguire *et al.* (2007). According to Foucault (1977) the modern prison, with its mechanisms of total surveillance, represents a new form of knowledge and power. Foucault’s seminal study *Discipline and Punish: the Birth of the Prison* (1977) examines the evolution and devolution, of western society’s theories on punishment. He applies this notion of power in tracing the rise of the prison system in France and the rise of other coercive institutions such as monasteries, the army, mental asylums, and other technologies of social control. Foucault claims that institutionalization was a form of controlling the socially undesirable. It was a state-sponsored method of “policing public hygiene” and ridding society of difference (Foucault 1977). These prisons, Foucault goes on to explain, like many institutions in post-seventeenth century society isolate those that society deem abnormal. This isolation seeks to attack the souls of people in order to dominate them in a way similar to how the torture and brutality of pre-seventeenth century society sought to dominate the physical

bodies of prisoners. Castel, Castel and Lovell (1979) state confinement was the method whereby society could control and exclude deviants. They describe this movement as a response to a collective fear where the reproduction of deviant individuals needed to be prevented. Jacob (2008) used the term social castration to describe confinement. According to Foucault (1995), confinement permitted the creation of a space for surveillance and behaviour modification. This was evident in the Minister for Justice Gerald Boland's (1944) response to criticisms of conditions in Dublin's Mountjoy prison as cited by Kilcommins *et al.* (2004, p. 58):

"...I do not pretend that Mountjoy is a heaven on earth, and it was never intended to be. Surely to goodness, not alone must we try to reform those people but there must be some element of punishment. Surely we are not going to namby-pamby as to make Mountjoy and Portlaoise so attractive that there would be a rush for accommodation there." (Dáil Debate 19 April 1944)

Dr Noel Browne described institutions as having the same objective of rendering deviant bodies and souls docile (as cited by Kilcommins *et al.* 2004). Ignatieff (1978) wrote that:

"...It was no accident that penitentiaries, asylums, workhouses, monitorial schools, night refuges and reformatories looked alike, or that their charges marched to the same disciplinary cadence. Since they made up a complementary and interdependent structure of control, it was essential that their diets and deprivations be calibrated on an ascending scale, school-workhouse-asylum-prison, with the pain of the last serving to undergird the pain of the first." (Ignatieff 1978, pp 214-215)

The effects on people in these institutions were similar. Russell Barton (1959/1976) describes 'institutional neurosis' as being characterised by symptoms such as apathy, lack of initiative, loss of interest and submissiveness. The cause of institutional neurosis was said to be factors such as loss of contact with the outside world, enforced idleness, brutality and bossiness of staff, loss of friends and personal possessions, poor ward atmosphere and loss of prospects outside the institution. Similarly, Erving Goffman (1961) described the 'total institution' as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" p. (xiii). In fact Nolan (1993) reports that Goffman's theory on the total institution referred to

psychiatric hospitals or asylums as 'dumping grounds' (p.14) used to rid society of the helpless. Prisons and asylums are a clear example of such institutions (Foucault 1977). So breaking the law was not necessary to get into prison-like institutions, such as asylums, but the institutional effects were similar. Perron, Fluet and Holmes (2005) state that health professionals are part of a political network of control over life (bio-power) that serves to regulate and govern individuals through discipline of the body and healthcare institutions function under these rigid terms of disciplinary power.

Foucault (1980) describes the power relation between the government and the governed as creating knowledge of human sciences. He refers to this as power-knowledge. In Foucault's interpretation, freedom from the pervasive influence of power is impossible. Because his conception of power exists not just in individual institutions of society like prisons but instead exists in the structure of society and more importantly in peoples through systems, escape from social control is impossible. Foucault (1977) wrote about how even the reforms in the system have been co-opted to further the goals of the state. Instead of a lessening of social control Foucault sees that the technologies change from the wheels and gallows of the seventeenth century to the disciplinary society of the nineteenth century to the emerging carceral city of the future. In this carceral city the dispersion of power will be complete. The technologies of control will emanate from all parts of society, walls, space, institution, rules, and discourse.

2.3.7 Mental Health Care in Prison

Knight and Stephens (2009) contend that prison ethos conflicts with the principles of health care provision which emphasise self-determination underpinned by a philosophy of recovery. O'Neill (2006) describes prisons as "toxic and inappropriate environments" (p. 87) in which to care for people with major mental illnesses. As mentioned earlier, Knight and Stephens (2009) assert that prisons, due to the growing numbers of people with mental health problems, provide inadequate treatment and so give rise to human rights violations of prisoners. This is particularly important considering that people do not surrender their rights to mental health care when they enter prison as is clearly outlined in Principle 20.2 with regard to criminal offenders:

“All such persons should receive the best available mental health care as provided in Principle 1.” (General Assembly Resolution 46/119 of 17 December 1991)

The right to the highest attainable standard of health is explicitly retained:

“States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees...to preventive, curative and palliative health services”. (UN Committee on Economic, Social and Cultural Rights, 2000)

States have a legal obligation under the European Convention on Human Rights to safeguard the health and well-being of people they hold in custody. Indeed Coyle (1997) notes that prisons should not be places of “depravity and inhumanity” (p. 32).

However the fifth report on Ireland from the Council of Europe Committee for the Prevention of Torture and Degrading Treatment (2011) is the most critical yet of the Irish prison system. It made the damning indictment of a prison system that is failing to meet the most basic human rights standards of safe and humane custody. It drew particular attention to the fact that mental healthcare was inadequate, as instanced in poor record keeping, over-reliance on medication and dirty observation cells. The Council of Europe Committee for the Prevention of Torture and Degrading Treatment (2011) report elaborates on the points made by Dressing & Salize (2009) in their report of the views of a panel of experts about prisons. The issues referred to include lack of places for psychotherapeutic treatment programmes, lack of beds for psychiatric inpatient treatment, and lack of appropriately trained staff. Other deficiencies were insufficient mental state screening routines, deficient or absent psychiatric aftercare, under funding, and insufficient cooperation with the general health systems (Dressing & Salize 2009).

Indeed, prisoners have a right to access a standard of healthcare that is equivalent to that available in the general population. The Irish Prison Service (2009) in its annual report highlighted its intentions of providing a range of care services to prisoners to a standard commensurate with that pertaining in the wider community. However, even with the availability of ten new beds at the Central Mental Hospital Dublin in 2008, there are still unacceptably long waiting lists for prisoners with mental health problems within Irish prisons.

Duffy *et al.* (2003) notes that there are three major points at which the Irish system departs from an equivalence with community psychiatric practice. In the first place, there is incomplete provision of treatment modalities in the prisons such as psychology services, occupational therapy and counsellors which may be available on an outpatient basis or as part of a day hospital treatment programme in the community. Secondly, patients requiring inpatient hospital treatment are transferred to a special security hospital (Central Mental Hospital) regardless of their security needs. And thirdly, acutely disturbed patients with mental illness in prison are often confined to isolation cells ('strip'/'pad').

The WHO (2006) is of the opinion that the detection, prevention and proper treatment of mental disorders, together with the promotion of good mental health, should be both a part of the public health goals within prison, and central to good prison management. However, it is well documented that many service deficiencies continue to exist (WHO 2006, Brooker *et al.* 2009, Dressing & Salize 2009, The Council of Europe Committee for the Prevention of Torture and Degrading Treatment, 2011). Brooker *et al.* (2009) reported a lack of screening processes that pick up problems when prisoners are committed and inadequate care in prisons in the United Kingdom. WHO (2006) urged that primary health care providers in prisons should be provided with basic training in the recognition and basic management of common mental health disorders. James *et al.* (2002) indicate that diversion schemes can majorly improve the recognition of mental illness and expedite admission to hospital. The ranges of diversion options are legislatively limiting as yet in Ireland (Whelan 2007). In fact even the most recent amendments to the Criminal Law (Insanity) Act 2010 did not include formalized provisions for a diversion scheme in Ireland. Furthermore, Dressing & Salize (2009) note that prisoners in Irish prisons do not have routine assessments prior to release. This can have major consequences on the reintegration of mentally disordered offenders into the community. This will be explored in greater detail later in this chapter.

2.3.7.1 Irish Prison Mental Health Service Provision

Dressing & Salize (2009) report that in Ireland the responsibility for prison mental health is that of the Department of Justice and Law Reform. This is further emphasised in the IPS Annual Report (2009) which states that the provision of healthcare is a statutory

obligation of the Irish Prison service. Dressing & Salize (2009) note that in Ireland, like many other European countries general practitioners screen all new prisoners on committal. Many GPs do not necessarily have training in specialist areas such as mental health. This may result in poor recognition of mental health problems at an early and often vital point (Brooker *et al.* 2009). The Irish prison service proposes to provide a model of primary mental healthcare ensuring that the principle of equivalence is adhered to. Currently the majority of mental health services are provided by consultation and liaison with the Central Mental Hospital (CMH). In-reach services are provided through collaboration with the CMH who provides specialised assessment and treatment. Dressing & Salize (2009) contend that in Ireland, inpatient treatment for psychotic prisoners is provided exclusively by forensic hospitals. Whereas in countries such as Cyprus, Denmark, Norway, Iceland, and Slovenia the referral of psychotic prisoners to psychiatric hospitals in the national health system, is the most frequently used option (Dressing & Salize 2009).

The Central Mental Hospital's National Forensic Mental Health Service provides twenty-one consultant-led in-reach sessions weekly at all Dublin prisons and also at Portlaoise and the Midlands prisons (IPS 2009 p.40). However, there are thirteen prisons situated around Ireland. This means that Cork, Limerick and Castlerea prisons have limited input from the National forensic mental health service. In 2005 Ireland's first Psychiatric In-Reach and Court Liaison Service (PICLS) was established. It operates from Cloverhill remand prison in Dublin. In 2008, ninety-one patients were diverted with sixty-seven going to community health facilities and twenty-four to general psychiatric hospitals. During 2009, one hundred and three patients were diverted – sixty-two to community health facilities and forty-one to general psychiatric hospitals (IPS p. 43).

Notwithstanding the huge personal and emotional costs for individuals and their families there are also enormous financial costs to the economy in sending people with mental health problems into prison. According to O'Shea & Kennelly (2008) the approximate cost of keeping people with mental health problems in prison was €22,629,000 in 2006. This figure is based on the prevalence rate of psychosis of 7.6% among remand male prisoners in Ireland (Linehan *et al.* 2005).

2.3.7.2 Model of Forensic Mental Health service for Ireland

The literature reveals various examples of what constitutes forensic mental health services. The word 'forensic' implies an association with the courts of law. The Faculty of Forensic Psychiatry of the Royal College of Psychiatry defines forensic psychiatry as a "speciality in psychiatry concerned with helping people who have mental disorder and who present a significant risk to the public" (cited by Mental Commission 2011, p. 7). However, Gordon and Lindqvist (2007) provide a much broader perspective on forensic mental health services. According to them, the composition of forensic mental health services includes the interface between mental health and the law, affording expert evidence in civil and criminal courts, and the assessment and treatment of mentally disordered offenders and similar patients who have not committed any offences.

According to Kennedy (2006) Ireland does not have or does not need a maximum security hospital due to its small population. However the Mental Health Commission (2005) recommends a regionalised forensic service model for Ireland. This would provide several high, medium and low security units throughout the country. Kennedy (2006) advocates a 'flat hub and spoke' model to ensure a better and more accessible service. This model is in line with the principles set out by the DoHC (2006) for a contemporary forensic mental health service.

"Every person with serious mental health problems coming into contact with the forensic system should be afforded the right of mental healthcare in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done."
(DoHC, p.136)

2.4 Pathways to Mental Health Care

There is no universal definition for pathways into care. It generally refers to the routes taken by people to seek help for health problems from statutory services after onset of symptoms. Thornicroft & Tansella (1999) elaborate further to include the subsequent sequence of contacts within an episode of care. Access to mental health services can vary from GPs, A&E departments, voluntary organisations, police, the courts and the prison system.

Morgan *et al.* (2004) suggest that the pathway to care has to be studied as a social process subject to a wide range of influences, including the cultural context within which illness is experienced. Mechanic (1968) described the concept of illness behaviour, which broadly refers to the ways in which individuals and others, perceive, evaluate and act upon the symptoms of illness. Pescosolido (1998) refers to research identifying two perspectives on mental health service use. Firstly, the medical perspective, developed originally in social psychology and sociology, examines entry into care as a subset of medical service use by applying the medical utilisation model (e.g. Koos 1954, Anderson 1963). Secondly, there is the legal perspective whereby coercive mechanisms are used to force people into care against their will (e.g. Lidz & Hoge 1993). Thornicroft & Tansella (1999) suggest that an analysis of patients' pathways can reveal key local weaknesses, such as points at which referrals fail to connect, or areas of wasteful overlap, where several agencies concurrently provide similar services. Morgan *et al.* (2004) conducted a review of the literature in which they argued that the understanding of pathways into care is incomplete as it focuses on medical frameworks only. Service delivery involves many different professionals and organisations which can often lead to confusion and conflict. Goffman (1961) was seminal in his writing of the illness career for people with mental illness. He contested that the hospital played a pivotal role in the development of one's illness career. Thus the long term affect being that a person became institutionalised (Goffman 1961). However more recently the term 'illness career' is used to describe the sequence of actions related to the attempt to rectify a health problem (Pescosolido 1992, p. 1111). This firmly places the topic of pathway to care within a sociological theoretical framework (Pescosolido 1992, Pilgrim *et al.* 2011). Many of the sociological studies on pathway to care refer to this issue in terms of a social process which involves many others in the help-seeking behaviours such as clergy, police, legal professions as well as family and friends (Freidson 1970, Kadushin 1966 as cited by Pescosolido 1992). Furthermore, Lincoln & McGorry (1995) suggest one of the main barriers for not receiving help for mental health problems is having a poor social network. This is particularly noteworthy considering a major concern for service users upon discharge from an acute psychiatric setting involved achieving social integration (Nolan *et al.* 2011). This involved developing or maintaining interpersonal relationships as well as matters of finance, accommodation and employment (Nolan *et al.* 2011).

2.4.1 Overview of the Literature on Pathways to Mental Health Care

An exploratory review of the research on the topic of pathways to care revealed a diversity of perspectives, of methodological approaches and of designs utilised. Several studies explored pathways to mental health care from a range of different perspectives such as ethnicity (Bhugra *et al.* 1997, 2004, Tsakanikos *et al.* 2010), intellectual disabilities (Bookle *et al.* 2010, Tsakanikos *et al.* 2010), child and adolescent (Sayal 2006, Boydell *et al.* 2006, Cratsley *et al.* 2008), personality disorders (Hayword & Moran 2007), and offenders with mental health problems (Melzer 2000, 2007, Mezey 2007, Howerton *et al.* 2007, Dressing & Salize 2009). The vast majority of these studies were concerned with access to mental healthcare within the prison system or after release (Melzer 2000, 2007, Mezey 2007, Howerton *et al.* 2007, Dressing & Salize 2009). Several studies focused on the influence of many different factors on a person's pathway to mental healthcare, factors such as access, geographical location, and early intervention/duration of untreated psychosis, service use, first episode psychosis and satisfaction with service provision (Gater *et al.* 1991, 2005, Steel *et al.* 2006, Singh & Grange 2006, Brunet 2007, Coton *et al.* 2008, Lahariya *et al.* 2010). Reflecting on a comprehensive review of the literature on this topic it was clear that various methodologies were applied. The majority used quantitative approaches and only two used a mixed-methods approach (Bhugra 2004, Rogers 2002). There was no consistency found in terms of the instruments used in these studies. The types of instruments used ranged from Pathways Encounter form (different versions), Interviews and Psychiatric & Personal History Schedule. Also a large amount of the studies used secondary sources to collect data, sources such as case notes, family, carers, clinicians' views or published literature reviews (Lincoln & McGorry 1995, Sayal 2006, Melzer 2000, Boydell *et al.* 2006, Cratsley *et al.* 2008). Some of these sources were used either solely or in conjunction with each other. Overall the majority of the studies on this topic merely describe factors such as service provision/utilisation and referral rates.

The following sections will present the literature on this topic and integrate it specifically under three main headings:

- mental health policy and practice in Ireland,

- factors influencing access to mental health care and
- help-seeking behaviours of mentally disordered offenders.

2.4.2 *Mental Health Policy and Practice in Ireland – an overview*

In 1966 the Government Commission of Enquiry on Mental Illness began the pattern of change to a modern mental health service. The main recommendations of this enquiry were

- to provide small acute psychiatric units in general hospitals,
- to provide a range of community based facilities,
- to develop multi-disciplinary teams,
- to involve general practitioners more in mental health care, and
- to develop child psychiatric services.

Little money was spent and very slow progress was made toward reaching these targets (Webb *et al.* 2002). This was followed by *Planning for the Future* (Department of Health, 1984), which was the result of a major review of the Irish mental health services. This policy suggested many changes to the way in which services would be delivered. However, most of its recommendations never came to fruition. According to Walsh (1988) one of the main reasons for this was that health services were over-institutionalised and there was unwillingness on behalf of trade unions during this period of high unemployment to move towards community-based services which could have resulted in job losses. Change has been very slow, clear deficiencies in services remain such as long waiting times and important services remain underdeveloped *Quality & Fairness - A Health System for You* (Department of Health & Children 2001). Furthermore, the document states that “by doubling health funding over the last four years, the Government has moved the debate on health funding from resources alone to both resources and reform” (Department of Health & Children 2001, p 10). This is particularly relevant as O’Shea and Kennelly (2008) note a 50% decline in the GDP spent on mental health services in Ireland between 1984 and 2005, from just under 14% in 1984 to 7% in 2005. In 2010 spending on mental health services fell to 5.3% of the health budget which is almost 3% less than the recommended expenditure of 8.24% on mental health (DoHC

2006). Ireland's expenditure on mental health falls way behind many of our European neighbours such as Luxemburg, the United Kingdom or Sweden. O'Shea and Kennelly (2008, p.5) observe that Ireland's per capita expenditure on mental health has increased considerably since 1984 but most of this is spent on salaries rather than new services.

Long overdue reform of the legislation on mental health was enacted in 2006 and the same year saw the launch of a comprehensive policy framework for mental health services for the following seven to ten years - *A Vision for Change* (DoHC 2006). However, these major advancements in Irish mental health legislation and policy happened twenty-two years after publication of *Planning for the Future* (DoH 1984). The policy of *A Vision for Change* (DoHC 2006) aimed at updating and extending *Planning for the Future* (DoH 1984). Yet a fundamental difference between these two policy documents is the consumer-oriented approach to the delivery of services adopted by *A Vision for Change*. The overarching principle for the delivery of mental health services in Ireland is now dependent on a primary care approach (DoHC 2006). The Department of Health and Children defines primary care as:

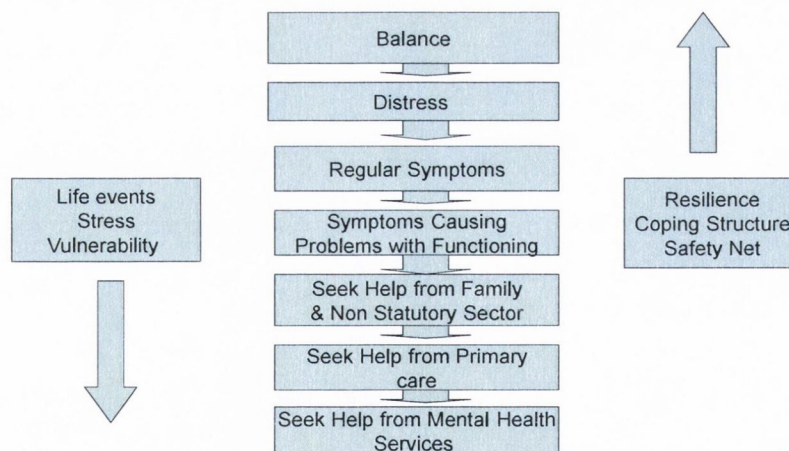
“Primary care is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.”

(*Primary Care: A New Direction* p. 15)

Primary care is regarded as the first point of contact that people have with a healthcare provider. This level of access to healthcare should be available to all people regardless of who they are, where they live, what their income is or what health and social problems they may have (DoHC 2001, p.15). The model of primary care promoted for Ireland is intended to ensure that services are coordinated and integrated across the boundaries of health and personal social care to the benefit of the consumer in terms of better quality, better outcomes, better cost-effectiveness and better health status (DoHC 2001, p.15). Such a development in health care provision is consistent with *The Declaration of Alma-Ata*, which outlined the importance of the concept of primary healthcare in the promotion of quality healthcare (WHO 1978).

As stated earlier primary care is generally regarded as the first point of contact people have with the health and personal social services (DoHC 2001). The WHO reiterated the importance of primary care in mental health in its report *Mental Health: New Understanding New Hope* (2001). This report recommended that treatment for people with mental disorders should be provided in primary care as this “enables the largest number of people to get easier and faster access to services”. The key role of primary care in the recognition, assessment and treatment of Mental Health issues is clearly articulated in the national policy document *Vision for Change* (2006). The Irish College of General Practitioners point out from its observations of the development of the UK primary care mental health services that "the cardinal requirement for mental health services in this country is not a large expansion and proliferation of psychiatric agencies but rather a strengthening of the family doctor in his/her therapeutic role." Figure 1 shows a typical, albeit simplistic, view of a pathway through care service (DoHC 2006 p. 22).

Figure 2.1 Possible Pathways through Services (McKenzie et al. 2004)



There is no doubt that the process of deinstitutionalisation of mental health services and the establishment of services in primary care, community centres and general hospitals, in line with patient and family needs, can support social inclusion (European Commission, 2005, Salize *et al.* 2008, p. 527). Primary care is vital for two reasons. Firstly, most mental health problems are dealt with in primary care without referral to specialist

services and secondly, the GP in primary care is also the main access point to specialist mental health care for most of the population. GPs have a key role as 'gatekeepers' to the mental health service (DoHC 2006).

In Ireland, however, general practice is a private enterprise with the vast majority of people paying for GP services out of their own pockets (Wren, 2003). The state pays for approximately thirty per cent of the population in the form of a capitation fee (Hyde *et al.* 2004). DoHC (2001) affirmed that non-medical card holders will continue to meet their own general practitioner costs and to pay modest charges for treatment as public patients in public hospitals. Wren (2003) described how the hybrid payment system for GPs creates multiple tiers within primary care. Hyde *et al.* (2004) highlight the importance of equity, and of improved access to mental health services. However in areas of social and economic deprivation this problem is further compounded by the difficulty of recruiting GPs where mental health needs are the greatest (DoHC 2006). Consequently people whose mental health problems are not adequately addressed have a very high risk of ending up in prison (O'Shea & Kennelly 2008, p. 37).

2.4.3 *Factors Influencing Access to Mental Health Care*

Gater *et al.* (2005) suggest that an understanding of the way people seek care for mental health problems is increasingly recognised as important for planning mental health services. It is not uncommon for people with mental health problems not to seek help for them (Bebbington *et al.* 2000, Okello 2007). The World Health Organisation (2003) reported that approximately 47% of people with major depression remain untreated. Lay supports are often the preferred choice of support for people with mental health problems (Oliver *et al.* 2005, Biddle *et al.* 2004). However it is particularly interesting to note that many individuals, particularly males, choose not to seek any form of help for mental health problems (Oliver *et al.* 2005). Okello (2007) suggests that this may result in a delay in gaining access to appropriate care and treatment thus affecting the prognosis of the problem.

Many models of help-seeking have been identified and described within the literature (Andersen 1995, Aday & Andersen 1974, Goldberg & Huxley 1980, Goldberg 1995). Goldberg & Huxley (1980, Goldberg 1995) developed their model in order to understand

better the various points at which people seek help for their mental health problems. This model outlined different levels of engagement with mental healthcare services in the community, primary care and in-patient services. The five levels at which mental health problems could be apparent are:

- (a) in the community,
- (b) among attendees of primary care,
- (c) as recognised by primary care providers,
- (d) among individuals referred to outpatient mental health services, and
- (e) among those admitted to hospitals.

Conceptually people move through filters from one level to another in order to gain access to the most appropriate mental health care and treatment. Zwaanswijk (2005) describes the various filters. The first filter occurs when the problem is recognised by the individual and the decision to consult a GP is made. The second filter involves the GP recognising the problem. The third filter is engaged when there is a referral to mental health care by the GP. The final filter occurs with the admission to a mental health care facility. The GP has a gatekeeper function and a central role in the help-seeking process. This model is useful not only in understanding epidemiological findings and pathways into care, but also as the starting point for evaluating the needs of patients with mental illness. However O'Sullivan *et al.* (2007) urged that this model grossly underestimates referral to psychiatric services if used in isolation.

Many factors are associated with why people do not seek help for mental health problems. Goldberg & Huxley (1980) suggest that barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness by health professionals and lack of understanding about the benefits of services by professionals and potential service users. Paykel *et al.* (1998) suggest some reasons for a reluctance to seek help from GPs. These include stigma, lack of confidence in health professionals, being prescribed pills and fear of being labelled and its subsequent consequences. Other barriers reported are self-identification of a mental health problem, lack of or poor insight, and embarrassment, difficulty in discussing mental health problems, and overestimation of one's coping abilities (Wing *et al.* 1994, Wrigley *et al.* 2005)

According to Boydell *et al.* (2006) the pathway to mental healthcare may be non-linear, complex and dynamic. A UK study on ethnic minority groups showed that black people were less likely to come through primary care services and were also most likely to be dissatisfied with primary care compared with white people (Bhugra *et al.* 2004). Lincoln & McGorry (1995) explored pathways to care for young people experiencing a first episode of psychosis. Shaw (2007) concentrated her research on pathways to care taken by adolescent offenders with mental health problems within a British prison. Hayward & Moran (2007) studied personality disorder and pathways to inpatient psychiatric care. Again in another UK prison based study, Howerton *et al.* (2007) explored factors that influence help-seeking for mental distress among offenders at both pre and post release stages. Howerton *et al.* (2007) found that factors such as distrust and lack of confidence in primary mental health services following release to be major barriers in seeking help for their mental health problems.

2.4.4 *Help-seeking Behaviours among Mentally Disordered Offenders*

There is limited research exploring help-seeking behaviours among mentally disordered offenders in particular. Howerton *et al.* (2007 p. 1) highlight that this group is predominantly more likely to be associated with lower socioeconomic status, increased level of impulsivity, limited coping skills, social isolation and a history of self-harm and attempted suicide. Mentally disordered offenders are much more likely to be homeless (Crowley 2003, Duffy *et al.* 2003). Furthermore, drug and alcohol dependence is much more prevalent among mentally disordered offenders (Kennedy 2003).

Paykel *et al.* (1998) suggested that one of the main reasons for not seeking help from a GP for a mental health problem is stigma. However, for mentally disordered offenders, in particular, the stigma experienced is often much greater. Indeed, Hartwell (2004) refers to the notion of triple stigma experienced by mentally disordered offenders. Edwards (2000) describes how stigmatisation can affect ex-offenders' in terms of finding a job and social acceptance after serving their sentence. This experience is consistent with Cusack's *et al.* (2003) Foucauldian perspective on stigma which shows not only how power can be seen to work, but also how it acts in an adverse manner.

Howerton *et al.* (2007) ex-prisoners with mental health problems stated that distrust and lack of confidence in primary mental health professionals would discourage them from seeking help. Deane *et al.* (1999) note that offenders often found it difficult to establish a therapeutic alliance with health professionals upon release from prison. Deane *et al.* (1999) are of the opinion that this may be due to the fact that their only experience with figures of authority has been in the context of abuse or coercion. Grant (2007) asserts that negative attitudes about mental disorders held by correctional staff and health professionals, and the culture among other inmates may deter people from seeking help. Howerton *et al.* (2007) reported that offenders wanted their GP to listen to them, to provide appropriate information, to treat them with respect and compassion.

Beresford (2005) alludes to a pharmacological dominance due to the mental health system's over-reliance on drugs and their crude usage in practice (p. 87). Medical intervention can help but may often need to be combined with other treatment approaches. Tedstone Doherty *et al.* (2008) do acknowledge the need for a more combined approach for the treatment of mental health problems (p. 53). Hence, Mezey (2007) suggests that, strategies to enhance social inclusion for offenders are as important as medical interventions for example, housing support, education, access to work, and specialist input from probation services and the voluntary sector

2.5 Conclusion

The growing number of people with mental health problems raises much concern and debate on both humanitarian and ethical grounds in society. It is evident from the literature that it is necessary to map the pathways to care of people with mental health problems within the criminal justice system while trying to gain access to and maintain links with mental health services before entering prison. Central to this is the gaining of an understanding of this issue from the perspective of the service user. This will provide an opportunity to plan more appropriate services and resources for this population.

It is clear from this review of the literature that prison is an unsuitable and quite often inappropriate environment for people with mental health problems. The Bradley Report (2009) shows that, while public protection remains the priority, there is a growing consensus that prison may not always be an appropriate environment for those with

severe mental illness and that custody can exacerbate mental ill-health, heighten vulnerability and increase the risk of self-harm and suicide. WHO (2001) reports that there are factors in many prisons that have negative effects on mental health. Foucault's seminal study *Discipline and Punish: the Birth of the Prison* (1977) examines the evolution and devolution, of western society's theories on punishment. Foucault (1977) contends suggests that institutionalisation was a form of controlling the socially undesirable in that it was a state-sponsored method of "policing public hygiene" and ridding society of difference (Foucault 1977). However it is contended that the criminalisation process was a direct result of the deinstitutionalisation policy introduced by many countries worldwide (Penrose 1939, Teplin 1984, Abram & Teplin 1991). This process resulted in an extensive number of individuals with mental illness being directed towards the criminal justice system rather than to the health system. Panzer *et al.* (2001, p. 41) posited that prisons now had a new function to incarcerate a growing number of people with mental illness. They go on to observe that people with mental illness were sent to jail at about eight times the rate at which they were sent to public psychiatric hospitals.

WHO (2007) report that there are nine million prisoners world-wide, of whom at least one million suffer from a significant mental disorder, and even more suffer from common mental health problems such as depression and anxiety. There is often co-morbidity with conditions such as personality disorder, alcoholism and drug dependence. Gunn (2004) noted that there has been a steady reduction in psychiatric beds over the past twenty years but a continuing increase in the number of mentally ill offenders and an increase in the general prison population with major mental problems (cited by Penhale & Parker 2007, Brennan 2006). Penrose's law (1939), showed an inverse relationship between the number of mental hospital beds and the number of prisoners in any given society, suggesting that a reduction in psychiatric hospital beds leads to an increase of mentally ill people in the criminal justice system. In Ireland, figures show the occurrence of a similar trend. Figures indicate a steady decline in psychiatric inpatients corresponding to a steady increase in prisoners (Brennan 2006, Kelly 2007). Kelly (2007) found that between 1963 and 2003, the number of psychiatric inpatients decreased by 81.5% (a five-fold decrease) and the average number of prisoners increased by 494.8% (a five-fold increase).

The association between mental illness and crime has long been the focus of much debate and controversy (Gunn 1977, Monaghan & Steadman 1983, Prins 1990, Blackburn 2001, Taylor 2004, Sirotich, 2008). However, Blackburn (2001) notes that the association between mental disorder and crime is not a straightforward one and that all research in this field suffers from major methodological problems which preclude more than tentative conclusions. Points which are specifically highlighted include the clinical orientation of the researcher and the fact that the target population of those who are mentally ill being disproportionately represented (e.g. Taylor & Gunn 1984). Wessely & Taylor (1991) state that studies in this area have typically relied on samples whose representativeness is questionable.

Gater *et al.* (2005) suggest that an understanding of the way people seek care for mental health problems is increasingly recognised as important for planning mental health services. Goldberg & Huxley (1980) described different levels of engagement with health care in the community, primary care and in-patient services. Their model is useful not only in understanding findings and pathways into care, but also as the starting point for evaluating the needs of patients with mental illness. Barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of services (Goldberg & Huxley 1980). Singh & Grange (2006) state that pathways to care need to be viewed as a broad concept to include help-seeking behaviours, service use as well as non-sought routes to mental healthcare such as the justice system and A&E departments. As suggested earlier, Morgan *et al.* (2004) note that pathways to care need to be studied as a social process subject to a wide range of influences, including the cultural context within which illness is experienced. Singh & Grange (2006) assert that, there are two ways to research pathways to care. The first focuses on service utilisation and the second on exploring pathways to care from a community perspective in the context of social process.

In order to plan services effectively, there is a need to gain an understanding of the experiences of people with mental health problems within the Criminal Justice System in trying to access/maintain a link with mainstream mental health services prior to incarceration.

CHAPTER THREE – METHODOLOGICAL AND PHILOSOPHICAL ISSUES

“Scientific principles and laws do not lie on the surface of nature. They are hidden, and must be wrested from nature by an active and elaborate technique of inquiry.”

(John Dewey, *Reconstruction in Philosophy*, 1920, p. 32)

3.1 Introduction

Sir Francis Bacon (1561-1626) was an English philosopher and champion of modern science. Bacon's best known aphorism was that 'knowledge is power'. However, Dewey (1920) contested that Bacon's notion of knowledge excluded a vast amount of knowledge which did not give power (p. 29). According to Dewey (1920) human beings are social beings whose experiences are influenced by political, religious, industrial and societal powers. Based on this assumption Morgan *et al.* (2004) quite accurately noted that it is impossible to understand individuals' pathways into care because it is currently only examined from one perspective-that being medical. Therefore it is hardly surprising that there is a non-existent knowledge base in Ireland of the experiences of people with mental health problems who had offended, while accessing and maintaining links with community mental health services prior to imprisonment. This lack of knowledge is particularly noticeable from two perspectives from that of the service user and secondly, from a national and an international perspective. For this reason to gain a rich and comprehensive understanding of the topic of pathway into mental health care it is crucial that it is considered within a sociological theoretical framework (Pescosolido 1992, Pilgrim *et al.* 2011). Consequently to address this deficit in knowledge it is fundamental to give due consideration to the various methodological paradigms which guide this form of inquiry.

Indeed according to Creswell *et al.* (2003) it is imperative for a researcher to gain a comprehensive understanding of the different worldviews or paradigms of scientific inquiry before embarking on a research study. In fact Crotty (1998) asserts that when setting out on a research journey, it is important to make explicit not only to the reader, but also oneself, the epistemological, ontological, theoretical and methodological assumptions that have shaped and guided the research process. Within nursing a clear

definition of research is difficult to articulate due to the constantly evolving and expanding role of the nurse (Parahoo 2006, p. 9). It has been suggested, however, that the "exact nature of the definition of research is influenced by the researcher's theoretical framework" (Mertens, 2005, p. 20). Research within social and behavioural sciences has gone through and continues to go through a major shift. Initially the empirical tradition of research held a dominant position for much of the twentieth century. Then towards the latter end of that century the constructivist/interpretivist tradition began to gain momentum. This came as a direct challenge to the positivist tradition. Then relatively recently, within the last twenty years a third tradition developed. This is generally referred to as a mixed methods approach. The philosophical foundation of mixed methods research was and remains to some extent strongly contested (Howe 1985, Sandelowski 2001, Bryman, 2007, Morgan 2007).

This chapter considers the philosophical foundations of research and how these foundations influence the development of a comprehensive and elaborate technique for penetrating an institution in such a way as to address the absence of knowledge on this issue from the perspective of the service user. It begins by conducting an in-depth exploration of various philosophical stances of scientific inquiry. Following from this an explicit rationale for the philosophical and methodological considerations pertinent to this research is laid out.

3.2 Scientific Inquiry – Opposing Worldviews

A theoretical framework, as distinct from a theory, is sometimes referred to as a paradigm (Mertens 2005, Bogdan & Biklen 1998). The word paradigm comes from the Greek word *paradeigma*, meaning 'a pattern, model, or plan.' Kuhn (1962), a notable philosopher of science, introduced the concept of 'scientific paradigm'. According to Kuhn a paradigm does not supply answers, but is more likely to result in a lot of unanswered questions. Weaver and Olson (2006 p. 460) define paradigms as "sets of philosophical underpinning from which specific research approaches flow". It is suggested that paradigms represent the values, beliefs, and practices that guide a particular field of inquiry (Kuhn 1962, Morgan 2007). This in turn influences what should be studied, how it should be done and how results should be interpreted. Furthermore, Tashakkori &

Teddlie (1998) go on to state that paradigms are opposing worldviews or belief systems that are a reflection of and guide to the decisions that researchers make. Hanson *et al.* (2005) provide a useful and a more specific framework by which a paradigm can be understood. They identify four distinct components of a paradigm namely, epistemology, ontology, axiology and methodology. The issue of defining a paradigm has and remains the focus of intense debate. Kuhn (1962) professed that the term lacked conceptual clarity. Indeed, Suppe (1977) noted that the term could have several different meaning, ranging from “a concrete scientific achievement” to “a characteristic set of beliefs and preconceptions” (p. 11). Adding to this ambiguity, Kuhn (1962) contends that changes occur in paradigms in discontinuous, revolutionary breaks called ‘paradigm shifts’. Kuhn’s (1962) idea of a paradigm shift helps to explain how a new paradigm replaces an older inadequate body of knowledge in order to provide appropriate answers to questions, resulting in the dominant paradigm being replaced by a new inquiry. Capra (1986) provided an altered version of Kuhn’s description of a paradigm to include the paradigm shift: “A constellation of achievements, concepts, values and techniques shared by a community and used by that community to define legitimate problems and solutions.” (Capra 1986, p. 11)

Tashakkori and Teddlie (1998) used the term ‘paradigm wars’ to describe the dichotomy which occurred between positivists and interpretivists. Tashakkori & Teddlie (2009) suggest that these disagreements were predominantly a result of challenges by interpretivist researchers to the generally regarded dominant positivist research movement during the 1960s. According to Onwuegbuzie and Leech (2005) positivists believe that research is value free while interpretivists believe it is influenced by the researcher. This is based on the assumption that positivism is objective whereas the interpretivist inquiry is subjective. Tashakkori & Teddlie (2009) professed that this period of conflict led to the birth of the mixed methods approach to research. This is the basis of the pragmatic or mixed methods paradigm. Hence, it is now recognised that there are three methodological paradigms (Tashakkori & Teddlie 2009, Johnson & Onwuegbuzie 2004) which exist within social and behavioural sciences research. These are quantitative (QUAN), qualitative (QUAL) and mixed methods (MM) research. Johnson & Onwuegbuzie (2004) proposed that the mixed methods paradigm may bridge the gap between the

quantitative and qualitative positions. However this notion is widely contested (Howe, 1985, Sandelowski 2001, Bryman, 2007, Morgan 2007). McMillian & Schumacher (2006, p. 401) draw attention to certain disadvantages of using mixed methods research. Among these are the researcher's level of competence in using both quantitative and qualitative methodologies, the extensive data collection resources, the subsequent management of this data and finally, the possible misinterpretation of the true mixed methods typology. Interestingly, Andrew & Halcomb (2006) have counter-argued by stating that the purpose of mixed methods research is not to replace either qualitative or quantitative research, but rather to extract the strengths and diminish the weaknesses in both approaches within a single study. This is referred to by Johnson and Onwuegbuzie as the fundamental principle of mixed methods research which aims to "combine the methods in a way that achieves complementary strengths and non-overlapping weaknesses." (Johnson & Onwuegbuzie, 2004, p. 18) Within these three communities there are four distinct paradigms these are:

- post-positivism\positivism,
- constructivism\interpretivism,
- transformative perspective and
- pragmatism Tashakkori & Teddlie (2009 p. 84)

Philosophically, researchers make claims about what knowledge is, how it is known, the values involved, how it is described and the processes for studying it (Crotty 1994). Therefore, it is the choice of paradigm that sets down the intent, motivation and expectations for the research. Mertens (2005, p. 8) states that "the dominant paradigms that guided early educational and psychological research were positivist and its successor post-positivist". The notion of 'positivism' derives from the positive sciences which emphasise tested and systematized experience rather than undisciplined speculation (Kaplan 1968). Positivist researchers believe in the assumption that 'reality is out there' and that reality is stable, observable and measurable. Furthermore, Mertens (2005) contends that "the ontology that positivists hold is that, one reality exists and it is the researcher's job to discover that reality" (Mertens 2005, p.11). Positivist philosophers believed that science can explain and predict human actions. For this reason they are often referred to as logical positivists. Positivism assumes an objective worldview. Hence

it often searches for facts conceived in terms of specified correlations and associations among variables. Porter (1993) suggests that theory based on the medical scientific positivist approach results in 'naïve realism'. Naïve realism is based on the philosophical notion that objectivity is possible and to be objective the positivist must accept the naïve realist assumption that there can be a direct correlation between being and knowledge. Contrary to this, it is strongly contested that the views, values and beliefs of the researcher must have an effect on the research process (Howe 1985, Porter 1993) and that an attempt to bracket values (Howe 1985, p. 12) may cause further bias. Porter (1993) posits that human action is constrained and enabled by social structures, and that action reproduces and can transform these structures. Positivist research excludes notions of choice, freedom, individuality and moral responsibility (Cohen *et al.* 2000, p. 17). Such disparities have resulted in the emergence of a second paradigm called the constructivist one.

The constructivist/interpretivist paradigm emerged with a different underlying assumption and methodology. The constructivist/interpretive paradigms are anti-positivist. In contrast to the fact that the positivists and post-positivists believe that reality is out there, the interpretivists' basic belief or ontology is that reality is socially constructed. Interpretivists – or naturalists, provide an alternative to positivism. Milburn *et al.* (1995) observe that interpretivists hold the belief that human beings actively construct the social world and that people are continuously involved in making sense of and interpreting social environments. According to Schutz (1973) interpretive theory involves building a second order theory or theory of members' theories. This is in contrast to positivism which is concerned with objective reality and meanings thought to be independent of people. Interpretivists assume that knowledge and meaning are acts of interpretation. Hence there is no objective knowledge independent of thinking, reasoning human beings. In fact interpretivists do not hold the view that reality is a fixed entity. They believe that human behaviour can only be understood when the context in which it takes place and the thinking processes that give rise to it are studied. They have a belief that the researchers' interactions with those being researched can actually enhance the findings. However they also recognise that the researcher may have preconceptions, which need to be addressed before conducting a study.

However, this paradigm also came to be challenged. Transformative researchers believe that the interpretivist/constructivist approach to research does not adequately address issues of social justice and marginalised people (Creswell, 2003, p. 9). Transformative researchers "believe that inquiry needs to be intertwined with politics and a political agenda" (Creswell, 2003, p. 9) and contain an action agenda for reform "that may change the lives of the participants, the institutions in which individuals work or live, and the researcher's life" (Creswell, 2003, pp. 9-10). The transformative paradigm comes from the perspective of critical theorists and participatory researchers who realised the imperfections of the constructivist/interpretivist paradigm. According to Mertens (2005) the transformative paradigm arose during the 1980s and 1990s partially due to dissatisfaction with the existing and dominant research paradigms and practices but also because of a realisation that much of the sociological and psychological theory which lay behind the dominant paradigms "had been developed from the white, able-bodied male perspective and was based on the study of male subjects" (Mertens, 2005 p. 17). Kincheloe & McLaren (2000, p. 279) assert that this paradigm is concerned particularly with issues of power and justice and the way the economy, matters of race, class and gender, ideologies, discourses, education, religion and other social institutions and cultural dynamics interact to construct social systems. The purpose of the critical/transformational paradigm is "...to bring about a more just, egalitarian society in which individual and collective freedoms are practiced, and to eradicate the exercise and effects of illegitimate power" (Cohen *et al.* 2000, p. 28). The transformative paradigm provides a tool to examine a world view with its accompanying philosophical assumptions that directly engage the complexity of researchers' encounter in culturally diverse communities when their work is focused on a social justice agenda (Mertens, 2005). Creswell (2003) notes that the transformative paradigm provides a useful theoretical umbrella to explore philosophical assumptions and guide methodological choices for approaches to inquiry that have been variously labelled critical theory, feminist, participatory, inclusive, human rights based, democratic, empowerment, or responsive. The transformative paradigm extends the thinking of democracy and responsiveness by consciously including the identification of important dimensions of diversity in evaluation work and their relation to discrimination and oppression in the world (Mertens 2005). According to Tashakkori & Teddlie (2009) transformative and the pragmatist perspectives

support the use of mixed methods yet they have characteristics that are quite divergent. Morgan (2007) refers to the pragmatic paradigm as pragmatism. Maxcy (2003) a neo-pragmatist observed that pragmatism could be traced back to philosophical pragmatists like Pierce, James, Dewey, Mead, Bentley, Rorty and Davidson. Maxcy (2003) contends that philosophically pragmatism is concerned with issues of social change, is built without deep foundations, and its dominant idea is idealism. Johnson *et al.* (2007) suggest that pragmatists reject the incompatibility thesis and claim that research paradigms can remain separate, but they can also be mixed into other research paradigms. Indeed, Greene and Caracelli (1997) assert that pragmatism “should not continue to be preoccupied with the explicit assumptive differences between paradigms that have been frequently offered as points of contrast, conflict and incompatibility” (p. 12). Maxcy (2003) wrote about the contributions that the philosophy of pragmatism made to the changing conceptions of research methodology resulting in a plurality of method and multiple methods philosophies. Cameron (2009) contends that pragmatism has a strong philosophical foothold in the mixed methods or methodological pluralism camps. Dewey, another proponent of pragmatism, emphasised the ‘transactional’ element of inquiry. Unlike Pierce, whose pragmatist views were grounded in science (Rescher 2000), Dewey’s theory of ‘knowledge and experience’ focused on the influence of experience as a basis for true reality. Johnson & Onwuegbuzie (2004) suggest the formulation of the research question as being the most fundamental part of a research project and that research methods should follow research questions in a way that offers the best chance to obtain useful answers. Johnson & Onwuegbuzie (2004) further state that many research questions and combinations of questions are best and most fully answered through mixed research solutions. Hence pragmatists choose their methods on the basis of the criterion of what will work best (Roco *et al.* 2002, p. 596).

3.3 Rationale for Philosophical Stance

3.3.1 Pragmatic paradigm

The central tenet of pragmatism is to reject the either – or choices and the metaphysical concepts associated with the paradigm wars, and to focus instead on ‘what works’ in getting research questions answered (Tashakkori & Teddlie 2003b, pp. 20–1, 2003c,

p.713). Tashakkori & Teddlie (1998) suggest that this leads to paradigm relativism —“the use of whatever philosophical and/or methodological approach that works for the particular research problem under study” (Tashakkori & Teddlie 1998, p. 9). While pragmatism is seen as the paradigm that provides the underlying philosophical framework for mixed-methods research (Tashakkori & Teddlie 2003, Somekh & Lewin, 2005), some mixed-methods researchers align themselves philosophically with the transformative paradigm (Mertens 2005). According to Mertens (2007) the transformative paradigm with its associated philosophical assumptions provides a framework for addressing inequality and injustice in society using culturally competent, mixed methods strategies. This mixed methods approach provides the transformative researcher with a structure for the development of "more complete and full portraits of our social world through the use of multiple perspectives and lenses" (Somekh & Lewin 2005, p. 275), while at the same time allowing for an understanding of "greater diversity of values, stances and positions" (Somekh & Lewin 2005, p. 275).

3.3.2 Philosophical stance

Crotty (1998) asserted that a crucial starting point for a research study should be the making explicit of the epistemological, ontological, theoretical and methodological assumptions that shape and guide the rationale for the study. This researcher faced a dilemma when considering the most appropriate paradigm for this study. The study explores the pathways to care of people with mental health problems within the Irish criminal justice system. The dilemma involved deciding between a pragmatic and a transformative philosophical basis for this study. As pointed out in chapter two, mentally ill people within the criminal justice system, the target population for this study, is an extremely marginalised and discriminated group (Brett 2003). The very places (prisons) in which they are located signifies a power imbalance (Crewe 2007), human rights violations (Knight and Stephens 2009) and are widely associated with depravity and inhuman standards of care (Coyle 1997, O'Neill 2006, WHO 2001, 2006, 2008, 2011). The transformative paradigm focuses on a social justice agenda and acknowledges challenges that researchers encounter in culturally diverse communities (Mertens, 2005). A key

component of the transformative paradigm is that the inquiry should contain an action agenda for reform (Creswell 2003, pp. 9-10).

The first step in attempting to manage this dilemma was to contact notable proponents of transformative and pragmatic paradigms, Professor Donna Mertens and Professor John Creswell respectively. Both of these have written prolifically on transformative and pragmatic paradigms. This researcher travelled to the sixth International Mixed Methods Conference 2010 in America to present a paper on the methodological considerations for this study. This provided an opportunity to gain expert advice, feedback and guidance and to meet some of the key researchers using both of these paradigms. A particularly useful piece of advice received was to summarise and compare both paradigms in terms of their philosophical underpinnings in relation to this research study (see Table 3. 1).

Table 3.1 Comparison of the philosophical stances of pragmatic and transformative paradigms (Creswell 2003)

| <i>Pragmatism Paradigm</i> | <i>Transformative Paradigm</i> |
|---------------------------------------|--|
| <i>Practical</i> | <i>Political</i> |
| <i>Problem centred</i> | <i>Empowerment issue-orientated</i> |
| <i>Pluralistic</i> | <i>Collaborative and participatory</i> |
| <i>Real-world practice orientated</i> | <i>Change-orientated</i> |

Following consultation with Professor Mertens and Professor Creswell and the completion of the above exercise, it became clear that this study is more compatible with the pragmatic paradigm. One of the main reasons for this decision was that this study may not bring about direct change for participants, a central tenet of the transformative paradigm. However this study will provide many other benefits for this group as described in chapter one (section 1.8), namely

- a better understanding of the experiences of people with mental health problems who have offended with regard to accessing and maintaining a link with mental health services prior to imprisonment,
- the provision a foundation for future research in this issue,

- the identification of gaps in policy, protocols and service delivery and
- the identification of areas of improvement for Criminal Justice System and relevant mental health services for people with mental health problems.

The following section provides the pragmatic philosophical stance for this research study. It also details the rationale and justification for the chosen research methods from epistemological, ontological, theoretical and methodological perspectives.

3.3.2.1 Epistemological stance (how we know what we know)

Epistemology explores the “nature of knowledge, its possibility, scope and general basis” (Hamlyn 1995, p. 242 cited in Crotty 2003). Epistemology provides a philosophical basis for deciding “what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (Maynard 1994, p. 10). Cherryholmes (1992) suggests that a pragmatic approach follows the notion of ‘what works’. It may involve using various methods to answer a research question and placing value on both objective and subjective knowledge. As shown in the literature review for this study, knowledge on issues relevant to the focus of this study is either empirically-orientated (e.g. Koos 1954, Anderson 1963) or described from a legal coercive perspective (e.g. Lidz & Hoge 1993). Morgan *et al.* (2004) assert that an over-preoccupation with empiricist epistemological research on ‘pathways to care’ would render it incomplete. It is particularly important to consider Pescosolido’s (1992, Pilgrim *et al.* 2011) views of how knowledge on the topic of ‘pathway to care’ should be considered, which is within a sociological theoretical framework. Therefore it is crucially important that the choice of theoretical framework for this study is purposefully selected to adequately inform the central variables being investigated.

Teddlie & Tashakkori (2009) contend that pragmatic epistemology concerned with the relationship between the researcher and the participant should be on a continuum rather than be polarized in favour of one or the other perspective. It is particularly relevant for this study is to have an interactive link between the study participants and the researcher during both phases to obtain a better understanding of the realities involved. Two factors are paramount to the success of this study. The first concerns an understanding of the participants’ culture and the environment in which potential participants are currently

residing and secondly, the building of trust with the study participants. Both phases of this study involved meeting participants directly for two reasons. During phase one it was vital to meet participants individually in order for them to give the stories of their experiences on this issue and for participants to gain trust in the researcher. In phase two meeting with participants gave the opportunity to provide assistance with questionnaires if required, as well as to having further personal contact. Mutual trust and good communication were vital factors for this study to progress. According to Patenaude (2004) prison research needs to be pragmatic and policy-oriented if it is to be useful. However as cautioned by Coffey (2006) such research as this must be conducted in an ethically robust fashion due to the fact that the target population for this may be considered a captive one.

As outlined in chapter one (section 1.7) these issues raise important epistemological challenges for a researcher due to the fact that potential participants are in prison. Prisons by their very nature are associated with power (Foucault 1977) and in particular an imbalance of power (Crewe, 2007). The methodological design for this study gave careful consideration to these issues. It involved techniques such as selection, recruitment of voluntary participation, validation and dissemination of the findings of the study.

3.3.2.2 Ontological stance (nature of reality)

“Ontology concerns the ideas about the nature of existence, and with the structure of reality” (Crotty 2003, p. 10). Eriksson & Kovalainen (2008) comment that “ontological assumptions embrace all theories and methodological positions” (p. 13). According to Crotty (2003, p. 10) ontological and epistemological issues tend to merge. Blaikie (1993) contends that ontology and epistemology cannot be separated. “To talk of the construction of meaning is to talk of the construction of meaningful reality” (Crotty 2003, p. 10).

The pragmatic view regarding ontology is consistent with the positivist or post-positivist research tradition in that the world is seen as objective and to exist independently of the knower. On the other hand, pragmatists question if one explanation of reality is better than another (Teddlie & Tashakkori 2009). According to Cherryholmes (1992) the

pragmatist's choice of a particular explanation indicates that it "is better than another at producing anticipated or desired outcomes" (p. 15). Hence the ontological stance taken from a pragmatic perspective will have major implications for the type of knowledge that is gathered.

The ontological stance taken for this study is one of subjectivism. This choice is consistent with the pragmatist axiological position. This decision is reflected and is made explicit in the research question for this study, in particular by the use of the word 'of' as opposed to 'for' in the title:

"What are the pathways to care of people with mental health problems within the Irish criminal justice system?"

The significance within the meaning of these words is that 'for' pertains to being "a description of" and 'of' pertains to "belonging to" (Oxford English Dictionary 2003). This study focuses on the experiences of this group and is solely concerned with their perspective on the issue in question.

This issue was raised by the Faculty of Health Sciences Research Ethics Committee and defended on the basis that this study is concerned with the experiences of this group regarding accessing and maintaining links with mental health services prior to imprisonment. The decision regarding the question for this study was made following a comprehensive review of the literature as described in chapter 2. Wallcraft *et al.* (2011) observed the emergence of the personal/collective self-advocacy movement in the work of service-user organisations worldwide. This led to a debate that life experiences are underrated in biomedical discourse and that real understanding of mental health problems must be based on listening to the views and life histories of patients (Curtis *et al.* 2000, Newnes *et al.* 2001 as cited in Wallcraft *et al.* 2011). As alluded to in the previous chapter, the majority of the studies on pathways to mental health care used secondary sources to collect data, sources such as case notes, family or carers' information, clinicians' views or previously published literature on this topic. For the present researcher this had implications for who should be asked to participate in this study. The design for the study focused on people with mental health problems who had offended. It specifically explores the narrative regarding their experiences of trying to access and maintain a link with mental health services prior to going into prison.

3.3.2.3 Theoretical stance

Morgan (2007) contends that the pragmatic approach to research is informed by a belief that the practicalities of research are such that it cannot be driven by theory or data exclusively. A process to enable one to move back and forth between induction and deduction is recommended (Morgan 2007, cited in Doyle *et al.* 2009). Morgan *et al.* (2003) suggest that the pathway to care must be studied as a social process, subject to a wide range of influences, including the cultural context within which illness is experienced. Mechanic (1968) described the concept of illness behaviour, which broadly refers to the ways in which individuals and others, perceive, evaluate and act upon the symptoms of illness. Pescosolido (1992) described 'illness career' as being a process which is concerned with the sequence of actions related to an attempt to rectify a health problem (p. 1111). Pescosolido (1992) firmly places the topic of 'pathway to care' within a sociological theoretical framework. This study utilises the concept of the 'illness career' to capture the narrative of potential participants on this issue. The pragmatic philosophy of a 'needs-based' approach to research (Johnson & Onwuegbuzie 2004, p. 17) allows for this flexibility.

3.3.2.4 Methodological stance (the process of research)

Methodology is concerned with how to obtain the desired knowledge and understanding of a research study. Mixed methods research uses the processes and procedures for collecting, analysing and inferring both quantitative and qualitative data in a single study, in sequential or concurrent studies and is based on priority and sequence of information (Green *et al.* 1989, Tashakkori & Teddlie 1998, Creswell & Plano Clark 2006, Creswell 2007). Johnson and Onwuegbuzie summarise the philosophical position of mixed method researchers in the following statement:

"We agree with others in the mixed methods research movement that consideration and discussion of pragmatism by research methodologists and empirical researchers will be productive because it offers an immediate and useful middle position philosophically and methodologically; it offers a practical and outcome-orientated method of inquiry that is based on action and leads, iteratively, to further action and the elimination of doubt; and

it offers a method for selecting methodological mixes that can help researchers better answer many of their research questions.” (Johnson & Onwuegbuzie 2004, p. 17)

Green *et al.* (1989) identified five major purposes for mixed-method research namely, triangulation, complementary, development, initiation and expansion. Medalie *et al.* (1996) contend that quantitative and qualitative methods can be mixed, in cases such as collecting qualitative data before quantitative data when variables are unknown, or using qualitative methods to expand quantitative results to advance study aims. Other benefits include the use of qualitative methods to generate themes to develop a more accurate quantitative instrument, and the fact that qualitative data can be used to further enhance the credibility of the findings of quantitative data and their relationships. Combined methods also increase the validity of the findings in that results can be confirmed by means of different data sources and this may also lead to the creation of a new hypothesis particularly where findings are contradictory (Greene *et al.* 1989, Bryman 2006, Creswell and Plano Clarke 2007).

The methodological stance taken for this study is influenced by the fact that most of the current research on this topic is provided from a predominantly epidemiological perspective (Morgan *et al.* 2004, Judge *et al.* 2008). Morgan *et al.* (2004) pointed out that a major reason that more is not known about pathways to care has to do with how the issue is researched. Morgan *et al.* (2004) concluded that such a mono-approach to studies on pathways to care fails to address the social context of help-seeking behaviours. Judge *et al.* (2008) confirm this point by noting the paucity of published studies on help-seeking behaviours among people with major mental health problems. A particular deficit occurs in studies which employ rigorous qualitative techniques (Judge *et al.* 2008). Morgan (2004) contends that such a mono-approach to research on this issue creates a static, one-dimensional model of pathways to care. Furthermore Pescosolido *et al.* (1998) observed that if this topic is not referred to from an epidemiological perspective it is considered from legalistic perspective. Particularly relevant with regard to this study is Ulmer & Spencer’s (1999) observation that positivistic and ‘value-free’ methodological orientations, although quite important to our historical understanding of aspects of incarceration, now seem antiquated and constraining in relation to contemporary interactionism(s) and narrative forms (cited in Bosworth 2008). Pescosolido (1992,

Pilgrim *et al.* 2011) contend that help-seeking behaviours and the subsequent pathways to care need to be viewed as a dynamic social process. Indeed there is a need for a more sophisticated methodological approach in order to understand more clearly how people interact with the health system (Pescosolido 1998, p.284). A pragmatic exploratory sequential mixed methods approach in this study provides a framework to address the many methodological issues involved in understanding better the help-seeking behaviours of potential participants. This framework is presented in the following chapter.

3.4 Rationale for Study Design

3.4.1 Exploratory sequential mixed methods design

According to Creswell & Plano Clark (2007) when referring to 'exploratory sequential design', a sequential mixed methods design explores experiences by using a qualitative approach followed by an explanation of those experiences using a quantitative approach. As noted by Onwuegbuzie and Teddlie (2003), some individuals who engage in the qualitative versus quantitative paradigm debate appear to confuse the logic of justification with research methods. That is, there is a tendency among some researchers to treat epistemology and method as being synonymous (Bryman 1984, Howe 1992). Doyle *et al.* (2009) state that the rationale for deciding on a methodology is based on which approach will best suit the research question. This is the most fundamental point in any research study (Johnson & Onwuegbuzie 2004). Rauscher & Greenfield (2009) notes that a researcher must make three major decisions before deciding which design strategy is most appropriate for a project:

- the priority given to the quantitative and qualitative data and methods,
- the sequence of implementation of methods for data collection, and
- the phases in which the data and findings will be integrated.

Underlying these decisions is the aim of the overall project. Creswell and Plano Clarke (2007) suggest using a 'decision tree' to assist researchers in making some of the major decisions prior to selecting a mixed methods design. Creswell and Plano Clark (2007, pp. 79–84) identify three main dimensions in analysing a research question:

- I. The timing dimension – what will the timing of qualitative and quantitative methods be? In which order will the researcher collect and use the data? Will it be concurrent (both sets of data are collected at the same time) or sequential (one set is collected before the other)?
- II. The weighting dimension – what will be the relative importance, weight or priority given to qualitative and quantitative methods and data in answering the study’s questions? The general possibilities are equal weighting to both approaches, or unequal weighting, with one approach carrying more weight.
- III. The mixing dimension – how will qualitative and quantitative methods be mixed, and especially how will the two data sets be mixed? The possibilities here are that the two data sets can be merged, one can be embedded within the other, or they can be connected in some other way.

Figure 3.1 below outlines the decision tree for this study and will be followed by a detailed rationale for each of these decisions.

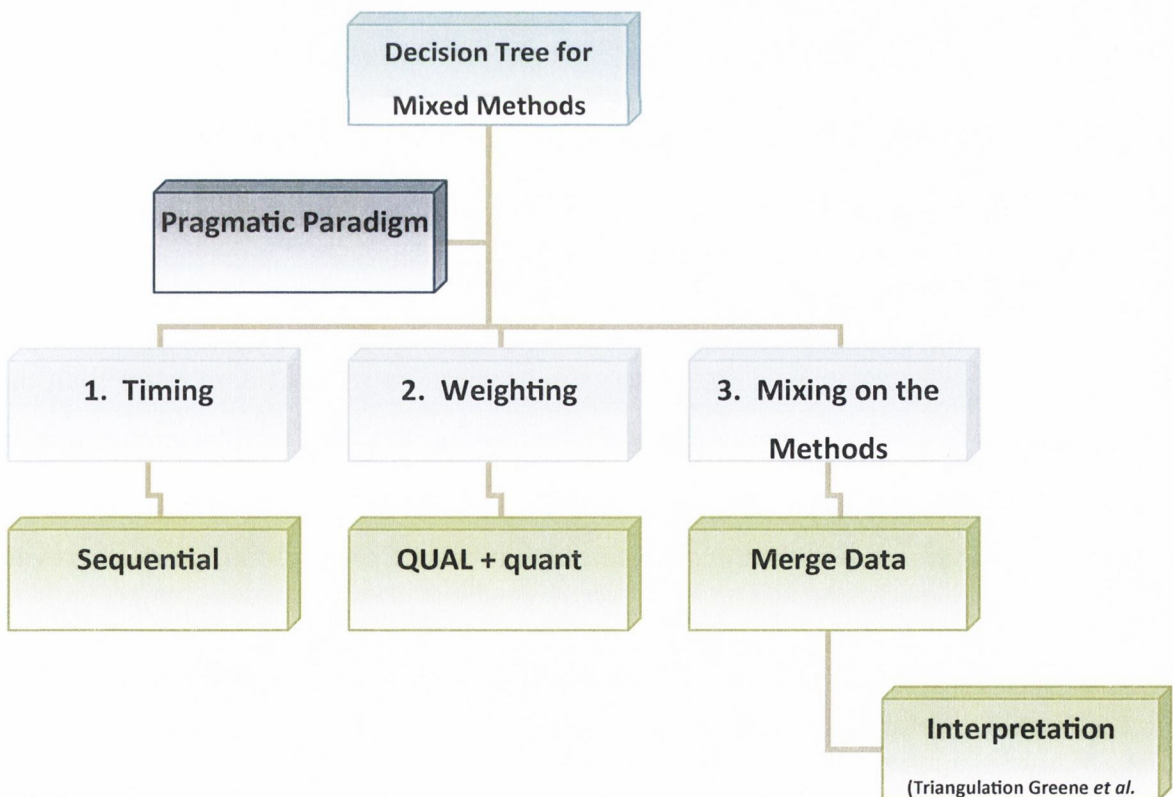


Figure 3.1 Decision Tree

3.4.1.1 Timing

Rauscher & Greenfield (2009) contends that within a sequential exploratory design, data collection and analysis occur in two distinct phases – one preceding the other. This study is compatible with the exploratory design process that occurs when, in a two-phase mixed methods design, qualitative data are collected in the first phase, and quantitative data in the second. This design is usually used in order to gain a better understanding of the in-depth experiences of a group before measuring its distribution and prevalence (Creswell and Plano Clark 2007, p. 75). Therefore phase one of this study involved conducting in-depth interviews with a smaller sample of participants. The aim of this phase was to gain an understanding of the experiences of this group of people with regard to gaining access and maintaining a link with mental health services prior to incarceration. Based on the emerging themes from this phase an instrument was adapted for the phase two data collection stage where a larger sample was used. The primary aims of phase two were to provide a more comprehensive demographic profile of a larger sample of prisoners with mental health problems and to corroborate, strengthen or refute findings from phase one of this study.

3.4.1.2 Weighting

Hanson *et al.* (2005) refer to this stage as the researcher deciding on how the data collection process will be prioritised. Prioritisation refers to the weighting, given to the two types of data, equal or unequal (Creswell & Plano Clarke 2007, Creswell *et al.* 2003, Tashakkori & Teddlie 2003, Morgan 1998).

Unequal priority occurs when a researcher emphasises one form of data more than the other, starts with one form as the major component of a study, or collects one form in more detail than the other (Morgan 1998). By prioritising qualitative methods, researchers gain a more in-depth understanding of people's lives and empirically reveal the paths through which social and economic factors shape health conditions (Rauscher & Greenfield 2009 p. 4). According to Bradley *et al.* (2007, p. 1768) qualitative research methodologies can generate rich information about healthcare including, but not limited to, patient preferences, medical decision-making, culturally determined values and health beliefs, consumer satisfaction, health-seeking behaviours, and health disparities.

The design of this study places a greater emphasis on the qualitative phase. It uses interview data to explore and understand participants' experiences of accessing and maintaining a link with mental health services prior to incarceration. This addresses the primary aim of this study.

The themes from this stage are used to adapt the data collection instrument for phase two which addresses the second aim of the study. However Lincoln & Guba (1985) note that qualitative interviews alone with a small sample will provide in-depth knowledge of a topic but this knowledge is not capable of being generalised. Therefore, by using this design (QUAL-quant) the issue of generalisability can be addressed as well as to addressing the aims of the study.

3.4.1.3 Mixing of data (integration)

In mixed methods studies, data analysis and integration may occur by analysing the data separately, by transforming them, or by connecting the analyses in some way (Caracelli & Green 1993, Onwuegbuzie & Teddlie 2003, Tashakkori & Teddlie 1998 as cited by Hanson *et al.* 2005 p. 227). Rauscher & Greenfield (2009) opines that integration remains one of the most important factors to consider in mixed methods research. In mixed methods research, integration can occur at the data collection, analysis, interpretation and results stages, or a combination of these stages.

Yin (2006) devised a framework of procedures for maximizing the integration of components within a single project. The five procedures put forward by Yin (2006) are: (a) research question(s), (b) analysis, (c) sampling, (d) instrumentation and data collection, and (e) analytic strategies. The first and most crucial point in this framework is the research question and its compatibility with a mixed methods approach. It follows from this that there will be research questions that suggest the use of both quantitative and qualitative methods in collecting data (Tashakkori & Creswell 2007, p. 207). When two or more methods have been integrated into each of these procedures, the stronger the mix of methods there will be. Conversely, if each method uses its own isolated procedures, the result will give rise to separate studies using different methods. Hence, even though studies may be complementary, they may not really represent mixed methods research (Yin 2006, p. 46). This study is integrated at three points: firstly, the research question,

secondly in the adaptation of the data collection instrument for phase two and thirdly in the interpretation of the results within the discussion chapter.

3.5 Summary

As proposed by Crotty (1998) this research journey is marked by a comprehensive exploration of the philosophical foundations of research. It provides an explicit account of the epistemological, ontological, theoretical and methodological assumptions that inform and guide this research.

An in-depth examination of the evolving worldviews which form the foundations of research was conducted. This revealed how factors such as 'paradigm shifts' led to new bodies of knowledge (Kuhn 1962) as well as showing how 'paradigm wars' (Tashakkori & Teddlie 1998) have influenced the birth of alternative worldviews such as constructivism and interpretivism, transformativism and pragmatism.

Health research has largely been controlled by epidemiological research (Morgan 2004, p. 744, Judge *et al.* 2008). This approach had delivered good quality information. However it is argued that it only provides a one-dimensional perspective on certain health-related matters (Morgan 2004). Indeed it is considered that this omission has led to the exclusion of a crucial body of knowledge on the issue of pathways to care. Pescosolido (1991, 2011) asserts that help-seeking behaviours and the subsequent pathways to care need to be viewed as a dynamic social process. Gathering a more accurate multi-dimensional perspective on how people seek help for their mental health problems and interact with the health care system requires a more challenging approach in how it is considered by researchers (Pescosolido 1998, p. 284).

Of particular relevance with regard to this study is Ulmer & Spencer's (1999) view that a more pragmatic approach to research which aims to understand better social factors leading to incarceration places value on narrative forms of inquiry. This study employs a pragmatic exploratory sequential mixed methods approach. It provides a framework which addresses several methodological issues identified within this study with regard to understanding better the help-seeking behaviours of people with mental health problems within the Irish Criminal Justice System.

CHAPTER FOUR – RESEARCH METHODS

"All truths are easy to understand once they are discovered; the point is to discover them." (Galileo Galilei 1564-1642)

4.1 Introduction

Pragmatism is seen as a paradigm that provides the underlying philosophical framework for mixed methods research (Tashakkori & Teddlie 2003, Somekh & Lewin 2005). This research is underpinned by pragmatism. It utilises an exploratory sequential mixed methods design. The potential participants for this study are prisoners with mental health problems who are incarcerated within the Irish Prison System. Therefore, the design selected for this study provides this group an opportunity to have their voices heard with regard to their experiences of accessing and maintaining links with mental health services prior to imprisonment. This design was selected following careful consideration of the methodological issues relevant to this type of research. The study is conducted in two phases. The first is the qualitative phase and the more dominant part which makes use of semi-structured interviews. The second is the quantitative phase which uses an adapted version of the Pathways Encounter Questionnaire.

This chapter provides a detailed account of and the rationale for the methodological choices appropriate for this type of study. In particular it discusses the research methods, recruitment approach and approach to sampling, the procedures for data collection and the approach taken in analysing both data sets. Particular issues requiring explicit explanation due to the nature of this study are the negotiation process to access study sites, the development and adaptation of the data collection instruments and ethical issues. The latter issue requires considerable attention due to the vulnerability and the environment in which potential participants for this study are located (Coffey 2006).

4.2 Study Design

Mixed methods research involves specific processes and procedures for collecting, analysing and interpreting both qualitative and quantitative data in a single study (Green

et al. 1989, Tashakkori & Teddlie 1998, Creswell & Plano-Clark 2006). However, conflicting views remain, with regard to what constitutes mixed methods research (Tashakkori & Teddlie 2003, Green 2007, Creswell and Plano-Clark 2007). Earlier writings of mixed method research refer to it as triangulation (Denzin 1970). According to Denzin (1970) triangulation involves the combined use of two or more data sources, investigators, methodological approaches, theoretical perspectives. Redfern and Norman (1994) maintain that triangulation overcomes the bias of 'single-method' studies and state that its use is effective for examining complex social issues. However, Tobin & Begley (2004) warn of the possible oversimplification of the use of triangulation as a research design. Sandelowski (1995) posited that triangulation should only be used when data from one source is used to support data from another. However, Johnstone (2007) pointed out that no useful discussion or explanation has been forthcoming as to how researchers might handle conflicting evidence from a research project. Tobin and Begley (2004) further note that what is paramount when designing a study is for the researcher to demonstrate logical understanding, of what is done, how it is done and, equally importantly, why it is done (p. 394).

This research utilises an exploratory sequential mixed methods design. This design ensures that the aims and objectives of the study can be achieved. Phase one aims to gain an in depth understanding of the experiences of prisoners with mental health problems regards trying to access and maintain a link with mental health services prior to incarceration. The second phase of this study follows on from phase one by embedding the emerging themes from the first phase. This is facilitated by adapting the Pathways Encounter Form. This allows for the collection of data from a larger sample of prisoners with mental health problems within the CJS system. The Pathways Encounter Form provides an opportunity to quantify pertinent factors such as:

- if contact with community mental health services was established prior to imprisonment and if that contact was maintained,
- did participants experience delays in accessing help for mental health problems,
- what types of contacts were sought to address mental health problems,
- how help-seeking was initiated - for example who suggested the need to get help for mental health problems,

- how contact was established and finally,
- what forms of treatments were most commonly provided when contact was established.

4.3 Negotiation of Access

Gaining access to a prison for research purposes is an enormous challenge. Hence, a crucial and vital starting point for this study was to ensure that access to the proposed study sites could be achieved. This necessitated that a consultation process be established with relevant personnel within the Irish Prison Service Headquarters (Appendix 1) requesting authorisation to access Irish prisons. Two ethics committees were approached in order to carry out this study. The committees were the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin and the Irish Prison Service Research Ethics Committee. Ethical approval was granted from both of these committees (Appendix 12 and 13). However, even with authorisation from the Irish prison services headquarters to carry out this study and the relevant ethical approval, the final decision to enter each prison still had to be negotiated with the relevant prison Governor. This process was aided by the visiting consultant psychiatrist to each prison. This person's role involved introducing the present researcher to the relevant Governor. It provided an opportunity to explain the nature and purpose of the study as well as to request permission to access that prison. A study Information Leaflet (Appendix 2) was provided to each Governor providing more comprehensive study information and contact details. Consequently, access to all prisons was granted and relevant resources provided such as office space, supervision by a prison officer and an ID card where applicable.

4.4 Data Collection

4.4.1 Introduction

Researchers collect data in a mixed methods study to address the research questions or hypotheses (Creswell & Plano-Clark 2011, p. 171). The aim of data collection procedures is to systematically collect and analyse data to make it comprehensible with a view to discovering relationships and patterns hidden within it. According to Creswell and Plano-

Clark (2011) in mixed methods research it is essential to know the general procedures of collecting both qualitative and quantitative data. This study utilised a sequential exploratory design which involved, the collection of qualitative data initially followed by the quantitative data collection stage. This section provides an exhaustive account of the process for the collection and analysis of the qualitative and quantitative data for this research.

4.4.2 Eligibility Criteria

The population refers to “all the elements that meet certain criteria for inclusion in a given universe” (Burns & Grove 1997, p.58). Polit & Beck (2004) distinguish between target and accessible population. The target population is the total possible population who could potentially participate in a study and about whom generalisations are made. The accessible population refers to those individuals that meet the eligibility criteria and are accessible to the researcher as a pool of subjects for a study (Polit & Beck 2004). The target population for this study are prisoners with mental health problems within the Irish Criminal Justice system. The inclusion and exclusion criteria for both phases of this research are outlined below.

4.4.2.1 Inclusion criteria

A prisoner is included if her or she:

- is attending the prison in-reach mental health clinic,
- has been diagnosed with a mental disorder (DSM IV TR),
- is at least 18 years old,
- is willing to voluntarily participate in the study,
- understands the purpose and process of the research, and
- is able to give informed consent.

4.4.2.2 Exclusion criteria

A prisoner is excluded if he or she:

- has not been diagnosed with a mental illness (DSM IV TR),
- is not willing to participate in the study,

- experiencing illness and considered after consultation with medical and nursing personnel too ill to give consent,
- does not understand the purpose and process of the research,
- is not able to participate or respond in the interview, and
- is under the age of 18.

4.5 Phase one

According to Corbin & Strauss (2008) qualitative researchers can choose from a variety of data collection methods. Among these are interviews, observations and videos, documents, drawings, memoirs and case notes (Corbin & Strauss 2008, p. 27). In qualitative research the main methods of data collection are semi-structured interviews and observations). A qualitative research interview is defined as "an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena" Kvale (1983, p. 174). Changes can be made in relation to the respondents during the research process with the result that this approach is not always predetermined. Brett Davies (2007) propose that "at its best, this method can lead to significant advances in our theoretical understanding of social reality" and "is particularly good at enabling the researcher to learn at firsthand about people's perspectives on the subject chosen as the project focus" (2007, p. 29).

4.5.1 Interviews

The type of method utilised to collect data for a research study must be influenced by the primary objectives and the research question (Crabtree & Miller 1999, Denzin & Lincoln 2000). Two data collection methods were considered for this study - focus groups and semi-structured interviews. In keeping with the exploratory nature of this research and the environment in which this research took place, it was considered that a semi-structured interview approach would provide the most suitable means by which to address this topic (Miller & Crabtree 1999). Many factors influenced this choice. An interview setting provides an environment for participants to speak openly and confidentially. Providing an outlet in which participants can speak candidly about their

lives or experiences can often be quite beneficial (Bosworth 2008 p. 1508). According to Berg (2004) semi-structured interviews serve two opposing yet complimentary purposes. They use predetermined questions on topics and also allowing the interviewer freedom to digress. Another reason for deciding on this method in preference to focus groups is that within the prison environment it is considered less problematic to manage a one-to-one interview than a group one from a security perspective. Bosworth *et al.* (2005) assert that, conducting prison research presents major challenges. Interviewing in prison presents unique sets of obstacles and 'methodological landmines' of which inexperienced researchers may be unaware (Schlosser 2008, p. 1501). Schlosser (2008) further comments on the critical nature of the researcher's role in the entire process of interviewing inmates and the subsequent outcome of a research study. He recommends the use of the concept of 'identity moments' as a technique to address this issue. Asking questions like "What do you think got you on the path to prison?" (Schlosser 2008, p. 1516) can encourage a narrative which will make life events more complete and accurate (Furstenberg & Davis 1984).

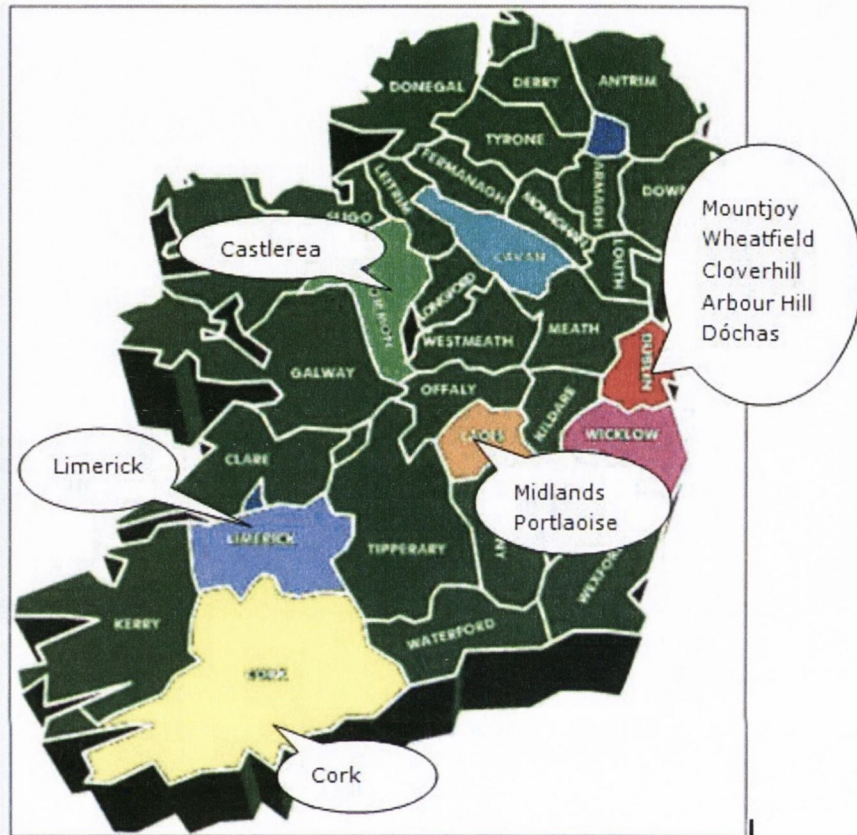
Hence, in-depth semi-structured interviews were conducted in order to understand the experiences of the participants through their own descriptions of trying to access and maintain a link with mental health services prior to incarceration. An interview schedule was developed, which included relevant probes, to gather the required data and to ensure that the appropriate topics were covered (Appendix 15). This schedule was devised following a comprehensive review of the literature on the broad topic. The questions were designed to be open-ended thus encouraging the interviewee to speak freely and also allowing the interviewer to probe further in response to significant replies (Bryman 2008).

4.5.1.1 Preparation for the interview

Before each interview the audio recording equipment was tested to ensure that it was in working order and that the microphone was at the correct position to pick up the participant's voice. It is vital that recordings are clear and audible to ensure accuracy when transcribing the data.

4.5.1.2 Sample

The Irish prison population is distributed across sixteen places of detention (Kennedy *et al.* 2003). Those relevant to this study are shown in the map below.



Prisons for committal and reception serve specific geographic catchment areas. Other prisons have national functions catering for those serving longer sentences, or those requiring higher or lower levels of security (Duffy *et al.* 2003). During 2006 there were a total of 12,157 committals to prison. A total of 9,700 persons accounted for the 12,157 committals (IPS 2006). Since the inception of this research there has been a considerable increase in committals to Irish prisons. A total of 13,758 persons accounted for 17,179 committals to Irish prisons during 2010 (IPS 2010). Prisons were selected for phase one of this research by using a purposive method. This was to ensure access to a legal status (sentenced or remand), gender and a city/rural mix among participants. Hence, the prisons selected for participation for this phase of the study were Mountjoy and Dóchas

Centre, Midlands and Cloverhill prisons. In each of these prisons people presenting with mental health problems are referred to an in-reach mental health clinic. Prison in-reach mental health clinics are provided in all prisons by a visiting team of health professionals on a weekly basis. Some prisons have fully resourced teams and others have only a visiting consultant psychiatrist and a forensic community mental health nurse (FCMHN). The average number of people attending each of these three clinics is twenty. Therefore the total target population for this phase of the study is sixty (n=60). A quota sampling method was utilised to gather the sample. A total of fifteen interviews (five in each site) was conducted. In the Mountjoy and Dóchas prison three female and two male participants were interviewed thus ensuring that a proportionate gender mix was achieved.

4.5.1.3 Recruitment

Munthe *et al.* (2010) assert that a major ethical risk involving research among participants with psychiatric problems who have offended concerns the sometimes binary role of the researcher. This research adheres to ethical principles set out by two ethics committees relevant to this type of research as discussed earlier. Furthermore, it also acknowledges the additional protection pertaining to biomedical and behavioural research involving prisoners as subjects, as cited by Gostin *et al.* (2007), who state that:

“Prisoners may be under constraints because of their incarceration which could affect their ability to make a truly voluntary and un-coerced decision whether or not to participate as subjects in research.” (Section 46.302)

Therefore the purpose of this section is to provide a comprehensive account of how the protection of prisoners’ rights was addressed during the recruitment process for this research. Initially, a letter was sent to the Director of Healthcare of the Irish Prison Service requesting permission to access the selected prisons to carry out interviews for phase one of the study (Appendix 1). This letter also provided an information leaflet about the study (Appendix 2). In order to uphold the rights of all potential participants, a gatekeeper was utilised to access the sample in each site. The aim of this was to protect the interest of potential participants and ensure voluntary participation. FCMHNs working in the prison in-reach mental health clinics were requested to act as gatekeepers (Appendix 3). This letter also provided an information leaflet about the study (Appendix

2). The gatekeeper distributed an information pack to those who met the inclusion criteria. This information pack provided a letter of invitation (Appendix 5) and an overview of the research, explaining the nature and purpose of the study, how to participate, potential benefits and harm, data collection procedures, time commitment, voluntary participation, the right to withdraw without prejudice to care, assurance of confidentiality, and an offer from the researcher to discuss and answer any questions (Appendix 5). An expression of interest form (Appendix 4) and a sealable self-addressed envelope for potential participants to return, indicating interest in the study, were also enclosed. Outgoing mail is censored before leaving a prison thus breaching ethical principle of confidentiality. Therefore replies from potential participants were placed in a collection box for the researcher to collect. Interviews were conducted in a private office within the prison in-reach mental health clinic. Due to the nature of the environment the researcher and the interviewee must be in view of a prison officer at all times to ensure a safe environment. Thus, a prison officer was outside the office but was unable to hear the content of the interview. Written consent was requested before the each interview began (Appendix 7). Interviews were recorded with the permission of the participants.

4.5.1.4 One-to- one Interviews

The aim of this phase of the study was to explore participants' experiences of what facilitated, or did not, their access to mental health services prior to incarceration. Individual interviews were conducted with fifteen people who had a diagnosis of mental illness and who were attending the prison in-reach clinic. Interviews were conducted in the Midlands, Cloverhill and Mountjoy/Dóchas prisons. A semi-structured interview schedule (Appendix 15) was used for this purpose. Interviews lasted approximately 30-40 minutes. The length of the interviews varied. This was in some cases influenced by prison routine for example, an interview being terminated by a prison officer because meal breaks were due to start. On one occasion an interview was split for this very reason. On that occasion I listened to the recording of the first part of this interview before the participant returned. On the participant's return I summarised the content of the earlier part of the interview to the participant and invited comments regarding accuracy prior to recommencing the interview.

Each interview commenced with a general introduction, where the reasons for doing this study were clearly and concisely stated. The ground rules for the interviews were set out at this stage. Participants were reminded that confidentiality was guaranteed. However, the participant information leaflet (PIL) describes certain situations in which this may need to be breached. Due to the nature of the environment anonymity in relation to participation in the study could not be guaranteed. Participants were also reminded that they had the right to withdraw at any time without prejudice to their care or treatment. Participants were also reminded that a transcript of their interview could be provided for review, on request. Written consent was then requested before each interview began (Appendix 7). All participants were reminded of the fact that their presence at this interview was voluntary and appreciated. Right through the interview participants were regularly asked to reaffirm their satisfaction with the process. The exact same question format was used for all the interviews. All interviews were audio-recorded with the permission of the participants. Field notes were taken to complement recordings and to ensure accuracy.

4.5.2 Analysis of qualitative data

Fossey *et al.* (2008) describe qualitative analysis as a process of reviewing, synthesizing and interpreting data in order to describe and explain the phenomena or the social worlds being researched. The purpose of the analysis is to provide structure for, to organise and to find a meaning for the data. Qualitative data analysis starts during the data collection stage whereas quantitative data analysis does not start until the data is collected. Qualitative data analysis is subjective to a greater extent because no two researchers will comprehend information in the same way. However, this factor can be reduced by using a transparent structured approach to the analysis process and by leaving an audit trail. All written notes and audio-tapes were kept for this reason and also for seeking validation from participants. Therefore, all hardcopy and electronic records were stored either in a locked filing cabinet or password encrypted computer respectively. These were only accessible by the researcher and will be stored in this manner for a period of five years following completion of the study as per the Data Protection (Amendment) Act 2003 guidelines.

4.5.2.1 Techniques and data analysis

This section provides the rationale for using a Computer Assisted Qualitative Data Software Analysis (CAQDAS) for this phase of the study. Qualitative Research Solutions International (QSR) developed two software packages for qualitative data analysis. The original program, was called NUD*IST, which stands for Non-numerical Unstructured Data, Indexing, Searching. The second is called NVivo, first produced in 1999, and designed to provide the same services as NUD*IST but in a much more refined way. It was named 'in vivo' coding – meaning participants' own words are used.

Jones (2007) identified several advantages of using NVivo software. These range from reducing the timeframes for analysis, providing more thorough and rigorous coding and interpretation, and providing researchers with enhanced data management.

4.5.2.2 Categorization and coding

The organisation of data is essential for accurate data analysis. A system must be developed to categorize and code the data. Then themes and patterns will start to become clear. Strauss and Corbin (1990) stress how important it is to name a category, so that the researcher can remember it, think about it and, most of all develop it analytically.

A systematic approach of data analysis was utilised for this study. This process set out to describe the meaning of the participants' experiences described in the fifteen interviews conducted, by identifying essential themes. Colaizzi (1978) provides a systematic framework for analysing data. This method is based on the philosophical ideal that truth is found in the lived experience. Colaizzi's (1978) framework consists of the following seven steps:

1. Reading and rereading the participants' descriptions of the phenomenon to acquire a feeling for their experience and make sense of their account.
2. Extracting significant statements that pertain directly to the phenomenon.
3. Formulating meanings for these significant statements. The formulations must discover and illuminate meanings hidden in the various contexts of the investigated phenomenon.

4. Categorizing the formulated meanings into clusters of themes that are common to all participants. Referring these clusters to the original transcriptions for validation and for confirming consistency between the researchers' emerging conclusions and the participants' original stories. Not giving into the temptation to ignore data which do not fit or prematurely generating a theory which conceptually eliminates the discordance in findings thus far.
5. Integrating the findings into an exhaustive description of the phenomenon being studied. Employing a self-imposed discipline and structure to bridge the gaps between data collection, intuition and description of concepts. Describing includes coding segments of text for topics, comparing topics for consistent themes, and bridging themes for their conceptual meanings. Based on this description a prototype of a theoretical model about the phenomenon under investigation is formulated.
6. Validating the findings by returning to some participants to ask how it compares with their experiences.
7. Incorporating any changes offered by the participants into the final description of the essence of the phenomenon. (Colaizzi 1978, pp. 48-71).

4.5.2.3 Data Management

All interviews were audio recorded with the permission of the participant. On completion of each interview the audio recording was uploaded into a password encrypted folder which was stored on my college computer. All computer based data was stored as per the Data Protection (Amendment) Act 2003 guidelines. Also, a code was assigned to each person who agreed to participate in the interview. The code is known only to me as the principal researcher. A master list with the names and coding was kept separately from the data in a locked cabinet in my workplace office (Trinity College, Dublin). In order to preserve privacy the record of consent was stored in a locked, secure cupboard away from the recordings and written transcripts. Only I have access to this filing cabinet.

All data were transcribed verbatim (Appendix 16). They were done personally for two reasons. Firstly, to ensure accuracy - every single word as the participant stated it was transcribed. Every effort was made to use participants' actual words for example 'me ma'

instead of 'my mother'. Secondly, the transcription process afforded me the opportunity to gain a deeper connection with the raw data. This process took a considerable amount of time. The average ratio for transcription is 1:4, for example a one hour interview could take at least four hours to transcribe. However, for me this process took approximately double that ratio (1:8). As I was transcribing the data I regularly referred to the field notes which I took during the interviews. This served the purpose of integrating the emotions and feelings expressed by participants during the interview. The typed transcripts were read several times to get a clear and deep understanding of the content.

The transcripts were uploaded into the NVivo software package. To ensure that any vital information would not be omitted other relevant sources of data were also imported. These sources included field notes, observations, literature review, relevant articles and government reports. NVivo 8 stores data in 'nodes' which are like virtual filing boxes. It provides an opportunity for all information on a theme to be summarised together as one unit (QSR International 2008). Nodes hold data, which have been coded from the relevant sources. In other words, they are a collection of meta-themes extracted from the data analysis. Four types of nodes were used during the analysis process for this study, these included: - free nodes, tree nodes, case nodes, and relationship nodes (QSR International). Bringer *et al.* (2004) assert that the built-in tools within the NVivo 8 software for recording decisions, conceptual and theoretical thinking, links between memos, documents, nodes and models, to assist in the development of a dynamic audit trail to meet the criterion of transparency.

One of the first steps in qualitative data analysis is to reduce the large volume of text into more manageable components. This provides an opportunity to observe for patterns within the text. These can then assist in reaching meaningful conclusions about what the participants said. However a possible difficulty with breaking down data into smaller parts is the potential for meaning to be lost or misinterpreted. Therefore, throughout this process I consistently referred back to the original source of data to clarify and check the context in which statements were made. Colaizzi's (1978) framework for data analysis was utilised for this process. This framework was utilised within the NVivo software package as a strategy for data analysis. The data from the interviews were analysed using observations, recordings and transcripts. Initial coding was done manually affording an

opportunity of getting a greater sense of the true content of the interviews. As referred to above, in qualitative research data analysis starts during data collection (Mays & Pope 2000). Therefore, some of the themes and categories developed at this stage could be incorporated into an integrated whole. Bradley *et al.* (2007) compared three strategies for the analysis of qualitative data - taxonomy, themes, and theory. Ryan & Bernard (2003) contend that themes are best used to describe specific experiences of participants by clustering them into meta-themes. This technique is particularly important for this research as the primary focus is on participants' experiences.

4.5.3 Application of Data analysis framework

Colaizzi's (1978) framework for data analysis was utilised for this process. The following sections will clearly demonstrate the application of this framework to the analysis process.

4.5.3.1 Read and transcribe data

After each interview the data was manually transcribed verbatim to ensure accuracy and also get a greater sense of it. The interviews were audio-taped and written notes were also taken, to ensure accuracy and to provide an audit trail (Morse & Field 1996). This reduced the subjective effect of this method. The transcripts were printed and then read several times in order to identify themes and meta-themes. Tape recordings and field notes were used to identify changes in tone or recurrent themes emerging. These latter are noted in brackets in the following quotations.

'Ye can't keep doing that you know talk to different people all the time ye get fed up with that ... you could see six people for a year maybe you know moving on...moving on ...moving on [in an angry and disillusioned tone]' p.10

Through open coding data can be broken down and similarities and differences examined. Table 5.1 outlines the open codes used for the interviews and demonstrate how these were grouped into related codes for later use in forming broader categories from the transcripts. This table outlines the main categories and the related codes, which emerged from the Interviews

Table 4.1 Open codes used

| Broad Categories | Related Codes |
|---|--|
| Background Icebreaker Background information | Life events, mental illness - onset, family history, life events- abuse, barring order, illicit drug use, substance misuse, previous prison admission(s), education, culture, homelessness |
| History of contact Experiences of contact with mental health services prior to entering prison | diagnosis - accurate, misdiagnosis – common , referral-self\other source, insight, stigma, previous admissions – amount, pathway to care, treatment approaches, symptom management, non\compliance, medication, linking with services, availability of services, barriers, language, motivation, lack of confidence, disengagement |
| Contact while in prison Experiences in relation to mental health problems while in prison | Stigma, Prison admissions, assessment while in prison, Treatment approaches, motivation, diagnosis, power imbalance, services \addiction \ probation \ psychology \ social workers, cannot be turned away, Central Mental Hospital, referrals. |
| Expectations Future expectations and needs | Treatment approaches, preferences, management of symptoms, talk therapy, combination of treatment, support\professional\family, accommodation, better services, development, positive attitudes. Opportunities, employment, training, planning (pre release) |
| Conclusion to the interview and additional comments | Treated normal, included, choice, given a chance. |

4.5.3.2 Extract significant statements

Significant statements were then extracted from the clusters identified in Table 5.1. This example relates to ‘background information’.

Table 4.2 Example of how significant statements were identified and extracted from interview 1

How it all started I had depression for year but I was wrongly diagnosed I have bipolar depression they just said it was depression [doctors] I always new ...well I didn't if you know what mean. **A lot of things happened to me a lot of things...Major incidents happened to me....** like I boxed for [his country] and coached but eh as I said major things happened to me before I started coaching.... **I eh was in a serious car accident my best friend was killed and I broke my neck.** (Page 1, Lines 1–6)

The following two tables provide examples of how significant statements were identified relating to ‘Experiences of contact with mental health services prior to entering prison’

Table 4.3 Example of how significant statements were identified and extracted from interview 6

Yeah well as I say I was in [psychiatric hospital]... as an outpatient but **I never bothered staying there... they were useless....** I ended up out on the streets more times and **I'd stay in hostels and that sometimes....** And then I'd go home for a while but things weren't great there. (Page 1, Lines 24–28)

Table 4.4 Example of how significant statements were identified and extracted from interview 7

I was once prescribed Prozac by my GP eh about 5 years ago. He knew I didn't like taking tablets I'm not interested in meds [states that he is a bit confused about this period] he remembers feeling down I suppose.... You know marriage trouble and the young lad and the court case in relation to this.

‘You initiated this visit [GP] yourself’yeah I went back a couple more times he [GP] wanted to give me a mild sedative or a sleeper but I said no I don't see the point in taking medication. So when I go off the tabs the problems still exist that's how I feel you know.

(Page 3, Lines 126–132)

4.5.3.3 Formulate meaning for each significant statement

Colaizzi (1978) suggested that creative insight was needed at this stage. However, according to Clarke (1991) as cited by Holloway & Wheeler (1996), it is important to refer back to the transcripts to ensure the original words and meanings of the participants are used. At this stage significant statements are reviewed for their meanings.

Table 4.5 Process of creating formulated meanings from significant statements

| Significant Statement | Formulated Meaning |
|--|--|
| How it all started I had depression for year but I was wrongly diagnosed I have bipolar depression they just said it was depression [doctors] (Participant P1) 'they [mental illnesses] were only picked up this year while I was in prison this time' (P3) | Being misdiagnosed caused a significant problem |
| I was once prescribed Prozac by my GP [about 5 years ago]. He knew I didn't like taking tablets (P7) | There was no choice of treatment offered when help was sought. |
| I was in [psychiatric hospital]... as an outpatient but I never bothered staying there... they were useless.... (P6) | Disengagement with mental health services, no faith in health professionals. |
| me sister and me father have a history of depression so yeah there is a lot of illness in the family and all that...(P1) | There is a family history of mental illness |
| I won't even get into a hostel now... now that I'm in for arson... they won't let you in if you done that... so I don't know.... At least prison can't turn you away and they do look after you well (P6) The stigma and all that especially in the country... yeah yeah I was in a really rural area and everybody would know everybody else's business and that. (P4) | There is still a major stigma regarding mental illness, however it is worse if there has been involvement with the Criminal Justice System. There is also the stigma of the professionals who are providing services. |

5.3.3.4 Formulated statement arranged into clusters of themes

Once the meaning of the statement was determined a theme was developed. Each theme identified was recorded as a key theme. After developing the theme, characteristics that defined each particular theme were placed into an attribute category.

Colaizzi (1978) suggests that these clusters of themes should be referred back to the original protocol in order to validate them. This process is repeated for all related codes. Key themes are into clusters of themes and then interpreted as a meta-theme (See Table Six).

Table 4.6 illustrating the emergence of themes from theme clusters and formulated meanings

| Formulated meanings | Clusters | Emergent themes |
|--|---|--|
| Being misdiagnosed has caused significant problems (P1) life circumstances had a big impact on what has happened (P6), Having never got much of an education. I can't really read or write.' (P9) | Background Information | Predisposing factors to involvement with the Criminal Justice System CJS |
| Being discharged too soon and not having support You're just left out to fend for yourself really.'(P12), language problems are a barrier to accessing health care (P8), lack of insight caused a delay in seeking help for mental health problems (P15), stopped taking prescribed medication (P15), help wasn't available (P1), constant turnover of staff was difficult of deal with (P10), There was a spiral of events that lead to involvement with the CJS- drinking, drugs barring order and homelessness (P5) | Experiences of contact with mental health services prior to entering prison | Factors influencing access\maintaining links with mental health services prior to involvement with the CJS |
| they (mental illnesses) were only picked up this year while I in prison this time' (P3) | Experiences in relation to mental health problems while in prison | perceptions of mental health care provided in prison |
| A combination of treatment approaches would be better (P13), There is a power imbalance between doctor and patients – patients need to be heard (P15), Would like to be given a chance in life (P10) | Future expectations and needs to manage mental health problems | Continuity of mental health Care |

4.5.3.5 Integrate results into an exhaustive description

At this stage the results are integrated into an exhaustive description of the investigated topic (Colaizzi 1978, pp. 48-71). The four emergent themes or clusters were identified and are presented in Table 5.1. They were then examined to see how well they can be integrated into the individual interviews. This process involves extracting quotes from the transcripts to exemplify the themes. Memos which were set up during the analysis process are also included here.

4.5.4 Validity and reliability

Combining research approaches can achieve various aims, including corroborating findings, generating more complete data, and using results from one method to enhance insights obtained with the complementary method (Creswell & Plano Clark 2007). Another benefit is that the credibility of the findings of quantitative data is enhanced. Combined methods also increase the validity of the findings (Greene *et al.* 1989, Bryman 2006, Creswell & Plano Clarke 2007). Morse *et al.* (2006) suggest particular strategies to enhance the validity of mixed-methods studies. These involve recognising the role of the complementary strategy and adhering to the methodological assumptions of each method. Indeed, this enhancement is similarly recognised in other areas of research which employ a mixed methods approach to enhance the validity and reliability of a study (Abowitz 2010).

Mays & Pope, (2000) contend that a common criticism of qualitative research is that it lacks scientific rigour, generalisability and is considered little more than a collection of and personal impressions. Furthermore, Rolfe (2006) suggests that is not possible to guarantee objectivity in qualitative analysis. Yardley (2000) proposes sensitivity to context, commitment and rigour, transparency, coherence, impact and importance as the criteria by which qualitative studies should be judged. Ryan (2009) recommends the need for transparency to ensure the 'trustworthiness' of the data analysis. Lincoln & Guba (1985) identified four criteria for establishing the trustworthiness of qualitative data - credibility, transferability, dependability and confirmability. These criteria were applied to demonstrate how validity and reliability were achieved for phase one of this study.

Credibility – The method of triangulation involves comparing data collected through different methods such as qualitative and quantitative ones (Patton 1990). It is

considered that triangulating data can improve the credibility of study findings, so that each source of data supports the other (Redfern and Norman 1994). However, to ensure credibility of methods for this study, a test was conducted. This study used a gatekeeper to access the sample. This meant that the possibility of gatekeeper bias needed consideration. Such bias can occur when a gatekeeper may be protective toward those in their care, and may hinder access rather than enable it (Groger *et al.* 1999). This study tested for gatekeeper bias by comparing the results of the demographic characteristics from this study with those of an earlier study involving a similar population but using a randomised selection technique.

Mays & Pope (1995) suggest that another technique to establish credibility is by means of member checking where the researcher's initial analysis and tentative themes are returned to the participants for validation of the researcher's interpretation. None of the participants requested a copy of their transcript. Nevertheless, the rapid turnover among the prison population would have been an enormous challenge. Additionally, the content of the interview was summarised at various points during the interviews for the purpose of seeking clarification. Bryman (2008) contends that credibility can be shown if the interview measures what it is supposed to measure and in so doing is a form of internal validity. In this study the interviews generated data which answered the research question and so can claim the necessary credibility.

The possibility of research bias needs to be acknowledged and addressed (Robson 2002). This was done by liaising regularly with supervisors, peer debriefing, attending ongoing training sessions, attending and presenting at relevant conferences and linking with key researchers in the field where this was applicable.

Dependability refers to data stability over time and over conditions (Lincoln & Guba 1985). An example of assessing dependability involves undertaking a stepwise replication, where several researchers are divided into teams. These teams investigate the data sources separately and later compare the results. Dependability can be enhanced by altering the research design or data collection as new findings emerge during data collection (Curry *et al.* 2009). The sequential design adopted for this research promoted dependability because the themes from phase one assisted in fine tuning the data collection instrument for phase two.

To ensure *confirmability* Appleton (1995) suggests that the researcher develops an audit trail which is the systematic collection and documentation of data allowing an independent auditor to draw conclusions about the data. This process was aided in the current study by the use of NVivo 8. This software package provides a very clear and concise map of how categories and themes are developed. Morse & Field (1994) explain that an audit trail is useful for understanding the researcher's "decisions, choices and insights" especially when "the focus of interview questions changes as themes or concepts begin to emerge from the data". It is also important to be able to report at what time and for what reason changes occurred (Morse & Field 1994).

Transferability refers to the extent to which the findings from the data can be transferred to other settings or groups, a concept similar to that of generalisability. However, it is important to note that data produced from a qualitative method are once-off and must be seen in the context in which they were gathered (Sandelowski 1986). The design utilised for this study afforded the opportunity of accessing a sample nationally, of the prison population. The findings are considered in a national context and recount the experiences of this population with regard to accessing and maintaining a link with mental health services prior to incarceration.

4.6 Phase two

As discussed in chapter three, the design utilised for this study places a greater emphasis the qualitative phase. By using a (QUAL-quant) design, the generalisability of the study findings is improved (Hanson *et al.* 2005). Indeed, multiple methods can be used in a single research study to merge the representativeness and generalisability of quantitative findings and the in-depth, contextual nature of qualitative findings (Greene & Caracelli, 2003). Hence the primary aims of phase two are to provide a more comprehensive demographic profile of a larger sample of prisoners with mental health problems and to corroborate, strengthen or refute findings gleaned from phase one. It quantifies factors such as:

- whether contact with community mental health services was established prior to imprisonment and if that contact was maintained,

- did participants experience delays in accessing help for mental health problems,
- what types of contacts were sought to address mental health problems,
- how help seeking was initiated,
- who suggested the need to get help for mental health problems,
- how contact was established and finally,
- what forms of treatments were most commonly provided when contact was established.

4.6.1 Questionnaire

A questionnaire is a data-collection method requiring written or verbal responses from a predetermined population to a written set of questions or statements in order to make some inference about the wider population (Kelley *et al.* 2003). It is one of the most commonly used methods of data collection within health research (Saunders *et al.* 2007, p. 355). Questionnaires can generate data from which concepts and hypotheses can be formulated producing new knowledge inductively. However, predetermined questions leave little flexibility to allow participants to give their opinion on the topic being researched (Oppenheim 1992). The mixed methods design utilised for this study provided an opportunity for participants to have an input in the adaptation of the questionnaire for phase two of data collection. Moreover, the findings from the quantitative phase can help contextualize the findings from the qualitative phase of this study. Saunders *et al.* (2007) contend that mixed approach to research may yield a more valid outcome.

4.6.1.1 Questionnaire design

Data for this phase of the study was gathered by using a modified version of the 'Pathways Encounter Form' (Appendix 11). Permission to use this questionnaire was granted by its authors (Appendix 8). This is a standardised, structured instrument which has been successfully used in several primary and secondary mental health care settings (Gater *et al.* 1991, Gater & Goldberg 1992, WHO 1995, Bhugra *et al.* 2004, Hayward & Moran 2007). However, the 'Pathway Encounter Form' has not yet been evaluated for its

psychometric properties. This is a limitation which will be discussed in the section on study limitations.

The questionnaire has three parts. Part A provides a brief introduction to the study and secures informed consent. Part B has a combination of questions from three main sources

- CORS Instrument (Circumstances of Onset of Symptoms and Relapse index), the questions used and adapted from this instrument helped to develop a structure to create a demographic profile of participants.
- Questions which emerged from phase one of the study and,
- Questions which emerged as a result of suggestions from the expert panel. One such suggestion led to a question about change in living circumstances at time of onset of symptoms.

Permission to use the CORS index was obtained (Appendix 17). The primary aim of part B of the questionnaire was to present a more comprehensive socio-demographic profile of the larger population concerned and to understand better some areas of functioning such as living circumstances and any changes in these, the matter of a barring or protection orders, education and employment status around the time of current onset of illness and how some of these factors may have contributed to participants' experience of accessing help for their mental health problems. Part C of the questionnaire was aimed at providing information about the delay in seeking help for mental health problems from the point of the earliest subjective view of the onset of symptoms to making the first contact to address these. It also intended to provide descriptive information on factors such as referral pathways, the range of contacts made, and types of treatment provided at each of these stages. The final section of part C identified whether contact with mental health services was established prior to current imprisonment and if that contact was maintained. This instrument relied on self-reporting, which is limited by people's ability to recall events, dates or contacts.

4.6.2 Validity and reliability

Polit & Beck (2004) assert that validity is concerned with an instrument's potential to measure what it is designed to measure. The design of a questionnaire requires careful construction to reflect attributes of the concept or aspects of the topic being researched. A questionnaire must produce valid and reliable data to be of use to a researcher. Polit & Beck (2004) purport that validity and reliability is not fully independent of each other. However Burns & Grove (2005) contend that validity is more important to establish than the reliability of an instrument.

There are two important questions, which the researcher must ask when assessing the validity of a questionnaire:

- Does the questionnaire address the research question?
- Do the questions adequately represent the different attributes of the concepts or the different aspects of the issues being studied?

The Pathways to Care Encounter Form (Gater *et al.* 1991) has been used extensively in various settings and cultures worldwide (Gater *et al.* 1991, Gater & Goldberg 1991, WHO 1995, Bhugra *et al.* 2004, Hayward & Moran (2007). The testing of reliability focuses on three factors - internal consistency, stability and equivalence (Polit & Beck 2004). *Stability* is the extent to which the same scores are obtained when the instrument is used with the same people on different occasions.

- *Internal consistency* is the degree to which the subparts of an instrument are all measuring the same attribute.
- *Equivalence* is the degree of similarity between alternate forms of a measuring instrument.

4.6.2.1 Expert panel

A crucial step to ensure the validity of this instrument was the formation of an expert panel of reviewers. The key role of this panel was to review the questionnaire from the perspective of its face validity (Polit & Beck 2004). The expert panel consisted of two experts from the Irish Service User Advocacy Network and two health professionals from

the academic arena. All of the panel have expertise in the area of mental health. Feedback ranged from issues about sexuality, language and living circumstances. For example one member of the expert panel observed that in part B question B2 'Marital Status' omitted to include 'same sex relationship'(Appendix 9). Another suggestion concerned question B4 in 'Change in living circumstances'. A question was included within this section with regard to being a subject of a barring or protection order. This directly stemmed from the qualitative phase of this study and was further emphasised by a panel member representing the Irish Advocacy Network. Language used throughout the questionnaire was also considered inappropriate in some instances. An example of this was the use of the word 'Carer'. This word was changed to 'Contact'. This comment was based on the assumption that the word 'Carer' might suggest that actual care was provided (Appendix 10). Other suggestions concerned language where question B5 (a) about education used the Irish version of an educational qualifications. In question B6 the word 'salaried' was replaced with 'paid'.

However, any possibility of expert panel bias needs to be acknowledged (Mc Gartland *et al.* 2003). In order to overcome this limitation a pilot study was conducted. Participants for the pilot study were selected using the same inclusion criteria as the main part of the study. Participants in the pilot study were asked to contribute any comments or suggestions with regard to the instrument. (See section 4.6.2.3 below).

The reliability of a questionnaire refers to the consistency accuracy, precision, stability, equivalence and homogeneity with which respondents understand, and respond to, all the questions (Polit and Beck 2004).

The review of the literature in chapter three shows that there is no consistency between the various instruments utilised on research into pathways to mental health care. Therefore, it was not possible to establish consistence psychometric properties among the various studies on this issue. As a result, a number of steps were taken to ensure reliability of the questionnaire. These were an inter-rater reliability test and a pilot study (Polit and Beck 2004).

4.6.2.2 Inter-rater reliability

When reliability is based on the principle of equivalence between researchers in coding behaviours, estimates of inter-rater (or inter-observer) reliability are obtained (Polit & Beck 2004, p.387). To obtain inter-rater reliability for this study, a number of questionnaires were completed by a colleague in Cork prison. This colleague received information and a Pathways study information pack prior to completing the questionnaires with participants. The results of these were coded by both researchers separately. Both sets of data were then compared for differences or similarities. A high level of consistency was shown between both sets of data.

4.6.2.3 Pilot study

Conducting a pilot study provides evidence of forward planning by a researcher (Polit & Beck 2004, p. 215). This exercise ensures efficacy which strengthens and enhances the rigour of research (Polit & Beck 2004). A pilot study is intended to establish the validity reliability and feasibility of the instrument being used. The two questions, which a researcher must ask when assessing the reliability of a questionnaire:

- Are the questions clear and unambiguous enough for respondents to understand and respond to them in the same way each time they are presented, and for the respondent to understand them in the same way as others do?
- Do all respondents interpret the instructions given by the researcher in the same way?

A pilot study of the adapted Questionnaire (Pathway to Care Encounter Form) was conducted in Arbour Hill prison. A particular landing of this prison was selected for this purpose so that it could be easily excluded when conducting the main part of the study. It was distributed to a small group of people similar in characteristics to the intended population. The aim of this process was to establish if the predetermined questions were clear, understandable and relevant to the topic under investigation. Recruitment for this exercise followed the exact same procedure as that for the recruitment of participants for the main part of phase two of the study. Participants were invited to comment on the questions in the questionnaire – were they clear, understandable and relevant. There were two main concerns identified by the pilot participants. The first related to

comments from two pilot participants about the level of English used throughout the questionnaire. The questionnaire was prepared in accordance with the NALA guidelines. This was because the literacy levels among the Irish prison population is quite low (Morgan & Kitt 2003). Hence, this aided the process of establishing whether potential participants were clear about the purpose and the nature of the study and what getting involved entailed. However, two of the pilot participants suggested that the language used in the questionnaire was basic and found it a little patronising. Following consultation with research supervisors and members of the expert panel it was considered that the reason for adhering to NALA guidelines for this type of research outweighed these two comments. Therefore, no adjustments were made to this aspect of the questionnaire. The second concern raised by pilot participants related to questions which requested dates. Many stated that they found it difficult to remember dates and therefore found this part of the questionnaire off putting. Adjustments were made to the questionnaire to reflect this suggestion.

4.6.3 Sample

The sample was drawn from the Irish prison population. Polit & Beck (2004) assert that in order to increase the generalisability of a study participants should be selected from least two or more sites. The questionnaires were administered in seven prisons throughout Ireland excluding a landing of Arbour Hill which was used as the pilot study site. A method of quota sampling was utilised for this phase. It is acknowledged that non-probability sampling is less likely than probability sampling to select an accurate representative sample (Polit & Beck 2006, p. 292). However, quota sampling does reduce the risk of sampling bias by stratifying a population to enhance representativeness (Polit & Beck 2009, p. 314). The stratification of the population ensured that prisoners who had a diagnosis of a mental illness were included. Also many of the prisoners attending prison in-reach clinic were known to psychiatric services prior to incarceration (O'Neill 2006, WHO 2007). Therefore these people may be best suited to respond to this research question. Participants who had difficulties with literacy skills were given assistance where this was needed. The assisted questionnaire was administered to all those who, once assessed by their clinicians (FCMHN) and deemed competent to participate, met the

inclusion criteria and were willing to participate in the research. The average number of people attending each of the fifteen in-reach mental health clinics is 20, giving a total of 300 approximately for this phase.

4.6.4 Recruitment

A letter was sent to the Director of Healthcare of the Irish Prison Service requesting permission to administer assisted questionnaires in the various prisons in the Republic of Ireland (Appendix 1). This letter provided an information leaflet for the study (Appendix 2). The visiting clinicians for prison in-reach mental health clinics were requested to act as gatekeepers for the study (Appendix 3). They are Forensic Community Mental Health Nurses (FCMHN). The gatekeeper's role was to assess those who were competent to participate, who meet the inclusion criteria and who were willing to participate in the research. All those attending the prison in-reach mental health clinic who met the inclusion criteria were invited to participate in this phase of the study. Consent was obtained through ticking a consent box on the first page of the questionnaire.

4.6.5 Analysis of quantitative data

Quantitative research sets out to measure phenomena and so numbers need to be attached to the data. A coding manual was provided by Richard Gater on receipt of the original questionnaire. Data were coded and entered into the Statistical Package for the Social Sciences version 18 (SPSS-18). The next step before analysis is to ensure that data is entered accurately. This process is referred to as screening and cleaning the data (Tabachnick & Fidell 2007, pp. 60-116, Pallant 2010, pp. 43-49). Errors can be identified by running 'case summaries' in the SPSS.18 package. In quantitative analysis there are four levels of measurement:

1. Nominal measurement where numbers are assigned to variables. These numbers have no value and are simply a means of coding or categorising information. This occurs when numbers are assigned to gender or qualifications. These can then be analysed manually or by computer.

2. Ordinal measurement takes place where variables are ranked into categories based on levels of satisfaction or dissatisfaction. Numbers may be attributed to each category for coding purposes. This does not inform the researcher how satisfied or dissatisfied the respondent is because there are no in-between levels. This restricts the findings.
3. Interval measurement uses a scale similar to ordinal scales it is more precise because it gives readings for in-between categories. Scholastic Aptitude Tests (SAT) are based on these scales.
4. Ratio measurements are the highest level of measurement in research terms because they have an absolute zero and therefore provide information about the importance or degree of a variable.

How quantitative data is analysed and presented depends on the research question. Three levels of research have been identified - are descriptive, correlative and experimental. The level is determined by the research question. Descriptive questions are analysed by descriptive statistics and the three main features used by researchers to do this are frequency, central tendency and dispersion.

The quantitative data from this research needed to be changed into numeric categories. There are several statistical techniques used to explore relationships among variables, such as correlation, multiple regression or factor analysis. However an important decision needs to be made at this stage of analysis. Is the data parametric or non-parametric (Pallant 2010, p. 111)? According to Pallant (2010) parametric statistical tests are considered to be more powerful than non-parametric ones. Parametric tests must satisfy certain assumptions to have statistical value. Interestingly, within the field of social science much of the research does not meet the criteria for parametric tests. The type of data gathered in this study is non-parametric. Non-parametric tests were used, since characteristics of the data gathered for this study did not meet the criteria for parametric analysis, criteria such as being normally distributed (Polit and Beck, 2004). The non-parametric tests which were applied for the present analysis were: Chi-Square to test differences in prevalence and the Mann Whitney U test to measure differences between groups. The level of significance was set by $\alpha < .05$.

4.7 Ethical issues

Ethical approval for this study was granted by two separate ethics committees. These were the Faculty of Health Sciences Ethics Committee in Trinity College and Irish Prison Services Research Ethics Committee (Appendix 12 and 13). Beauchamp and Childress (1989) describe the biomedical ethical principles underpinning healthcare as being respect for autonomy, doing no harm, and doing good and acting justly. Additionally, the Declaration of Helsinki states that research involving human subjects must not take priority over the rights and interests of individuals (World Medical Association 2004). A critical point for a researcher concerns the mechanisms which need to be put in place to protect the wellbeing of potential research participants. According to Burns & Grove (2005) it is the responsibility of the researcher to ensure ethical principles are rigidly adhered to at all times throughout the research process. In order to ensure that this process is adhered to meticulously the principles as outlined by LoBiondo-Wood & Harper, (2002, p. 267) were utilised as a framework for this study. These principles are respect for persons, beneficence, and justice.

The right to self-determination is based on the ethical principle of respect for persons. This principle advocates that humans are capable of controlling their own destiny (Burns & Grove 2005, p. 166). Obtaining informed consent from human subjects is essential for the conduct of ethical research (Burns & Grove 1997, p. 209). However, obtaining informed consent is more complex than usual in this research because of the involvement of the perceived vulnerability of the group in both phases. In spite of this people who have mental illness do not, in fact, have impaired decision-making ability (Grisso & Appelbaum 1995, Roberts 2002). Indeed, involving those most affected by an issue is an ethically appropriate way to conduct research and is compatible with the ethos of inclusion advocated in modern mental health discourse. Keogh and Daly (2009) note that people with mental or emotional health problems and people with cognitive impairment are frequently considered vulnerable groups. Definitions for vulnerability vary. Moore and Miller (1999) suggest that a diagnosis of an illness renders one vulnerable. This may result in such people being excluded from research studies. According to Tee and Lathlean (2004) an individual is deemed vulnerable if their cognitive function impacts on

their ability to understand the nature and purpose of a research study and their ability to make an informed decision about participation in this research. However, the World Medical Association's Declaration of Helsinki (1964 and last revised 2008) states that vulnerability cannot be defined and so it should not be assumed that vulnerability is a universal characteristic of everybody with a mental health problem. Nonetheless Black *et. al.* (2007) acknowledges that accessing a perceived vulnerable population raises several ethical challenges.

The design utilised for this research acknowledged that people who engage in this study are perceived to be vulnerable. In fact, participants in this study are considered doubly vulnerable in that they have a mental health problem and are prisoners. Research which involves vulnerable populations is important in uncovering issues requiring attention, in informing policy, in evaluating programmes and services, and in tracking how social and economic change affects people with disabilities (NDA 2009). Additionally, in order for mental health professionals to gain an insight into the needs and experiences of service users it is advisable to include them in relevant research (DoH&C 2006, Mental Health Commission 2005). Indeed, Atkinson (2007) points out that to exclude such groups would further 'stigmatise and marginalise them' (p. 134).

Obtaining informed consent from human subjects is essential for the conduct of ethical research (Burns & Grove 1997, p. 209). Obtaining informed consent is more complex than usual in this study because of the involvement of a perceived vulnerable population. Potential participants were given sufficient written and verbal information about the nature of the study and the nature of their involvement. Every effort was made to ensure that this information was understood. Firstly, NALA guidelines were used. Secondly, any questions asked by potential participants were answered with honesty and accuracy. Only when participants were satisfied with these answers and the information provided did the initial process of consent begin. The principle of 'process consent' was also utilised. A gatekeeper was used to identify suitable candidates as per the inclusion criteria for this study. The sample was then selected from this cohort. This was done to ensure that the rights of potential participants were upheld and that those participating had the mental capacity to give informed consent.

The right to privacy is based on the ethical principle of justice, which involves treating people with respect. Based on the right to privacy, the subjects have the right to be assured anonymity and the right to assume that all data collected will be kept confidential (Burns & Grove 2005, P 172). This researcher organised and facilitated the research process. The information collected remained anonymous when transcribed and treated confidentially. None of the participants who took part in this study are able to be identified in the final report. All data were coded to protect the anonymity of subjects.

Participants have the right to be assured confidentiality and the right to assume that all data collected will be kept confidential. The requirement to maintain participant confidentiality subject to the Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais 2000) was adhered to throughout this study. The information collected from the interviews was anonymised during the transcription stage. Additionally, no identifying comments were requested within the questionnaire. None of the participants who took part in this study or the prisons in which they were residing can be identified in the final report of this study. All data was coded to protect the anonymity of participants. However, participants were informed that, should any issues discussed, such as misconduct, in relation to the care provided that this would be brought to the attention of the relevant authority, for example the employer, the Medical Council, An Bord Altranais or An Garda Síochána. This information was clearly outlined in the participant's information leaflet.

There is no requirement to pass on details of other criminal involvement if divulged by the participants because they are already on a criminal charge. However, there were some exceptions to the duty of confidentiality when doing research with a prisoner population required specifically by the Irish Prison Service. The first occurs if the welfare of the participant warrants disclosure. The second arises if the welfare of another person warrants disclosure. Such a case is that of child protection where disclosure of child abuse is made against a named person or persons. Then the researcher is obliged to inform the appropriate authorities. A third exception occurs if the welfare of society in general is at stake. Fourthly, there is an obligation to disclose information on foot of a court order or under legislation, such as the Protection for Persons Reporting Child Abuse Act, 1998 (IPA

Guidelines Appendix 14). Again this information was clearly outlined within the participant's information leaflet.

The researcher was cognisant of adhering to the principles of the Freedom of Information (1997, 2003) and the Data Protection Acts (1998, 2003), in relation to this study and the information gathered. All data was collected, processed, and will be stored in accordance with the Data Protection (Amendment) Act (2003) for five years after completion of the study. Participants in both phases were assigned an ID number and no person, institute or health services were identified throughout the study. The master list of names and ID numbers was stored securely away from all other data.

The principle of beneficence is an obligation to do no harm and to maximise possible benefits (LoBiondo-Wood & Harper 2002, p. 270). Participants in this study were often actively engaged in treatment. In keeping with the Code of Conduct for Nurses (An Bord Altranais 2000), nurse researchers are bound to act in the best interests of participants. Procedures which were put in place in the event of a participant becoming distressed during the interview were to acknowledge this distress, to stop the interview and give the participant time to consider if they wished to continue or not. Also participants were reminded that if they wanted this researcher to contact the person in charge of their care, he would do so. However, this situation did not arise. Contact details were also provided to all participants of supportive services available within the prison, services such as AWARE, GROW, Shine, Irish Advocacy Network, Mental Health Association and other appropriate services.

It was important to acknowledge at an early point in this study that it might raise some very distressing and traumatic issues or events for participants. It involved reflection with the potential to evoke strong emotional responses to personal experiences with health and allied services. On one occasion a participant became very upset while he discussed many unsuccessful attempts to gain access to professional help. In this situation the benefit of having previous experience of conducting interpretive research ensured that the interview was managed in a respectful and empathic way to the participant's situation. In addition, time was allocated at the end of each interview to discuss any sensitive or emotional issues that arose for a participant should they wished to discuss it outside the recording process.

At all times participants' wellbeing was prioritised over the research study. Participants were informed that they could stop the interview at any time. In adopting a process approach to informed consent as discussed earlier, this researcher remained sensitive to participants' verbal and non-verbal signals. Should any indication of a participant becoming upset occur due to participation in the study, the interview would have been discontinued? It could recommence at another time if that suited the participant.

4.8 Integration of data

In mixed methods research the issue of integration is fundamental (Rauscher & Greenfield 2009). This study is integrated at three points

- In the formulation of the research question,
- in the adaptation of the data collection instrument for phase 2 and
- in the interpretation of the findings within the discussion chapter.

Essential to any research project is the question. Research methods should complement the research question in order to provide the best chance of achieving useful answers (Burke-Johnson & Onwuegbuzie 2004). A comprehensive review of the literature on the issue of pathways to mental health care facilitated an opportunity to fine tune the research question for this study. It was evident from this review that a vast amount of the research on this topic omitted a central component, namely, those directly affected by the experience of accessing and maintaining a link with mental health services. For this particular piece of research concerned prisoners with mental health problems. To adequately address this research question, integration of methods was considered the most appropriate approach. One of the main reasons for this was the environmental constraints of prisons. Prisons are difficult environments to gain access to for research purposes. Mixing methods for this study provided an opportunity to gain access to a large sample while still not impinging excessively on the prison system. Therefore, the findings are more useful and generalisable to the overall population. At the same time, the design employed provided the opportunity to emphasise the qualitative component, which was crucial in adequately capturing the experiences of this group on this issue.

There are many reasons provided for conducting mixed-methods research, some of which are triangulation, complementary, development, initiation and expansion (Green et al. 1989). This study uses qualitative methods to generate themes. These themes are then integrated in order to develop a more accurate quantitative instrument. This process ensured consistency between both phases of the study. Additionally, it enhanced the validity and reliability of the research findings (Greene *et al.* 1989, Bryman 2006, Creswell & Plano Clarke 2007).

Integration occurred during the process of interpretation of the findings from both parts of this research. This process highlights the strengths of the mixed methods design utilised for this research. The integration of the findings laid the foundation for a comprehensive discussion of the central issues which emerge from the conduct of this research. This created a forum where findings can be corroborated, strengthened or refuted.

4.9 Limitations

There are a number of limitations in conducting this type of research. According to Schlosser (2008), presenting the unheard stories of prisoners far outweigh surrendering to methodological limitations. That being said, research limitations need consideration when interpreting the results.

The sampling technique utilised for this study provided an opportunity to access a known group of people with mental health problems. It is important to recognise that this technique excluded those who may have had a mental health problem but were not recognised by the prison system as having such, and prisoners with mild to moderate mental health problems. Because these did not have a diagnosis they did not meet the inclusion criteria. The focus of this research was to gain an understanding of the experience of prisoners with mental health problems in accessing and maintaining a link with mental health services prior to incarceration. The technique used did provide a necessary sample. An alternative approach was not feasible. Another limitation of this study concerns the reliability of self-reporting and recall when gathering data. The Pathways Encounter Form relies on specific details, such as dates, in some instances. This issue was addressed by piloting the instrument as well as recruiting an expert panel to

review it. Both of these avenues raised concerns about the risk of information regarding dates being possibly inaccurate. The instrument was then adapted to exclude sections requesting specific dates as this was not the primary focus of this research. The primary focus of phase two of the study was, to gather a comprehensive demographic profile of a larger sample of prisoners with mental health problems. It examined factors such as previous contact with community mental health services and if this was maintained. It also explored if delays accessing mental healthcare were experienced, as well as the range of contacts made in order to address mental health problems. It also considered what forms of treatments were most commonly provided when contact is established.

The prison environment itself could also be considered limiting factor in this type of research. Access to prison for research purposes is a major challenge. This was successfully achieved by approaching the appropriate prison authorities and ethics committees. However, it was prison personnel that were most likely to create the most difficult challenges in accessing potential participants. This often delayed the process of gaining a sample to collect data. However, this did not influence the consultation with the participant once access was established.

The review of the literature revealed that a broad range of instruments could have been used to explore the issue of pathways to care. No psychometric properties for the range of measures were provided within any of the published research (Singh & Grange 2006). Therefore, it was not possible to make a direct comparison between published research and the findings of the present study. It is noteworthy that several steps were taken to establish validity and reliability for the adapted instrument utilised in phase two of this research. These included establishing an expert panel to test for content validity, conducting an inter-rater reliability test as well as conducting a pilot study using a sample which met the inclusion criteria.

This research utilised an exploratory sequential mixed methods design. This design provided an opportunity to address some of limiting factors of the research as well as acknowledging the limitations of previous research on pathways to care. According to Morgan *et al.* (2004) there is limited information on the issue of pathways to care, in part this is as a result of how it is researched. For example, it is predominantly researched from an empirical perspective, excluding the social context of help-seeking behaviours.

Judge *et al.* (2008) note a particular deficit of studies employing rigorous qualitative techniques. Morgan (2004) maintains that a singular approach to research on this issue creates a static, one-dimensional model of pathways to care. Pescosolido (1998, p. 284) asserts the need for an erudite methodological approach in order to understand more accurately how people interact with the health system. Indeed, Johnson and Onwuegbuzie (2004) advocate a needs-based approach to research methods. A mixed methods or eclectic approach to research does provide a more workable solution and produce a superior outcome (Johnson & Onwuegbuzie 2004, p. 17). Several known benefits of using a sequential (QUAL→quant) design have been identified (Greene *et al.* 1989, Bryman 2006, Creswell & Plano Clarke 2007). Among these is the provision of an opportunity to generate themes in order to develop a more accurate quantitative instrument. A second benefit arises because qualitative findings can be used to further enhance the credibility and validity of the findings of quantitative data and their relationships or vice versa. The design selected for this study provided a framework for addressing the methodological limitations involved in understanding more accurately the help-seeking behaviours of people with mental health problems prior to being imprisoned.

4.10 Summary

This chapter started by referring to a quote by Galileo "All truths are easy to understand once they are discovered; the point is to discover them." (Galileo Galilei 1564-1642). This describes the motto which influenced the researcher throughout this chapter. Rigorous attention needs to be given to how research is conducted to ensure that it is as accurate and as useful as possible. Despite this, it must be acknowledged that all approaches to research can have their weaknesses (Mays & Pope 1995). This chapter meticulously demonstrates how issues such as protecting vulnerable research participants were considered. At the same time it illustrates strategic and effective approaches taken to conduct research on this topic. It does this by providing a detailed rationale including examples for the methodological decisions and challenges confronted throughout this process. Matters which required particular attention were research methods, recruitment approach, procuring a sample, the procedures for data collection and the

approach taken to the analysis and integration of the findings. When conducting research of this nature, ethical concerns are paramount. Potential participants for this study are perceived as being doubly vulnerable. Therefore, ethical issues with regard to respect, beneficence, and justice were closely examined to ensure that potential participants would not be misinformed or exposed to any risk as a result of this research. Also within this chapter a detailed account is provided of process by which the data collection instruments were developed and adapted respectively. Particular attention is paid to how issues of validity and reliability were addressed.

CHAPTER FIVE – RESULTS OF QUALITATIVE PHASE

5.1 Introduction

This study involves both qualitative and quantitative methods of data collection. One of the main differences between these two approaches is the qualitative researcher's use of self when collecting data. This chapter explains how the qualitative data was collected and analysed for this phase of the study. As described in chapter four, results from each method are used to enhance credibility and validity and to strengthen, to challenge or refute of the overall study findings. A detailed account is provided of the many steps taken to ensure that the data was thoroughly and transparently analysed. Indeed Cousins & McIntosh (2005) advise that transparency of the research process when using qualitative methods is a key issue with regard to the 'trustworthiness' of the data analysis. This process is bolstered by the utilisation of Colaizzi's (1978) framework which ensured a structured approach was taken in this process. The aim of the qualitative phase of this research is to truthfully present the experiences of participants in this study (Patton 2002). By using the themes generated from this process it is intended that the integration between the qualitative and quantitative data generated during the next phase of the study would provide a comprehensive analysis to help understand the experiences of people with mental health problems within the criminal justice system while trying to assess mental health care prior to incarceration.

5.2 Demographic Profile

The prison population is steadily increasing. In 2010 the total annual committal figure stood at 17,179 to Irish prisons (Irish Prison Service [IPS], 2010). The daily average number of persons in custody for this same year came in at 4,290. This represents an 11.4% increase in the numbers committed to prison under sentence from 2009 (IPS 2010). The numbers of females in prison is also increasing. The average number of female offenders in custody in 2010 stood at 157, an increase of 25 (or 19%) on the 2009 level of 132 (IPS 2010). These dramatic increases are attributed to non-payment of fines (IPS 2010). However, such increases impose enormous pressure on an already chaotic

prison system. A total of fifteen (n=15) interviews (five in each site) were conducted. In Mountjoy and Dóchas prisons three female and two male participants were interviewed thus ensuring a proportionate gender mix was achieved. In order to uphold the rights of all participants, a gatekeeper was used to access the sample in each of these sites. Forensic community mental health nurses working in the prison in-reach mental health clinics were requested to distribute the information packs to the potential candidates who they assessed as being competent to participate and who met the inclusion criteria.

5.3 Emergent Theme One

Predisposing factors to involvement with the CJS

This theme deals with the various social, environmental and psychological factors experienced by participants prior to involvement with the Criminal Justice System CJS. All participants were first asked as an icebreaker to:

- Tell me about yourself?
- Tell me about growing up?
- Can you tell me about how you came to be in prison
- I'm aware that you are attending the prison in reach clinic about your mental health problem(s) can you tell me about this?

Participants identified a broad range of social, environmental and psychological experiences prior to their involvement with the CJS. Some examples of these are: Family history of mental illness, Homelessness – Barring\Protection order, Life events - abuse, trauma, suicide, bad experience with the education – i.e. expelled, dropped out, Stigma, Cultural issues and previous involvement with the CJS

Family History of Mental Illness

Six participants commented on a history of mental illness within their family. Below is an example of some statements by participants with reference to this matter.

“There is a lot of mental illness in me family me ma was in and out of [psychiatric hospitals] for years 2 of my sisters have mental illnesses. One of my sisters commit suicide

she drown herself....she jumped off the pier in [place in Dublin] and my other sister tried to do it too [suicide].” (P6)

“My mother was a manic depressive and my father had to get psychiatric help for his mental health problems and my eldest sister has been diagnosed as a schizophrenic. And I have been diagnosed with a schizoid affective disorder.” (P8)

“I had another sister but she committed suicide 2 years ago. I don’t know why I think she had a mental illness as well... but I’m not sure.” (P3)

“Me uncle on my mother’s side was very bad with mental illness as well he was in hospital a lot and me mother as well she took a nervous breakdown too, a few years ago. And eh she’s been in hospital [psychiatric] a couple of months ago and she’s on tablets and all that now you know. She doesn’t say too much about it she doesn’t want to be upsetting me because I am in here [prison].” (P13)

Memo

Maki *et al.* (2005) contest that the strongest factor leading to schizophrenia-related illness has been identified as familial risk with genetic loading. Phelan and her colleagues have shown in two studies instances of ‘genetic attributions of mental illnesses (Phelan 2005, Phelan *et al.* 2006).

Homelessness – Barring\Protection order

Several participants referred to experiencing difficulties while living at home with their family of origin. Five participants referred to a range of difficulties at home which resulted in them becoming homeless. Many of whom directly related this experience with getting involved in criminal activities.

“I left home at about 17yrs...ended up going to hostels for young offenders...got in with the wrong crowd and eh I ended up in [prison] and then I ended up in the [forensic services].” (P3)

"I ended up out on the streets more times and I'd stay in hostels and that [Forensic service] sometimes.... And then I'd go home for a while but things weren't great there"
(P6)

"I was homeless for a while and I had a principle of not wanting to go on the dole" (P11)

"I would go home or sleep rough and ended up in trouble again."(P15)

One participant commented on the fact that upon being released from prison that they would again be homeless.

"I m homeless at the minute I will have to organise somewhere to go when I get out of here [prison] ... but I don't know I can't go home or that." (P3)

Four participants referred specifically to either breaching a barring or being barred from their home at some stage prior to becoming involved with the law [CJS]

"But before that there was a spiral of events that led to my involvement with the law [young offenders centre] - drinking, drugs, barring order and homelessness at one stage."(P5)

"I ended up getting barred from the house. Then eh with that everything just came down on me... I had no house... she had the house everything was gone..." (P1)

"I wasn't supposed to be at the house either you know I was barred from there... because there used to be a lot of fights and that." (P6)

"I breached a barring order that me ex girlfriend took out on me. I was just looking to see me kid. I'm probably going to get a year for that because that's what I did the last time as well you know." (P3)

Memo

A significant relationship between homelessness and severe mental disorder has been shown in several studies (Nacro 1992, Zaph *et al.* 1996, Farrington 2008). Furthermore Zaph *et al.* (1996) reported an association between being homeless and having a history mental illness. A major barrier to accessing appropriate mental healthcare is homelessness consequently this is associated with a reduction in the support network of homeless people (DoH&C 2006 p. 143).

Life events

Participants reported having experienced a variety of traumatic life events in the years before going into prison. These ranged from abuse both sexual and psychological, suicide, and separation, alcohol & drug abuse and early involvement in offending behaviour.

The following statements are some examples of participants' accounts of being the victim of sexual abuse as children.

"I am here [prison] because I assaulted a family member. He abused me when I was a child" (P12)

I was abused there [detention centre for children]by him [Christian Brother]... that's when things starting going badly very badly." (P10)

The comments below present participants' stories of being the victim of psychological abuse. One participant described living in a remote part of the country and feeling unable to report or even talk to a local G.P. about such an experience. Another spoke of feeling excluded by his family as he was growing up. A third participant referred to being separated from his family following the death of his father when he was aged eight.

"I suppose I suffered from depression years ago but I was put down all the time... by my ex – husband I was tired all the time I had no energy at all you know."(P2)

"Well I grew up with a big group of lads I would have always felt like the black sheep of the family even my own brothers would have often wondered if I was adopted [jokingly]. I am the second eldest of six ... My older brother used to bully me...one day my brother came in off his motorbike and punched me ...that day I fought back I just kept kicking and kicking and hitting and hitting only that my father was there I probably would be serving life sentence for that. That was the only time that a fought." (P7)

"Well me father died when I was very young I was 8[years old] and me Ma is still alive. Well I got taken away then the night he died yeah I got taken away. I was taken to [detention centre for children] and then to [a different detention centre for children] and then [psychiatric hospital] and eventually on to here [prison." (P10)

Experiences of family trauma were referred to six by participants examples of these are the suicide of family member or parental separation.

"I had another sister but she committed suicide 2 year ago. I don't know why I think she had a mental illness as well... but I'm not sure." (P3)

“I had lots of problems growing up I think I just blotted them all out... my sister who commit suicide.... I miss her she was great [silence] I think I drink and do drugs just to get all that stuff out of me head.” (P6)

“My parents separated when I was about 2 and my mother travelled a lot you know. So eh... then my father was in the UK I hadn't seen my father in about ten or eleven years. I met him for a couple of hours.”(P13)

A common strand evident in most of the interviews was participants' references to their abuse of drugs and alcohol. Several participants commented on the effects of their drug and alcohol misuse had on their lives and related this behaviour to their offending and in some cases the mental health problems as well. Below are some examples of these comments.

“So basically at the age of 39 [years] I smoked hash became sick and ended up here. No eh I would have smoked it before when I was about 18 yrs for about a 6 months period but I went back to it at a period in my life were I smoked it again. There is no history in my family of mental illness. I can attribute my mental illness if that's what you want to call it to smoking hash you see cannabis for me really blighted my life there was no drug awareness then so at the early age of eighteen I should have been in college but I took a different road then that was it. I was spending my time out of my head listening to heavy music and all that. I dropped out of everything for a good six months till eventually I went back to work. It took its toll on me” (P14)

“I used to have a problem with drugs but not really now I'm on me methadone maintenance dose now so ok now.... I'm on 110 mills a day for the past 3 years now and when I get out of here I will get it in [Drug treatment centre]. I smoke the bit of hash still but not much now I used to be heavier on it. I used to get really strung out on heroine ... I got strung out bad once in the [prison] and I got into a fight I ended up getting over 100 stitches in me head. Fighting with me mate ... mad you know.” (P9)

“I got into taking drugs and eh I could see no other way of getting up [feeling normal] I was low.... Low low low all the time. So eh some bright spark said try cocaine that will get you up... it got me up alright...but jayus the down afterwards was unreal.... don't get me wrong... I loved it ...” (P1)

Participants reported involvement in petty crime from a very young age.

"I got kicked out of that because I stole something yeah yeah. So after that I was just hanging around stayed at home a lot in my room I didn't have many friends I think people didn't like me or maybe they were afraid of me I don't know..." (P15)

"I was nearly 14 yrs when I got 12 months in [a detention centre for young offenders] for robbing cars mainly you know..." (P9)

Education

Where education was concerned, four of the fifteen participants reported having gained higher level qualifications. However the majority of the participants stated that they either left school early or were expelled as a result of bad behaviour while attending school.

"I went to secondary school and got 465 points in my leaving cert and I got a degree in marketing and passed yeah and I got that." (P12)

"I was expelled for that at 12 years of age." (P9)

"So I never got much of an education. I can't really read or write." (P6)

"I got thrown out of school at second year because I was fighting I had tests done and all that and I was all right but I got thrown out before I got to do a junior cert or anything like that." (P15)

"eh I went to school me mother kept me in school but eh I got into a fight when I was 15 and then I was thrown out of school I was very close to doing my junior cert but I didn't get to do it. I really wanted to do my junior cert I wanted to have trade or something like that you know. But as I say I got into a stupid fight and eh the headmaster just took it into his head that I was the cause of it so then I was expelled you know" (13)

"I was always in trouble I got kicked out of school load of times so I didn't get much of an education." (P3)

"I had a very ordinary life lived on a farm in a country area nothing unusual or that. Didn't get much schooling but that was the norm you know." (P2)

Memo

A study on prison literacy levels found that half the prison population are at pre-level one and level one, literacy levels (Morgan & Kett 2003).

When diagnosed

Six participants stated here that their diagnosis was made either within the prison system or while they were assessed in the Central Mental Hospital [The Central Mental Hospital is Ireland's national high security mental health service. This service conducts mental health assessments for the Irish Prison System.]

"they [mental illness] were only picked up this year while I in prison this time" (P3)

"When I was in [prison] for the first time I was told that I had schizophrenia." (P10)

"While in the [prison] I was assessed and was told that I have a depressive disorder and I was put on tablets." (P5)

"yes when I was in prison the first time I was assessed by the psychiatrist and I was diagnosed with schizophrenia." (P4)

"So eh when I got into trouble with the police my solicitor got me assessed by a psychologist...so that's when I got diagnosed with bipolar." (P1)

All six participants made multiple references to the fact that they were misdiagnosed.

"How it all started I had depression for year but I was wrongly diagnosed I have bipolar depression they [doctors] just said it was depression I always new ...well I didn't if you know what mean. The first thing he prescribed me was [antidepressant] so of course it was good for a few months but then I was on this for a year or maybe two maybe could a been a bit more... but it wasn't doing me any good. So somebody said to me if there not agreeing with you... so then in me madness I went to another doctor... me sister came with me this time. Then he gave me medication. It didn't work either. But me sister came with me as I said and she said to the doctor that I think it is more than just depression... but the doctor said no no... he just has depression." (P1)

"But it was a long while afterward that they found schizophrenia and I didn't suffer from depression you know." (P3)

"yes and when I was younger I was diagnosed as a schizophrenic but that was it that was wrong ..." (P15)

"Well when I was in [psychiatric hospital] they said I had personality disorder... but nothing seemed to really happen you know." (P6)

Memo

The majority of the participants received a diagnosis of a major mental disorder i.e. schizophrenia or bipolar disorder.

5.4 Emergent Theme Two

This theme deals with factors influencing access\maintaining links with mental health services prior to involvement with the CJS

Contact with services about mental health problems prior to imprisonment

Participants were asked “Did you make contact with mental health services before you went into prison?” Thirteen of the participants replied to this question. Of them eleven had made varying degrees of contact with mental health services before they became involved with the CJS.

Six participants initiated their first contact regarding their mental health problems.

“No I went of my own accord... nobody told me to go and see him. I’ll never forget the day...one day I was just out in the garden fixing the lawnmower and then I don’t know what happened...I just went bonkers....I don’t know what it was so I said I m going to go see somebody... myself I said.” (P1)

“Also over the years I used to go to my GP and sometimes when I went to see him he would just give me some relaxing tablets you know.” (P13)

“I did yeah eleven year ago I had been in hospital before I was in [psychiatric hospital] ... It was a drink related thing.” (P14)

“In about 2000-1 was when I first went to see anybody about me depression. I just went to the normal doctor [GP] you know eh... depression runs in the family.” (P1)

“Yeah I felt I needed to get help for my mental health problems. I tried to get help for once yeah once I went to psychiatrist in the [psychiatric hospital], I was referred to another service.” (P3)

Memo

Tedstone Doherty *et al.* (2009) found that of those who reported mental health problems, (n=965, 57%) in the Republic of Ireland and (n=1000, 42%) in Northern Ireland had not sought help from the GP. The Demyttenaere *et al.* (2004) study showed similar findings to. Tedstone Doherty *et al.* (2008) showed that almost 10% of the sample had spoken to a general practitioner about mental health problems in the previous year, with an average of four visits per person recorded. Steel *et al.* (2006) claim that an average of three professional consultations is made prior to first contact with public mental health services. Those family doctors occupied a pivotal role in the help-seeking pathway with 53% of patients consulting a general practitioner.

Experiences with mental health services prior to involvement with the CJS

Practically all (thirteen) participants expressed negative views about how their mental health problems were managed prior to becoming involved with the CJS. These negative experiences ranged from an over reliance on medication and the use of repeat prescriptions, G.P. not ‘hearing’ problems – unwillingness to talk about problems, absence of services to be referred on to, or services not being inclined to admit a person to an in-patient setting. Listed below is a mixture of extracts exemplifying these experiences?

“He [doctor] never offered me anything other than medication... he never offered me a psychologist or anything. And he knew about me sister and me father and the history of depression in the family and all that...I just went back for another prescription you know. He never asked to see you like, just a repeat prescription. But they just weren’t working I was more down all the time you know what I mean than up.” (P1)

“No he [Doctor] never referred to anything like that no no. I think they were more concerned about the kids and everything else. So no he never asked anything about that

[mental health]. It was only when I came to [refuge centre] that there was help there yeah in the women's refuge centre. They really helped me and got me to see the right people you know." (P2)

"Nothing eh they just talked to me oh and eh some relaxing tablets and that was it. (P15)."

I've never seen a psychologist you know in hospital you spent most of your time just waiting around you just see your doctor for about 10\15 mins maybe weekly and beyond that you just really hang out you know.(P11)

"I was once prescribed Prozac by my GP eh about five years ago. He knew I didn't like taking tablets" (P7)

"Nobody talked about my problems or that there. And after the 3 weeks I was discharged by the doctor. I went back to my apartment in Dublin so I didn't really have any supports I had some friends in [home] and that but I didn't really have anything."(P12)

"What I didn't like about it was that the medication made me put on weight so that's why I stopped going to see the psychiatrist and stopped taking medication yeah a lot of weight." (P3)

"I got tablets and he [doctor] said I didn't need to be admitted and told me to stay at home and gave me an appointment for the Clinic [outpatient] ... I didn't keep it... I ended up on the streets got into drugs and that's when I started to get into trouble with the Gardai... Well as I say I got tablets not sure what they were you know... they [doctors] didn't tell ye anything." (P6)

"I didn't feel that my mental health problems were very well managed really nothing really happened... I feel that I've never got a break you know as such. I never got the treatment that I feel that I'd need. Never really got any treatment nothing has ever really been done for me. A lot of Doctors out there seem to want to take short cuts and just want to give you loads of medication...." (P10)

"I was very unhappy with how this whole thing was managed I think they should have kept me in when I told them how I was feeling and I was so paranoid about the devil and that I should have been kept in." (P13)

"Ye need to talk to somebody to get help and that and get the right treatment and all that. I don't think that people with mental health problems would end up in prison if they were picked up in time you know." (P3)

Memo

Linehan *et al.* (2006) showed that in Irish prisons, 91% of those with major depressive disorder and 66% of those with a psychosis were already known to community psychiatric services. Nolan *et al.* (2011) found that service users felt unprepared for the transition back to a community setting following discharge from an acute psychiatric ward.

Misuse of prescribed medication for mental health problems

Several participants described misusing prescribed medications by just telling the GP what they want, stopping medications due to lack of insight or the inappropriate use of them [overuse or self prescribing].

“Tablets you know with the prescription ye just tell the Doctor what you want and he writes it out for you.” (P9)

“But when I was first prescribed them I gradually built up my use of them. When I got to Galway first I was taking 18 [distalgesic] at a time 10 [medication for medical complaints] and others that was at one time and then three hours later I would take the same again.” (P2)

“I take the medication for a while and I would stop because I think I don’t need to take it because I feel ok again doctors say that is because the medication makes me feel well and that’s when I am at risk of stopping my medication. I don’t want to be taking it forever” (P15)

“I was suffering with me nerves in 2004 and eh it was me own stupid fault I stopped taking me medication you know. I stopped contacting me doctors I thought I was healed you know you know. And then it just hit me I used to get very bad I’d get delusion thoughts paranoia and that and I got really high so yeah I was really bad then.”(P13)

“I’ve gone on and off tablets you know ... I would stop taking my medication in the past I read up about the meds and I gave them up you put on weight and that and they would have a sedative effect I didn’t like that. Well I was on Clopixon and I had very bad side effects I couldn’t do anything I couldn’t even shave you know.” (P11)

Memo

Effective treatment of psychosis involves the use of antipsychotic medication. Yet, reported rates of non-adherence (non-compliance) with antipsychotics range from 20%-89%, with an average rate of approximately 50% (Larco *et al.* 2002). Adherence to antipsychotic medication is the single most important determinant of the long-term clinical outcome in patients with schizophrenia (Birnbaum & Sharif 2008). Lingam & Scott (2002) contest that illness characteristics or medication inexperience has been linked to poor medication adherence in affective type disorders.

Stigma

Stigma is one of the main factors influencing access to mental health services according to several participants' responses. It is identified as one of the barriers described by the participants. There are two main foci with regard to this issue. As a result, this issue is presented in two parts - stigma from a broadly societal perspective and within the prison system. This latter part is dealt with later in emergent theme three. Below are some examples of significant statements from several participants with regard to experiencing stigma from society:

"The stigma and all that especially in the country... yeah yeah I was in a really rural area and everybody would know everybody else's business and that." (P2)

"And some of them didn't want to know me when they realised that I had a mental illnessbecause of the stigma they just didn't want to know me. You know." (P11)

"Well as I said being from another country is a big problem. And I think what people think as well yeah stigma big time here yeah." (P8)

"I didn't have many friends I think people didn't like me or maybe they were afraid of me I don't know...." (P15)

"I think that psychiatric hospital there is an awful taboo about them You know there is still a huge stigma about them I don't care what anyone says. It is still alive and well." (P14)

"I was ok for a while but then I got bad again and the psychiatrists wanted me to go back to the CMH again but then I didn't want to go back there I refused because of my family because they didn't like the last time that I was there they slag me and stuff they would

call me ... a mad bastard ...your only a psychopath... you're no good to anybody you know it's a stigma."(P10)

Memo

The term "stigma" is derived from the Greek word for "tattoo-mark" and refers in its historical context to the use of a hot brand for marking the status of a person either as a devotee to the services of the temple, or by contrast, as a criminal or runaway slave (Osborne 1974). Goffman (1963) articulated that the use of stigma concept by society is a way to label and identify certain groups' inferiority, and rationalise the danger it presents. Hartwell (2004) refers to the notion of a triple stigma in relation to mentally disordered offenders. He describes the trajectories for mentally ill individuals with substance abuse problems and their community re-entry after involvement with the criminal justice system. Edwards (2000) describes how stigmatisation might affect ex-convicts in terms of job finding and social acceptance after serving their sentence. Cusack *et al.* (2003) depicts a foucauldian perspective on stigma which shows not only how power can be seen to work, but also how it acts in an adverse manner.

Reaction to treatments provided for mental health problems in the community

Participants were asked questions such as "What sort of treatment(s) you were offered for your mental health problems?" and "Can you tell me about how you would like to manage your mental health problem(s)?" For this theme there were twenty-four references from twelve participants and the majority of the comments related to being prescribed medication only and that often this did not work. Meanwhile many participants reported that their treatment plan was never reviewed. As a result they became non compliant or disengaged with that service.

"A lot of doctors out there seem to want to take short cuts and just want to give you loads of medication...I don't want that I don't want to be like a zombie and put on loads of weight." (P10)

“But as I said I got a couple of tablets and a prescription and they sent me home you know. It didn’t do anything for me...” (P13)

“Yeah well as I say I was in [psychiatric hospital] as an outpatient but I never bothered staying there... they were useless.... I ended up out on the streets more times and I’d stay in hostels and that sometimes.... And then I’d go home for a while but things weren’t great there” (P6)

“I went back a couple more times he (G.P.) wanted to give me a mild sedative or a sleeper but I said no I don’t see the point in taking medication. So when I go off the tabs the problems still exist that’s how I feel you know.” (P7)

“I didn’t like about it was that the medication made me put on weight so that’s why I stopped going to see the psychiatrist and stopped taking medication yeah a lot of weight.”(P3)

Other factors which contributed to participants becoming non-compliant or disengaging with services ranged from - no support following discharge, lack of talk-type therapies and too much changeover of health professionals.

“Well they [G.P’s] say you have depression or that I think they should have checked me after a month or two months you know. Well medication doesn’t seem to be working so eh let’s refer you to a psychologist ... I think that would have been the best thing you know. If that happened they would have found out that I have bipolar and not just ordinary depression. That would have made a big difference I think, definitely!!!” (P1)

“Ye can’t keep doing that you know talk to different people all the time ye get fed up with that ... you could see six people a year maybe you know moving on...moving on ...moving on [angry and disillusion tone].” (P10)

“Some of the medication they give you makes you feel very stupid and slow and makes you very fat ...all my body is covered in stretch makes [they are always there] from the amount of different medication that” (P10)

“I was in the mental hospital all I got was tablets nobody talked about the problems I have you know to do with the abuse and all the things that were dragged up when the case was brought against my father.” (P3)

5.5 Emergent Theme Three

The third emergent theme concerns perceptions of mental health care provided in prison.

Views about how mental health problems are managed in prison

Participants were asked to “Tell me about your experiences in relation to your mental health problems while in prison?” There were very mixed views given by participants in response to this question, some positive and some negative. Some of the positive views are listed below;

“Things are good in the [prison] yeah. I am happy with my treatment here ... it’s the best jail here yeah the [prison]. Staffs are very good. Especially the medical staff...” (P8).

“Well It’s alright you could get used to it you know but in a way I don’t want to get used to it because this is a slow pace than life itself so it would be hard to get back to normal again. So the longer you’re here the harder it is to get up and get going again you know. You could get just very lazy really.” (P11)

“Really well...It is very good they [prison and forensic services] are treating me well very well. I feel that my mental health problems are being very well managed in here. Yes I am very happy.” (P4)

“I find it good in here but the problem is that when I get out of here I stop taking the medication and then I get down again and drink and all the rest and end up in prison again.” (P9)

“I’m not happy I’m in prison now.... But to be honest with you I am glad because it was a way getting away from everything. I actually feel a lot better in here.” (P1)

“At least prison can’t turn you away and they do look after you well.” (P6)

Negative views

It is important to note that while there were some negative views of prison however the positive accounts outweighed these.

“Well I think that the treatment that I got in prison was hopeless they don’t really understand mental illness and how different it is for different people. They don’t really want to know ... I don’t think so anyway. I get no help no addiction counselling nothing I am on the same medication for the past five years.” (P14)

"There's not much help in this prison the only help I've had is coming down to see the doctor or the nurse but even at that they are not always the same people always well the nurse usually is." (P10)

"But people don't understand in prison and then they put you into a padded room with a bookthis just makes you worse and then the voices get worst... but if you are in the cell at least you have a telly that's something." (P10)

"When I went into prison the first time (2003) they didn't take it very serious you know... ah yeah talk to you later you know ...dismissive there was no real effort made to deal with my problems." (P13)

Memo

Nurse (2003) noted negative relationships between staff and prisoners as an important issue affecting stress levels of both staff and prisoners. Furthermore, Bowen *et al.* (2009) assert that changes to medication management which accompany entry to prison appear to contribute to poor relationships with prison health staff, disrupts established self-medication practices, discourages patients from taking greater responsibility for their own conditions and detrimentally affects the mental health of many prisoners at a time when they are most vulnerable. Gately *et al.* (2006) purported that the structured prison regime allowed some time to regain control over previously chaotic lifestyles but the lack of access to a healthy diet and exercise facilities as well as lack of opportunities to practice new health behaviours learnt whilst in prison, prevented a healthier lifestyle being adopted. Another main theme concerned the ability of prisoners to negotiate access to healthcare services and professionals.

Treatment approach while in prison

Several participants referred to receiving a more mixed treatment approach while attending the prison in-reach clinics.

"I am on Prozac here I like that yeah I like that I have also seen the psychologist..." (P8)

"I find it good in here but the problem is that when I get out of here I stop taking the medication and then I get down again and drink and all the rest and end up in prison again." (P9)

"To be honest with you when I came into the prison I went to the governor. You go to the governor straight away. Then I went to the doctor I told him what I was prescribed so

then em they gave me them so within a week I seen the psychologist and then fair play the first couple of months I seen them twice a month and then the last month or two once a month so they have been very good. They have kept an eye on me you know. They are asking me all the questions you know.” (P1)

“I find the treatment good I am well...I feel good Ye see things are grand in here [prison] but it’s when I get out...that’s when my problems start... I stop taking me medicationget in with the lads again and start taking drugs and drink and all.” (P6)

“eh I am on medication now and it is good it works and I don’t feel out of it you know like an zombie and I attend the a drug and alcohol awareness group I found that good because I know that I can’t take drink or drugs with this medication. I also did courses on how to manage your mental illness when I was in the [forensic service]. So that’s it I think overall it’s good really. I’ve learnt a lot” (P13)

“Well it good really I am on tablets and I get to see a counsellor [psychologist] about my problems as well. I think this is good because when I was in the mental hospital all I got was tablets nobody talked about the problems”(P12)

Many of these experiences are attributable to the fact that many of participants had successfully engaged with the prison in-reach clinic, this may be due to several factors for example they may be known to the prison mental health team due to previous committals or were successfully recognised as needing mental health treatment following assessment.

Seven participants reported that they were transferred to the [forensic services] for assessment and treatment from the Irish Prison service

“I am getting medications and I was doing courses em ... about drugs and alcohol awareness... and a wellness and recovery action plan. They are very good I find it helps me a lot. A lot of this was done while I was in the mental hospital [forensic] (P4)

“While I was on remand in [prison] I met doctors from the [forensic services] and eventually I was transferred to there for a little while and then was sent back to [prison] again.” (p14)

“I was seen by the doctor and nurse from the [forensic services]. That was went I finally got proper treatment for me mental health problems. Yeah only for the in reach team from the [forensic services] I don’t know what would have happened. I also did courses on

how to manage my mental illness when I was in the [forensic services]. So that's it I think overall it's good really. I've learnt a lot" (p13)

"I ended up in [forensic services] for a while... I liked it there it was good yeah. I found it helpful" (P3)

"So at the beginning I saw the GP in [prison]. And then I saw the doctor and a nurse from the [forensic services]. So when I went to the [forensic services] I got the diagnosis."(P12)

Stigma while in prison from fellow prisoners and staff

Examples of significant statements from the interview transcripts which described experiences of feeling stigmatised by health service providers or prisons personnel

"The services don't want to know you....once they hear that you were in prison or the [forensic services]." (P5)

"I won't even get into a hostel now... now that I'm in for arson... they won't let you in if you done that... so I don't know.... At least prison can't turn you away and they do look after you well." (P6)

"Officers slag me because I talk to [voices] you knowsimple bastard ...you mad man not all of them certain ones you know." (P10)

Memo

Edwards (2000) opines that not only does the prison inmate treated for mental illness face the stigma of being an ex-convict when released from prison, but he or she must also live with the stigma of being an ex-mental patient in prison and later when released. An earlier study (Edwards 1985) suggested that labelling a prison inmate mentally ill by virtue of his transfer to a mental hospital might increase time served in prison. This parallels Teplin's (1983, 1984, 1985) arguments that prisons are becoming repositories for mentally ill criminals. Campanelli *et al.* (2005), suggest that stigmatisation of offenders with mental illness increases the risk of re-offending.

5.6 Emergent Theme Four

Continuity of mental healthcare was the fourth emergent theme. When participants were asked, "Can you tell me about what services or supports you think would be useful to

help you manage your mental health problem(s) after you leave prison?" all stated that they would like or need ongoing professional support. This is illustrated by the following:

"I would like to attend my GP when I get out of here and have regular checkups with the psychiatrist and to stay on my medication. I would like to have therapy as well for the drugs I want to stay off them." (P4)

"I would like to see the same person [psychiatrist or nurses] not to be seeing different people all the time." (P9)

"They need to keep checking up on you and see how you are doing you know." (P1)

Combined treatment approach for mental health problems and future expectations

This subtheme follows on from participants views with regard to continuity of care. Participants stated that they need a treatment approach which enshrines openness and inclusiveness as well as more than just one approach.

"I would like to have a say into how and what treatment I get and for that matter if I even need treatment I don't think that happens now nobody took on board my views yet so I don't think they will start now. You are at their mercy they [psychiatrists] have the power." (P15)

"Em well I like to manage my problems myself I like to be in control and that's not how it happens I feel its cloak and dagger as soon as they close the door [psychiatrists] they make the final decisions definitely ... it's a, them or us situation like an imbalance of power I think."(P14)

Nine participants indicated that their mental health problems would be best managed by 'talk therapy' combined with medication appropriate to their illness.

"I need to be able to talk about me problems and the proper medication." (P4)

"Eh I am on medication now and it is good it works and I don't feel out of it you know like a zombie and I attend the drug and alcohol awareness group." (P10)

"To stay well and to see my GP and psychiatrist regularly... to have a good environment ... eh a healthy life you know... to have my medication to avoid taking drugs or any of them" (P4)

“From reading the book [Self help] I have to keep in control... I know I have to keep busy as in, working and going to the gym. Medication is just one thing it doesn’t solve the problem it’s a mix of things like as I say the activity.”(P1)

“I never want to end up in prison again I just need a chance I know I could do it with the right help all I need is that chance.”(P10)

Table 5.1 outlines the relationship between the emergent themes and the stages in the pathway to mental healthcare.

Table 5.1 Themes and their relationship to stages on Pathways to Care

| Themes | Stages in Pathway to Care |
|---|--|
| Predisposing Factors to Prison Admission Family history of mental illness Homelessness – Barring\Protection order Life events- abuse, trauma, suicide Education-expelled, dropped out Stigma Culture Previous involvement with CJS | Pathways to mental health prior to contacting mental health services |
| Factors Influencing Access to Mental Health Services Misdiagnosis Services not available Barriers to access Mental Health Limited treatment options Over reliance on medication Breakdown in communication with services | Pathways to mental health care once contact was established |
| Perceptions of Mental Health Services in Prison Positive experiences Negative experiences Combination of treatments Accurately diagnosed Transferred to CMH Prison can’t turn you away | Pathways to mental health pre release from prison |
| Continuity of Care | |

| | |
|---|--|
| Ongoing support Integrated care Involvement Hope | Pathways to mental health post release |
|---|--|

5.7 Validation

Colaizzi (1978) suggests that researchers should be flexible with the stages outlined. Wheeler & Holloway (1996) recommended that the exhaustive description (see Table 5.7) should be taken back to the participants to validate their findings, rather than the final, essential structure, because it appears to be more recognisable for them to comment on.

Due to the nature of the environment in which this phase of the study was conducted it was difficult to make contact with all of the original participants. Prisoners may be unavailable for various reasons for example, being frequently moved from prison to prison or are in segregation. One such example of this is evident in the following statement "I was one week on the landing but ended up spending 20 days in the seg [segregation] well it was for 40 days but they suspended 20 of them, I went in because I had a fight" (P 8). Also a particular feature of this sample is the regular use of segregation. If a person is segregated it is not possible for a researcher to speak to them. Also a number of the participants were on remand and had managed to be diverted to a psychiatric facility thus making it impossible for this researcher to locate them. However contact was made with two of the participants and the exhaustive description was discussed with them. Colaizzi's (1978) interview guide was adapted and used as the structure for validating these findings.

Do you recognise any of your experiences in this exhaustive description of your pathways to mental health care'?

Does this description have meaning for you?

Does it explain your pathway to care?

What aspects of your experience in relation to this topic have I omitted?

Both participants agreed that this description summed up their experiences and neither made any suggestions for change. This information is vital in the development of the

themes described in step seven. They form the core element for the remaining stage of the study.

5.8 Description reduced to themes

Colaizzi (1978, 48-71) suggests that at this stage the researcher should further reduce the data from the exhaustive description and if suggestions were made by the participants during the validation process in stage six above into plain and unmistakable themes. The themes which emerged are outlined on the following page below.

5.9 Themes

Theme One - Predisposing Factors to Prison Admission

Theme Two - Factors Influencing Access to Mental Health Services

Theme Three - Perceptions of Mental Health Services in Prison

Theme Four - Continuity of Care

5.10 Validity and Reliability

There were several steps taken to enhance the validity and reliability of the qualitative data obtained during this study namely:

1. The mixed methods design utilised for this study as described in chapter three where the results from each method were used to enhance the credibility and the validity of the findings.
2. The researcher contacted some of the participants of the interviews and discussed the exhaustive description with them as described in step six above.
3. The interviews were audio-taped and written notes were taken to ensure accuracy and to provide an audit trail, thus reducing the subjective effect of this method.
4. It has been shown that the use of a computer software package for data analysis may improve rigour of coding and analysis of the data (see chapter four).

5.11 Conclusion

This chapter outlined the process of data analysis and how it led to the study findings. The section began with an overview of data analysis process. It briefly outlined issues in relation to rigour and robustness and to the use of Computer Assisted Qualitative Data Software Analysis (CAQDAS) for data analysis. The themes generated from this phase of the study provided a comprehensive account of the experiences of people with mental health problems within the Irish CJS in relation to accessing mental health services both before and within the Irish prison system.

The four key themes in this chapter highlight the diversity of needs of this particular population and the relationships that exist between each. It also identified the perceived barriers to accessing appropriate mental healthcare as well as the types of problems for which they are likely to seek help.

These themes served two purposes. The first aided the adaptation of the data collection instrument for phase two of this study and the second facilitated the formulation of the most pertinent questions to be included in this instrument. This research provides an understanding of these experiences and generates evidence that has the potential to have an impact on the quality and structure of services and resources for this population.

CHAPTER SIX – RESULTS QUANTITATIVE PHASE

6.1 Introduction

The purpose of this phase of the study is to provide a detailed comprehensive socio-demographic profile of a larger sample of prisoners with mental health problems experience of gaining access and maintaining links with mental health services prior to incarceration. An adapted version of the Pathways Encounter Form was utilised to measure these experiences. The questionnaires were administered in seven prisons throughout Ireland. It quantifies factors such as:

- if contact with community mental health services was established prior to imprisonment and if that contact was maintained,
- did participants experience delays in accessing help for mental health problems,
- what types of contacts were sought to address mental health problems,
- how help seeking was initiated - who suggested the need to get help for mental health problems,
- how contact was established and finally,
- what forms of treatments were most commonly provided when contact was established.

Data analysis was conducted using the Statistical Package for the Social Sciences Version 18 (SPSS-18). The type of data gathered is predominantly non-parametric. Hence in some instances non-parametric tests were applied such as Chi-Square to test differences in prevalence and the Mann Whitney U test to measure differences between groups. The level of significance was set by $\alpha < .05$. Data for this phase of the study was collected over a nine month period from August 2010 to April 2011. Sections I to V directly correspond with the layout of the questionnaire used and section IV presents findings from statistical tests on factors influencing access to community mental healthcare. The results from the questionnaires are presented under the following headings:

- I. Demographic profile of the target population
- II. Process for gaining informed consent from participants
- III. Response rate

- IV. Demographic profile of participants
- V. Pathways to mental health care
- VI. Factors influencing access to community mental health care

6.2 Demographic Profile of the Target Population

All prisons targeted for this phase of the study have in-reach mental health clinics. However these are of varying models. Cork prison, for example, has a half-time psychiatrist and a visiting community psychiatric liaison nurse. This is similar to the model established in Limerick prison. On the other hand, all Dublin prisons, Portlaoise and the Midlands prisons have consultant-led in-reach sessions several times weekly. These are provided by the National Forensic Mental Health Service (IPS 2009). As described earlier in-reach mental health clinics are utilised to identify and gain access to the target population for this study.

6.2.1 Breakdown of Participating Prisons

The sample consisted of seven of the eight prisons throughout Ireland which have in-reach clinics. Cloverhill prison which caters mainly for remand prisoners was unable to provide staff cover to supervise this researcher's visits so access wasn't gained for this phase of the study. A breakdown of the responses to the assisted questionnaires is as follows: Cork prison (n=17, 15%), Arbour Hill prison (n=23, 20%), Limerick (n=19, 16%), Castlerea prison (n=18, 15%); Midland's prison (n=18, 15%), Mountjoy prison (n=19, 16 %) and the Dóchas Centre (n=3, 3%). Table 6.1 provides a comparison between the sample for this study and the daily average number of prisoners in custody for each participating prison. The sample from two of the prisons accessed for this study was not consistent with the average daily number of people in custody. These are Mountjoy and Arbour Hill prisons. Mountjoy is the main committal prison for Dublin city and county and the largest penal institution in the State. At the time of conducting this study, Mountjoy prison was running over its capacity by approximately n=40 or 6%. It is also the most populated of all the prisons accessed for this study. These factors contributed to the sample size accessed from this prison being lower than its average daily population. Whereas, the sample

gleaned from Arbour Hill prison was greater than the daily average number of people in that prison. It is one of the smaller prisons in the State. Its prisoner profile is largely made up of long-term sentenced prisoners. Therefore it is not as busy as many of the other prisons which are involved in this study. The remainder of the participating prisons are representative of their daily average population in custody.

Table 6.1 Examination of gatekeeper bias

Total sample (n=117) per participating prisons compared to whole population (n=2,507) of the daily average number of prisoners per each of these institutions in 2010:

| Institution | All prisoners in sample n=117 | Number of Prisoners in Custody n=2,507 IPS 2010 |
|-------------|-------------------------------|--|
| Arbour Hill | 23 (20%) | 153 (6%) |
| Castlerea | 18 (15%) | 378 (15%) |
| Cork | 17 (15%) | 303 (12%) |
| Dóchas | 3 (3%) | 131 (5%) |
| Limerick | 19 (16%) | 333 (13%) |
| Midlands | 18 (15%) | 542 (22%) |
| Mountjoy | 19 (16%) | 667 (27%) |

6.3 Process of Gaining Informed Consent from Participants

As discussed in chapter four because this population may be considered vulnerable a gatekeeper was used to gain access to a sample. This approach was used to protect the interests of potential participants and to ensure their voluntary participation. Once this process was complete the gatekeeper compiled a list of suitable and interested participants. This list was then used by the gatekeeper to approach potential participants on the days when interviews were to be conducted. Potential participants were asked by the gatekeeper to reaffirm their interest in the study, if they would agree to meet the researcher to discuss the study and answer any questions they had. Upon meeting potential participants the nature and purpose of the study was explained. Potential risks or benefits of participating in this study were clearly reiterated as outlined in the Participant Information Leaflet (Appendix 5) before agreement to participate was sought.

Potential participants were then asked to state in their own words their understanding of the study and what their involvement would entail. This was to ensure that they clearly understood what involvement in this study meant. On completion of this process any further questions were answered and potential participants were asked if they were still interested and would they like to participate in this study. As described in chapter four, consent was gained by ticking a box which was on the first page of the questionnaire (Appendix 11).

6.4 Response Rate

A high response rate of (n=117, 78%) was obtained for this phase of the study. There were n=150 participants identified by gatekeepers as being eligible in accordance with the inclusion criteria for participation in this study. Gatekeepers were forensic community mental health nurses, members of the in-reach teams from the National Forensic Mental Health Service. In Castlerea and Cork prisons the gate keepers were nurses employed by the Irish Prison Service (IPS). Potential participants were given the choice of completing a questionnaire themselves or they could avail of the assistance of the researcher or the FCMHN. A total of one hundred and seventeen (n=117, 78%) questionnaires were completed. The high response rate to this phase of the study may be attributable to several factors. As outlined earlier in chapter four this study was carefully designed to ensure confidentiality, to provide detailed information at an appropriate level of literacy, as well as offering to answer questions honestly and genuinely as they arose. A further factor was the use of a gatekeeper who was familiar with and had developed rapport with potential participants, provided assistance to fill in questionnaires if required. Also influential were the personal motivation and willingness of participants and critically their valuing the inclusive design of the study. This latter was borne out by several participants suggested that a study of this nature was long overdue and that it was good to be asked for their views on this very important issue for them. Possible sources of bias arising from the use of a gatekeeper included non-random selection, the mediating influence of the power role of the gatekeeper as distinct from the power role of the researcher. In order to test for this possible bias some demographic characteristics from this study are compared with the findings from a stratified random survey of prisoners (Table 6.2)

carried out in Ireland (Duffy *et al.* 2003). Many of these characteristics for this study are comparable to the earlier randomised survey. This indicates that the use of a gatekeeper in this study did not cause a bias.

Table 6.2 Comparison of demographic characteristics of participants in this Pathways study with National Forensic Mental Health Service 2004

| Demographics | Sample n= 117 | National Forensic Service 2004 n = 438 |
|---|------------------|---|
| Single | 73(63 %) | 267(64%) |
| Married/cohabiting | 25(21%) | 127(27%) |
| Separated/divorced | 18(15%) | 34(7%) |
| Widowed | 1(1%) | 9(1%) |
| On Disability Benefit | 44(43%) | 9(2%) |
| Employed before entering prison | 62(54%) | 200(42.6%) |
| Unemployed | 52(46%) | 218(53.2%) |
| Living with their family or in their own home | 79(68%) | 75.5% |

6.5 Demographic Profile of Participants

As described earlier this section of the questionnaire provides a more comprehensive socio-demographic profile of a larger sample of prisoners with mental health problems. It presents descriptive statistics on the socioeconomic characteristics of the participants' for example, age, gender, marital status, education and occupation. It also explores associations between factors such as living circumstances, if any change occurred in these, if there is a personal relationship involved, if this is the subject of a barring\protection order, education\employment status around the time of onset of illness. It also deals with whether or not these factors may have contributed to participants' experiences when accessing help for their mental health problems.

6.5.1 Gender Distribution

According to the inclusion criteria a proportionate number of males and females are included in this phase of the study (Table 6.3). Of the 117 people who participated in this study 90% (n=105) were male and 10% (n=12) were female. The average daily number of prisoners in custody in 2010 was 4,290. A breakdown of gender profile of these prisoners show that (n=4,133, 96%) were male and (n=157, 4%) were female (IPS 2010). This indicates an increase of female committals by 0.6% since 2009. This fact will be discussed in the following chapter in the context of key relevant findings from this study dealing with the high incidence of domestic violence, substance misuse and discrimination amongst female participants.

Table 6.3 Breakdown of the gender profile of the sample compared to the overall daily average number of prisoners in custody in 2010

| Gender | All prisoners in sample n=117 | Number of Prisoners in Custody n=4,290 IPS 2010 |
|--------|----------------------------------|--|
| Male | 105 (90%) | 4,133 (96%) |
| Female | 12 (10%) | 157 (4%) |

6.5.2 Age distribution

The age profile of the respondents clearly indicates a difference in the age distribution among the sample. The results identified that the majority of the respondents were in the mid-range age brackets of 26-35 and 36-45, 37% (n=43) and 30% (n=35) respectively, representing a total of (n=78, 67%) of the overall sample. Close to a quarter (n=27, 23%) were from the youngest age bracket and a total of 10% (n=11) were from the 46-56+ bracket (figure 6.1). This age distribution is reflective of the age distribution for the overall prison population (IPS 2009). However no association was detected between age distribution and gender of the participants (Pearson chi-square $\chi^2 = .261$, $df = 2$ $p = 0.878$, $\phi = .047$).

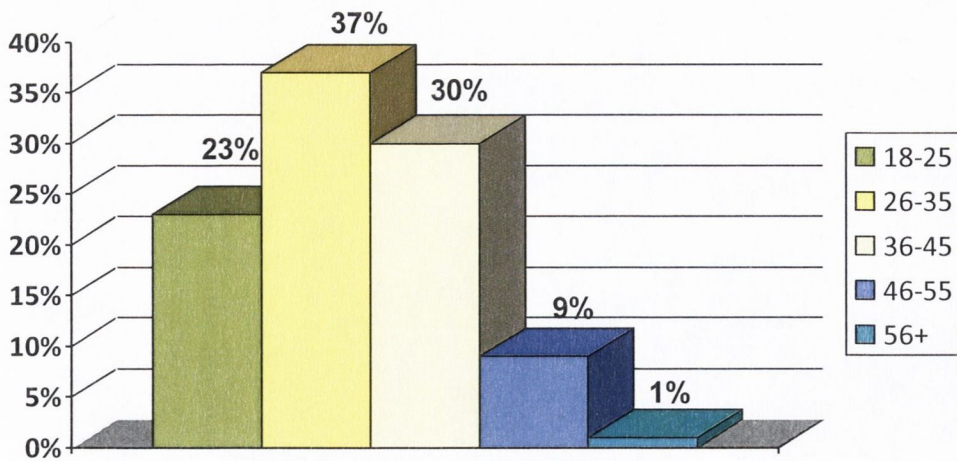


Figure 6.1 Age Profile of Participants

6.5.3 Marital Status

The majority of the sample are single (n=72, 62%). Of the remaining (n=19, 16%) are married or living as a married couple, separated or divorced (n=18, 15%) and in a same sex relationship (n=6, 5%) - see figure 6.2. In order to ensure that the assumptions of the non-parametric tests were upheld the categories for marital status were collapsed to assess if any statistical associations could be detected between this variable and other variables. This variable was reduced down to two categories 'In a relationship' and 'Not in a relationship'. The vast majority of the overall sample are not in any relationship (n = 92, 79%).

Practically all (n=11, 92%) the female participants in this sample were not in any relationship compared with a smaller percentage for male participants (n=81, 77%). A Chi-square test for independence (with the Yates Continuity Correction) indicated no association between gender and being in a relationship, $\chi^2 (1, n = 117) = 0.626, p = 0.429, \phi = .107$. This variable will be cross-tabulated with other variables mentioned above throughout the presentation of the results of other variables to test for statistical associations.

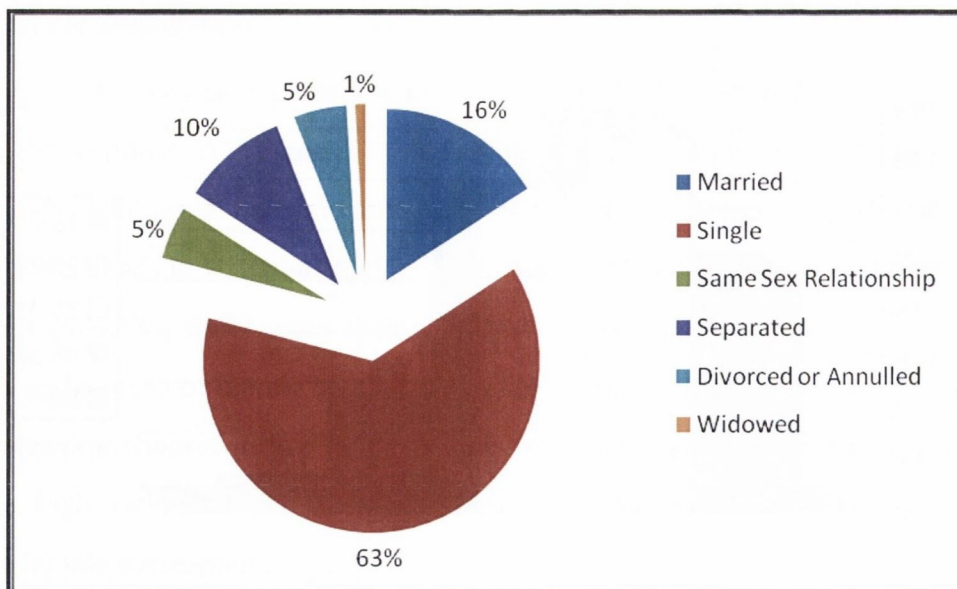


Figure 6.2 Marital Status

6.5.4 Living Circumstances

A large proportion (n= 43, 37%) of the participants were living with their family of origin at the time of onset of their current episode of psychiatric illness. The remaining participants' living circumstances varied from living with spouse or partner (n=20, 17%), homeless (n=14, 12%), in prison (n=13, 11%), living alone in apartment or home (n=10, 9%), living with others not a spouse or partner (n=6, 5%), in sheltered accommodation (n=4, 3%). The majority of those who selected the 'other' option of the question (n=7, 6%) referred to being living abroad at the time of onset of their illness (Figure 6.3).

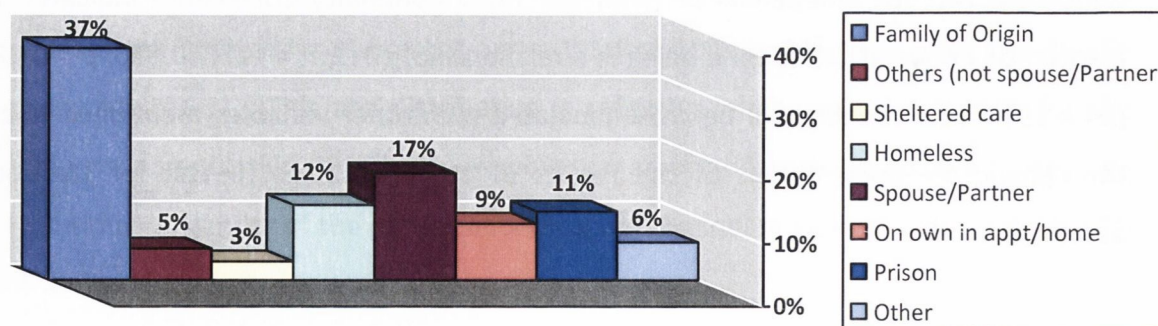


Figure 6.3 Living circumstances at time of current psychiatric episode

The majority of the participants (n=68, 59%) reported that their living conditions had changed at the time of onset of their psychiatric illness. However it is important to note that (n=31, 26%) of this sample were either homeless, living in sheltered accommodation or were in prison at the time of onset of psychiatric illness. Table 6.4 provides a detailed breakdown of the 'change in living circumstances' for each of the categories. A considerable number (n=24, 35%) of those living with their family of origin reported that their living circumstances did change following onset of current psychiatric symptoms. The next category whose living circumstances changed was for those people who were living with their spouse or partner (n = 13, 19%). This would suggest that those who were cohabiting were most likely to be affected by a change in living circumstances at the onset of psychiatric symptoms.

Table 6.4 Breakdown of change in living circumstances for each category

| Living Circumstances | Change | No Change | Total |
|----------------------|---------|-----------|-----------|
| Family of origin | 24(52%) | 19 | 43 |
| Spouse/partner | 13(65%) | 7 | 20 |
| Homeless | 7(50%) | 7 | 14 |
| In prison | 8(62%) | 5 | 13 |
| Living alone | 7(70%) | 3 | 10 |
| Miscellaneous\Other | 9(53%) | 8 | 17 |
| Total | 68(59%) | 49(41%) | 117(100%) |

The next question attempted to assess if there was any association between change in living circumstances and being the subject of a barring or protection order (Table 6.5). As referred to previously a substantial amount (n=68, 59%) of participants reported that their living circumstances had changed following the onset of psychiatric problems. The majority of the participants (n=71, 62%) were the subject of a barring or protection order and the remainder, a small proportion by comparison (n=44, 38%), were not. A chi-square test for independence (with the Yates Continuity Correction) indicated a association between a change in living circumstances and subject of a barring or protection order, χ^2 (10.795, n = 114) p = 0.001, phi =.326. Of those whose living

conditions changed, (n=50, 76%) were the subject of a barring or protection order. A Chi-square test for independence (with the Yates Continuity Correction) indicated also showed an association between living circumstances such as living with others or alone and being a subject of a barring or protection order, $\chi^2 (1, n = 115) p = 0.001, \phi = .008$. Hence this again suggests that for those people who are living with others are more likely to be the subject of a barring or protection order.

Table 6.5 Change in Living circumstances at time of onset of psychiatric episode and subject of a barring\protection order

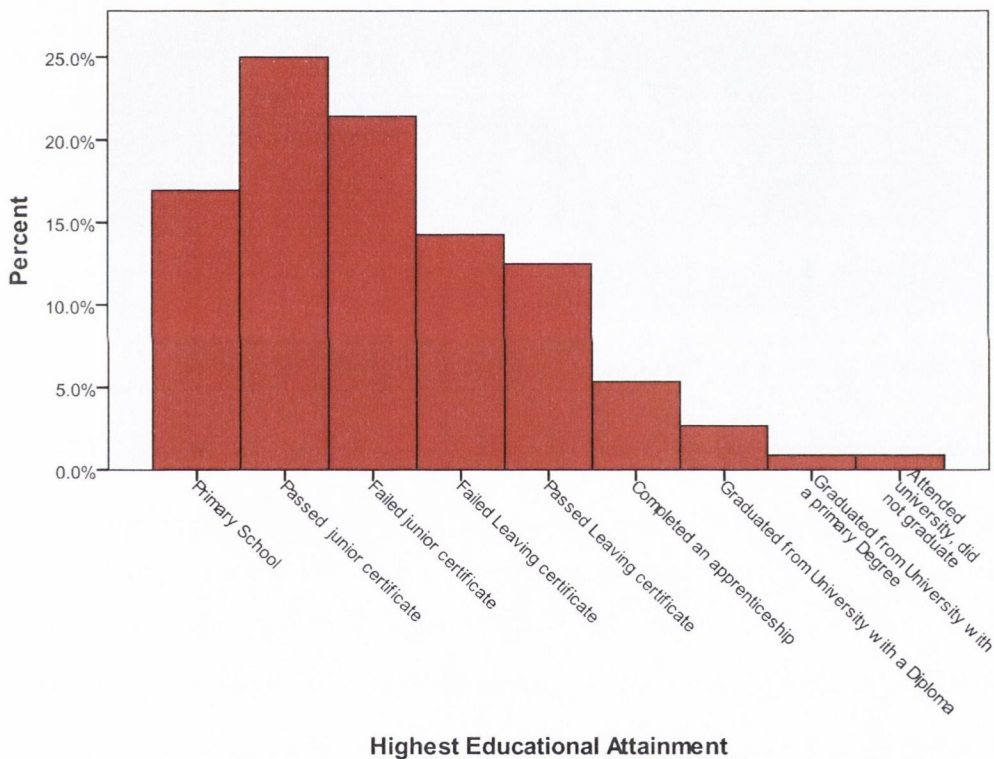
| | n | % |
|---------------------------------|----|------|
| Family of origin | 27 | 38 |
| Others (not spouse/partner) | 3 | 4 |
| Sheltered care | 3 | 4 |
| Homeless | 12 | 17 |
| Spouse/partner | 12 | 17 |
| On own in apartment, home, etc. | 3 | 4 |
| In prison | 7 | 10 |
| Other | 4 | 6 |
| Total | 71 | 100% |

6.5.5 Education

A minority of the participants (n=19, 16%) finished school at primary school level. Nearly a quarter of the participants successfully completed their junior certificate⁶ (n=28, 24%). A further (n= 24, 21%) did not complete their junior certificate examination, (n=14, 12%)

⁶ The Junior Certificate examination is held at the end of the Junior Cycle in post-primary schools. The Junior Cycle caters for students in the 13 to 15 year old age group. Students normally sit for the examinations at the age of 14 or 15, after 3 years of post-primary education.

of participants successfully completed the leaving certificate examination⁷, (n=11, 9%) failed this examination and a further (n=5, 4%) attended secondary school to leaving certificate level but didn't sit the examination. (n= 6, 5%) of the participants successfully completed an apprenticeship. (n=3, 3%) attended university and graduated with a Diploma. A further (n = 1, 1%) attended university and graduated with a primary degree and (n=1, 1%) attended university but didn't graduate. (n=5, 4%) ticked the 'other' option in this question. These participants were either educated abroad or did specialist training courses later in life. Figure 6.4 below presents the highest educational attainments for this sample on a histogram. No association was detected between educational success and having a paid position prior to going into prison (Pearson chi-square $\chi^2 = 1.635$, df = 2, p = 0.441, phi = 0.120).



⁷ The Leaving Certificate (Established) programme offers students a broad and balanced education while allowing for some specialisation. The certificate is used for the purposes of selection into further education, employment, training and higher education. The examination is the terminal examination of post-primary education. It is held at the end of the Senior Cycle in post-primary schools. The Senior Cycle caters for students in the 15 to 18 year old age group.

Figure 6.4 Breakdown of the educational attainments for this sample

Less than half (n=52, 45%) of the participants received an educational award (Figure 6.5). When these attainments are mapped on the national framework of qualifications fan it is evident that the majority (28, 24%) of the participants received an award equating with level three on the framework.

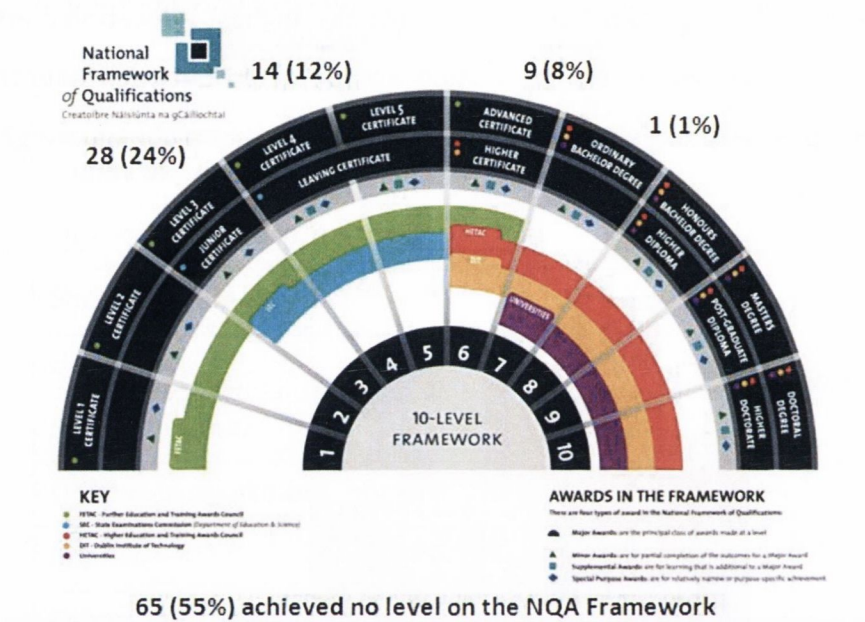


Figure 6.5 Level of Educational Attainments mapped on the National Framework of Qualifications fan

A substantial number of the participants reported that they were expelled from school (n=49, 43%) and the greater number (n=65, 57%) stated that they were never expelled from school. However, of these a large number did say even though it wasn't directly asked that they were suspended from school, and for some, on several occasions. This indicated that many of these participants were having behavioural difficulties while at school but these did not result in actual expulsions.

A chi-square test for independence (with the Yates Continuity Correction) indicated an association between being enrolled within an education programme and being expelled from school, $\chi^2 (1, n = 110) = 5.65, p = 0.02, \phi = -0.247$. A significant statistical relationship was also shown between being expelled from school and the highest level of

education achieved ($\chi^2 = 26.5$, $df = 10$, $p < 0.003$). A cross tabulation between these two variables show that of those expelled from school, the highest award achieved was a leaving certificate which was achieved by only ($n=2$, 4%). Hence there is a greater tendency for those who were expelled from school to break away from the education system at the stage they were at then and not gain any educational achievements.

The vast majority ($n= 82$, 73%) of the participants stated that they were not enrolled in an education programme at the time of the onset of their mental health problem. However ($n= 31$, 27%) stated that they were still enrolled in an education programme when their mental health problems started. Of these ($n=15$, 54%) continued attending their education programme, and the remainder ($n= 13$, 46%) stopped attending. A cross-tabulation of those who continued in the education programmes indicated that ($n=2$, 13%) successfully completed the junior certificate examination ($n=1$, 7%) successfully completed the leaving certificate examination and a further ($n=1$, 7%) graduated from university with a diploma. Of the remainder ($n=8$, 53%) were expelled from school.

Therefore nearly half ($n= 13$, 46%) of the ($n= 31$, 27%) who reported that their mental health problems started while still enrolled in an education programme left their education programme when their mental health problem began. However of those who remained on in their education programme ($n=15$, 54%) over half ($n=8$, 53%) would end up being expelled from their programme.

6.5.6 Occupation

Participants were asked to describe their various occupations since leaving school. The vast majority ($n=107$, 91%) had worked at some stage in their life. However most participants would predominantly fit within the unskilled working class group working as labourers, in odd jobs, as general operatives or shop workers. The duration of employment ranged from weeks to several years. A substantial number of participants ($n=44$, 43%) were in receipt of disability benefit prior to their current period of imprisonment.

Participants were asked if they had held a paid position before their current period of imprisonment. Of those ($n=114$, 97%) who replied to this question, ($n=62$, 54%) stated that they held a paid job before they went into prison. This figure indicated that just over

half of the participants managed to hold down a job before entering prison. This finding may suggest that for some of these participants prison may have exacerbated mental health problems or that mental health problems may have started while in prison. (n= 52, 46%) stated that they did not hold a paid position. (n=3, 3%) did not answer this question. Of those who held a paid position, (n=51, 85%) stated that they worked fulltime. Of those who worked fulltime, (n=35, 83%) reported that they would not be able to return to their employment upon release from prison. Those who said that they could go back to work were generally self-employed e.g. Taxi driver, farmer or employed by a family member. Of this sample, (n=21, 22%) never held any paid position. A total of (n=10, 9%) of the participants did not reply to this question.

A Mann-Whitney U test was conducted to evaluate if people working fulltime experienced a longer delay in seeking help for their mental health problems than people who worked part-time. A difference was detected between delay in help-seeking behaviour and working fulltime or part-time. The Mann Whitely U test showed that people who worked fulltime had a result of (Md = 2.0, n = 51) and those who worked part-time had a result of (Md = 1.0, n = 9), U = 111.0, z = -2.46, p = 0.01. However a further Mann-Whitney U test revealed no statistically significant difference in the delay in help-seeking and loss of job as a result of mental health problems (Md = 2.0, n = 45) and not losing a job (Md= 2.5, =63), U = 1324.5, z = -.581, p = 0.561.

Participants were asked "Did you ever lose a job due to your mental health problem?" Of the total number of participants who replied to this question (n=108, 92%), a large number (n= 45, 42%) reported that they had lost a job due to mental health problems. However (n=63, 58%) said that they never lost a job over their mental health problems. Yet a significant relationship between tendency toward loss of job and having a mental health problem was detected (Pearson chi-square $\chi^2 = 15.618$, df = 1 p = 0.0001, phi = 0.429). However no relationship was detected between holding a paid position and loss of job prior to the current period of imprisonment (Pearson chi-square $\chi^2 = 1.714$, df = 1 p = 0.190, phi = 1.28)

6.5.7 *Prison Circumstances*

The majority of the participants were serving a sentence (n=96) 84% and (n=18) 16% were on remand. Access to Cloverhill Prison was not accomplished for this phase of the study. This prison primarily caters for prisoners on remand. This accounts for the small number of participants who are on remand in this phase of the study. Sentence terms ranged from six months to life in prison. Slightly over half (n=59, 52%) of the participants who replied (n=114, 97%) to this question stated that the prison in which they were incarcerated in was located close to their place of abode. However (n=55, 48%) said that the prison in which they were held was not close to their place of abode. The vast majority of the female prisoners among this sample (n=8, 73%) reported that they were held in prisons which were not close to their homes or families. However a chi-square test for independence (with the Yates Continuity Correction) indicated no association between gender and the prison in which placed compared with where each gender had their place of abode, $\chi^2 (1, n = 114) = 0.16, p = 0.164, \phi = 0.160$. The vast majority of the participants (n=102, 88%) reported that they were receiving help for their mental health problems while in prison. This finding is probably due to the fact that all participants for this study were selected from prison mental health in-reach clinics. Hence they have already been identified by the prison system as requiring help for their mental health problems. A very small number of participants (n=14, 12%) stated that they were not receiving any help for their mental health problems while in prison.

The next question in this section required participants to 'list the types of help they were receiving for their mental health problems' verbatim. Of those who reported that they were getting help the majority (n=55, 54%) reported that they were getting medication 'only'. Many saying 'just meds' and in many cases participants felt that they needed more than just medication. For example "I wouldn't call it help" (participant 9). A further (n=48) 47% suggested that they were receiving a combination of approaches to their mental health problem. These ranged from receiving prescribed medication plus seeing a psychiatrist/nurse from the Central Mental Hospital or a psychologist from the prison service or attending visiting voluntary groups such as GROW, Narcotics Anonymous, AA, and Al-anon meetings. Finally the remaining (n=5) 5% reported that they were transferred to the Central Mental Hospital for assessment. Many of this group of

respondents referred to the combined approach to treatment more positively. For example, “Yeah it’s good I find it helps” (Participant 4).

6.6 Pathways to Mental Healthcare

The aim of this section of the questionnaire is to gather information with regard to participants’ level of contact with mental health services prior to imprisonment and to investigate if this contact was maintained. This section presents descriptive findings on many of the various factors with regard to accessing community mental health services such as referral pathways, range of contacts made, the types of treatment provided at each of these stages.

6.6.1 Contact with mental health services prior to Imprisonment

The majority (n=68, 59%) said that they were not regularly seeing a mental health professional before committal to prison. However practically all of the participants (n=111, 95%) had made some contact with mental health services prior to imprisonment. These findings suggest that a breakdown occurred between participants and the mental health services with which they were in contact. This finding raises many concerns regarding how participants managed their mental health problems following disengaging with mental health services. It is critical to explore the factors which may have led participants to disengage with these services. The significance of this will be integrated within the discussion chapter with the findings from phase one.

6.6.2 Delay in help-seeking

Participants were asked to provide their subjective view of the main mental health problem which prompted them to seek help in the first instance. The main mental health problems referred to ranged from feelings of anxiety\panic attack, sleeplessness, feeling suicidal, depression, mood swings, hearing voices, paranoia, dependency on drug and alcohol. Often a combination of problems was described such as anxiety and depression or drug and alcohol misuse and psychiatric symptoms (see Figure 6.6 below). However of all the symptoms referred to, paranoia and hearing voices were the most commonly

mentioned (n = 36, 32%). It was interesting to note that the majority of the participants did not refer to a diagnostic label but rather referred more to actual feelings or symptoms such as feeling low, being a bit high, hearing voices or moods being up and down.

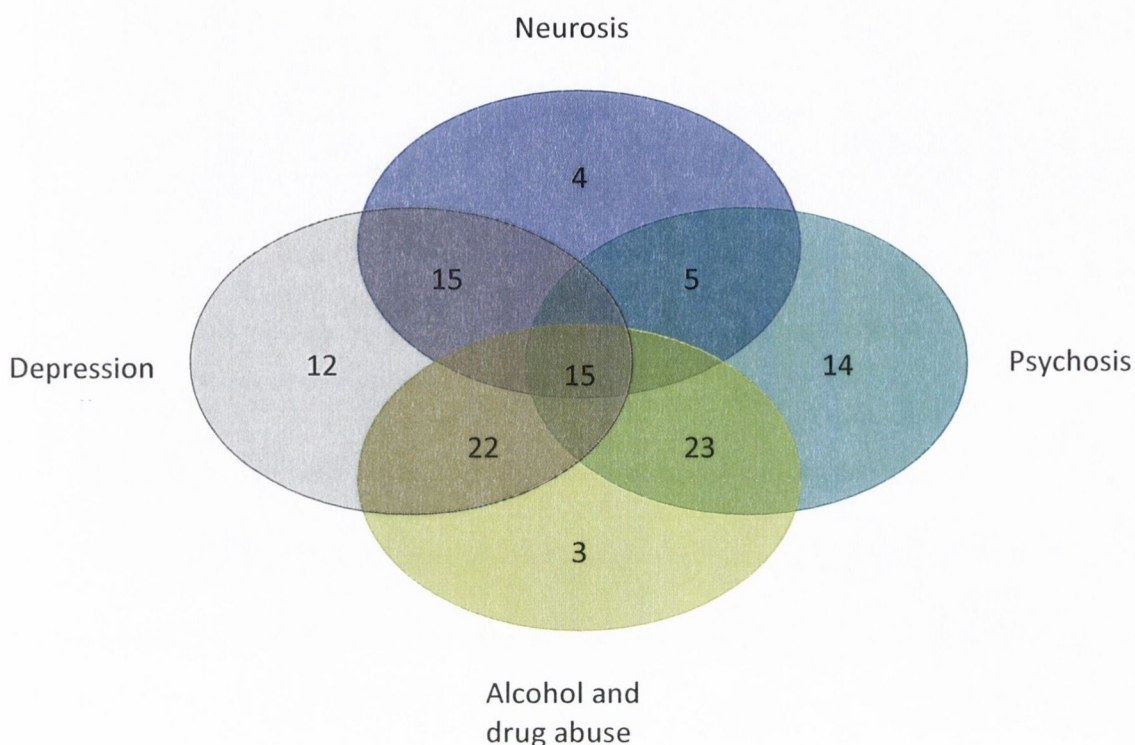


Figure 6.6 Venn diagram demonstrating level of co-morbidity among (n=117, 100%) of the participants

Participants were then asked when their main mental health problem began. Delay in help-seeking behaviour was calculated by subtracting the answer to question C 5 'How long ago did person's main mental health problem begin?' from the answer to question C 6 'How long is it since you first saw somebody about this problem?' The majority described some level of delay in seeking help for their mental health problems (Mean 3.8, SD 4.9, n=117). The delays ranged from zero to thirty years. A large number (n=42, 36%) of participants reported a delay in seeking help of one year or less. A further (n=32, 27%) experienced a delay of just over one year to three years. However the remainder (n= 43, 43%) experienced a delay of over three years. The distribution of age range with delay in seeking help for mental health problems is shown in Figure 6.7 below.

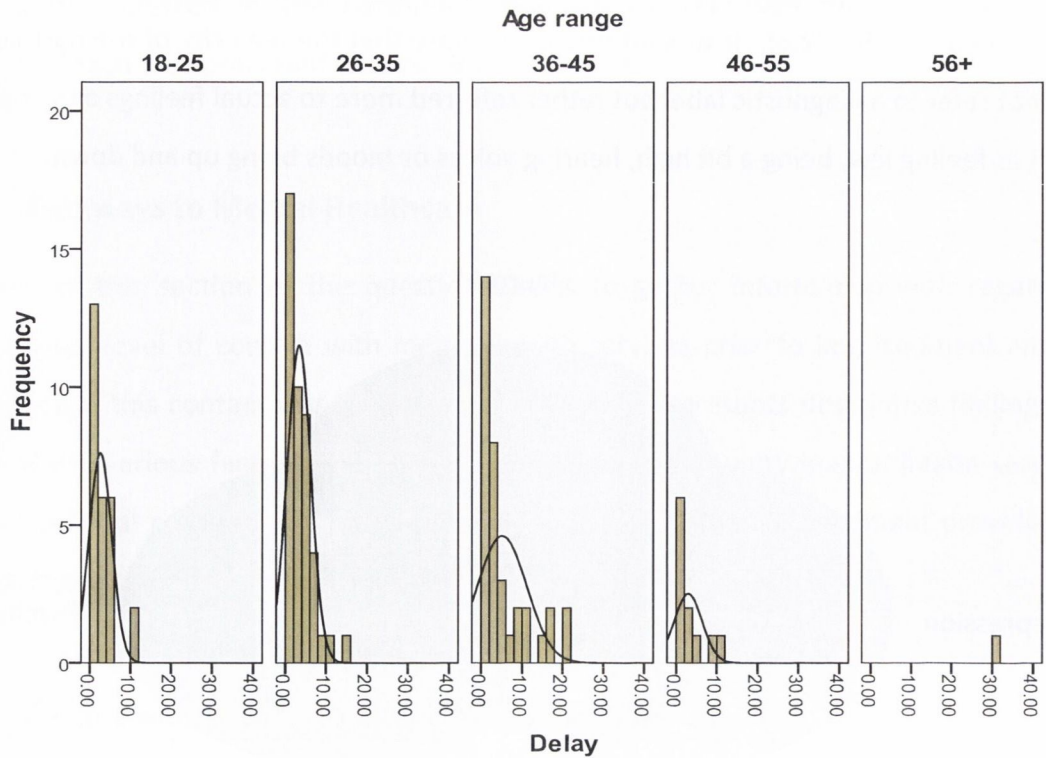


Figure 6.7 Distribution of delay in help-seeking

The histogram above shows skewness to the left for all of the age ranges with the exception of the 56+ range. This would indicate that the majority of the participants in all of the first four age ranges experienced a shorter period of delay in help seeking behaviour. The boxplot in Figure 6.8 below shows the extremes or outliers within the different age ranges which causes the spikes to appear in the histogram of Figure 6.8 above. However, the smaller number of participants ($n=13$, 11%) described extremely long (10 years or more) delays in seeking help for their mental health problems.

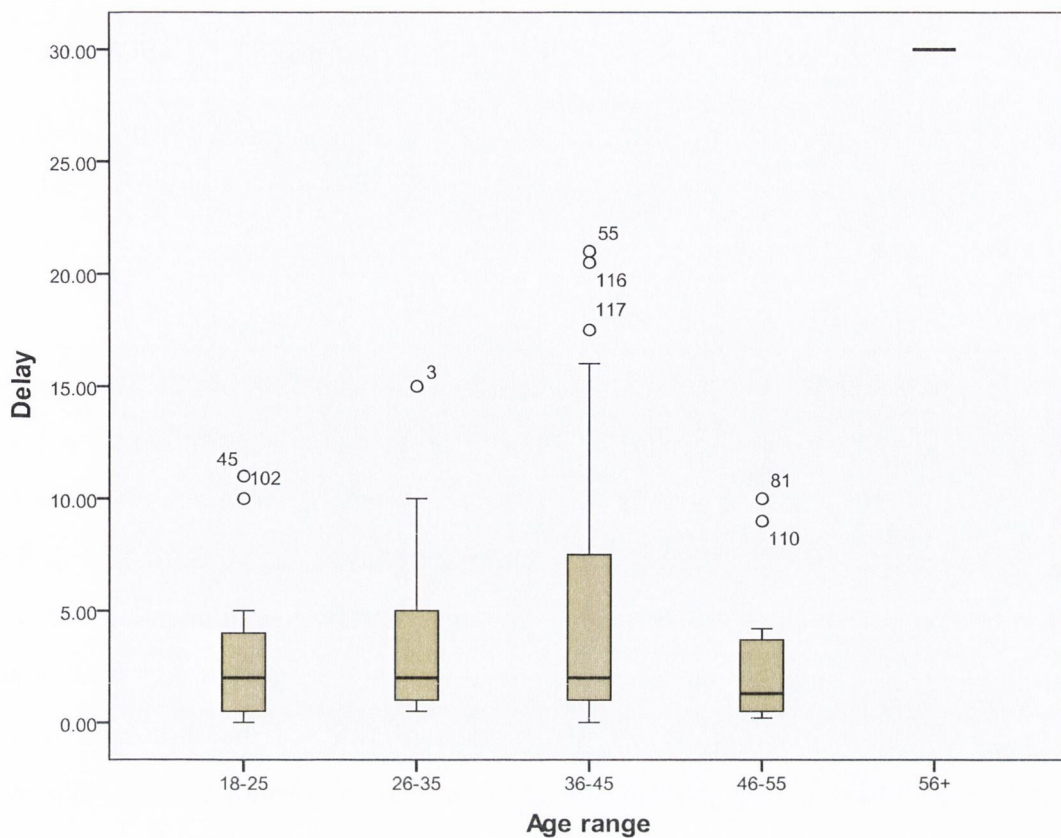


Figure 6.8 Overview of the extreme delay in help-seeking per age range

6.7 Contacts

All the participants (n=117,100%) replied to question C7 which asked who they first contacted about their main mental health problem. Just over half of the participants (n=62, 53%) reported that the GP was their first point of contact. A total of (n = 112, 96%) replied to question C10. This question asked who their second contact was about their main mental health problem. Psychiatric services were the most commonly referred to second contact (n=34, 30%). A total of (n=92, 77%) replied to question C13, which enquired about the third contact about their mental health problem. The third most common contact referred to was prison psychiatric services by (n=36, 39%). Finally (n = 72, 62%) replied to question C16, which concerned a fourth contact. The majority (n=47, 64%) were within the prison psychiatric system. Table 6.6 presents the contacts most commonly referred to at four points on their pathway to mental healthcare.

Table 6.6 Four most commonly contacted services about mental health problems

| Contact | 1st contact | 2nd contact | 3rd contact | 4th contact |
|------------|-------------------|-------------------------------------|--------------------------------|--------------------------------|
| Service(s) | GP (n=62, 53%) | Psychiatric services (n=34, 30%) | Prison services (n=36, 39%) | Prison services (n=47, 64%) |

6.7.1 Source of referral

The most common source of referral for participants' first contact about their mental health problem was a family member (n=50, 44%). The second most common source was self-referral (n=30, 26%) the next was for those participants who were already in prison. These were referred to their first contact by prison staff (n=12, 10%), Gardaí (n=6, 5%), participants, solicitors (n=2, 2%). A surprising finding was how few suggestions to seek help came from an employer or work colleague (n=4, 3%) considering how many participants were in employment. The significance of this will be discussed in the following chapter. The remainder of the participants were prompted to seek help by a friend (n=3, 3%) or teacher (n=2, 2%).

Referral to participants' second contact (n=36, 31%) was made by the service(s) named in question C7. (n=20, 17%) of family members or friends referred a participant to their second contact. Referrals from within the Criminal Justice System e.g. prison officers, solicitors or Gardaí amounted to (n=29, 25%). A smaller number of self-referrals were recorded at this stage (n=16, 14%). The remainder (n=6, 5%) comprised a variety of sources such as workplace or voluntary agencies like Simon Community.

For these participants the most common source of referral to their third contact came from within the Criminal Justice System (n= 31, 35%). (n=27, 30%) were referred to their third contact by the service(s) named in question C10. Self-referral to a third contact was made by (n=14, 15%) of the participants and family or friends accounted for (n=12, 13%) of referrals to this contact. Alarming, only (n= 4, 4%) had maintained a link with the service(s) named in question C7 who had referred participants to their third contact.

It is not surprising that the source of referral to participants' fourth contact was from the Criminal Justice System (n=35, 49%). The next most common was the service(s) named in C13 (n=19, 29%). (n=9) 13% self-referred and family or friends accounted for only (n=2)

3%. Only (n=2) 3% were referred from the service(s) named in question C10 and practically none of the participants (n=1, 1%) had maintained a link with their first contact identified in question C7.

Table 6.7 below presents an overview of the sources of referral to participants' contacts about their mental health problems.

Table 6.7 Source of referral to 1st 2nd, 3rd and 4th contacts

| Referral Source | Family n,% | Self-referral n,% | Previous contact n,% | Criminal Justice n,% | Other n,% |
|-----------------|---------------|----------------------|-------------------------|-------------------------|--------------|
| 1st Contact | 50, 44 | 30, 26 | N,A | 20, 17 | 4, 3 |
| 2nd Contact | 20, 17 | 6, 5 | 36, 31 | 29, 25 | 6, 5 |
| 3rd Contact | 12, 13 | 14, 15 | 27, 30 | 31, 35 | 0 |
| 4th Contact | 2, 3 | 9, 13 | 19, 29 | 35, 49 | 0 |

Table 6.8 presents the number of participants who had maintained a link with the 1st contact on their pathway to mental health care.

Table 6.8 Demonstrating referral by 1st contact to 3rd and 4th contacts

| | |
|---|------|
| Maintained link | n,% |
| Link between 1st contact and 3rd contact maintained | 4, 4 |
| Link between 1st contact and 4th contact maintained | 1, 1 |

6.7.2 Treatments Offered

This section of the questionnaire required participants to select three of the most frequently provided treatments at each of their four points of contact. Participants were asked to choose from a list of fifteen options provided. An 'other' option was also provided if a participant could not choose from this list. The results are presented as three of the most commonly selected options by participants for first, second, third and fourth treatments provided. (See tables 6.9, 6.10, 6.11 and 6.12 below.)

Table 6.9 Three most common treatments at point of 1st contact

| Treatment | 1st n,% | 2nd n,% | 3rd n,% |
|----------------------|------------|------------|------------|
| Sedatives, sleepers | 37, 32% | | |
| Antidepressant drugs | | 26, 22% | |
| Referral | | | 9, 8% |

Table 6.10 Three most common treatments at point of 2nd contact

| Treatment | 1st n,% | 2nd n,% | 3rd n,% |
|----------------------|------------|------------|------------|
| Sedatives, sleepers | 24, 21% | | |
| Antidepressant drugs | | 16, 14% | |
| Referral | | | 10, 9% |

Table 6.11 Three most common treatments at point of 3rd contact

| Treatment | 1st n,% | 2nd n,% | 3rd n,% |
|----------------------|------------|------------|------------|
| Antidepressant drugs | 28, 31% | | |
| Antipsychotic drugs | | 30, 44% | |
| Referral | | | 8, 12% |

Table 6.12 Three most common treatments at point of 4th contact

| Treatment | 1st n,% | 2nd n,% | 3rd n,% |
|--------------------------|------------|------------|------------|
| Counselling & Discussion | 18, 26% | | |
| Antidepressant drugs | | 19, 32% | |
| Referral | | | 14, 33% |

6.8 Factors influencing pathways to community mental health care

Phase one of this study found that the majority of the participants experienced many difficulties and challenges when trying to access mental health services in the community. Among these was dissatisfaction with the limited treatment options available such as over reliance on medication, being given repeat prescriptions, and not being able to talk to somebody about mental health problems. This section explores if associations can be detected between some of these factors and accessing mental health services in the community. The factors explored are being the subject of a barring or protection order and delay in accessing community mental health services, whether or not an association can be detected between GPs' over reliance on medication at first point of contact. A further association explored is between the source of referral and the type health professional contacted.

A delay in seeking help is considered in the context of participants' subjective view of the onset of symptoms mental health problems, which led to making their first contact. A Mann-Whitney U test revealed no statistically significant difference in the delay in the help-seeking of males (Md = 2.0, n = 105) and females (Md= 2.25, =12), U = 582.0, z = -.433, p = 0.665. Also no statistically significant difference was detected between delay in help-seeking and being in a relationship (Md = 2.0, n = 25) and not in a relationship (Md= 2.0, =92), U = 1058.0, z = -.614, p = 0.539. However a Mann Whitely U test detected a significant difference between delay in help-seeking behaviour and being the subject of a barring or protection order (Md = 2.1, n = 71) and not subject of a barring order (Md – 1.0, n = 44), U = 1167.5, z = -2.27, p = 0.02. This may suggest that for participants whose social supports are declining following becoming the subject of a barring or protection order may lead to experiencing difficulties or delay in gaining access to community mental health services.

The majority of the participants from phase one of this study reported receiving medication such as sedatives and/or antidepressants from their GP to manage their mental health problems. A chi-squared test for goodness-of-fit was conducted with variables from data gathered in phase two of this study to explore this issue further. A chi-squared test for goodness-of-fit test of the first contact and the main treatment

offered showed a statistically significant difference between treatment provided by each of the contacts ($\chi^2 = 211.643$, $df = 90$, $p = 0.0001$. $\Phi=1.345$). This suggests that a GP is more likely to provide sedative or sleeping tablets than any of the other contacts. The second most common treatment offered were antidepressants ($n=26$, 37%). GPs were most likely to prescribe these also ($n=18$, 69%).

As presented in Table 6.13 below, a GP was the first contact for the majority ($n=62$, 53%) of the participants in this study. However, a statistically significant difference in the tendency of a family member to suggest participants seek help from psychiatric services compared with those who self-referred was detected (Pearson chi-square $\chi^2 = 196.105$, $df = 72$, $p = 0.001$ $\Phi = 1.295$). Of those who self referred, ($n= 21$, 70%) went to a GP and only ($n=1$, 3%) went to psychiatric services. However of the family members who suggested a participant should seek help, ($n=33$, 64%) suggested visiting a GP and ($n= 10$, 19%) suggested going to psychiatric services first.

Table 6.13 Range of contacts

| Contact | 1 st n,% | 2 nd n,% | 3 rd n,% | 4 th n,% |
|----------------------|------------------------|------------------------|------------------------|------------------------|
| GP | 62, 53 | 20, 18 | 7, 8 | 6, 7 |
| Psychiatric Services | 14, 12 | 34, 30 | 14, 15 | 11, 15 |
| Prison Services | 19, 16 | 32, 29 | 36, 39 | 47, 64 |

The results from this phase two are integrated and discussed with the findings from phase one in the following chapter.

CHAPTER SEVEN - DISCUSSION

7.1 Introduction

This thesis started by referring to the Trecín statement on prisons and mental health and stated that:

“Without urgent and comprehensive action, prisons will move closer to becoming twenty-first century asylums for the mentally ill, full of those who most require treatment and care but who are held in unsuitable places with limited help and treatment available.

“(Trecín statement, WHO 2007)

The findings of this study strongly support the assumptions made in this statement. Therefore, these findings would propose a requirement to replace the word ‘will’ in this statement to ‘are becoming twenty-first century asylums’. Many of the findings of this study clearly indicate that the prediction of the Trecín statement is currently and rapidly taking place. As identified in the literature review the prevalence of mental illness amongst the prison population is extensively higher than that found in the rest of the population (Belcher 1988, Aderibigbe 1996, Singleton *et al.* 1998, Reed & Lyne 2000, Fazel & Danesh 2002, Kennedy 2005). Also mentally disordered offenders are usually known to mental health services prior to imprisonment (James 2002, O’Neill 2006, Linehan *et al.* 2006). However this study can reveal and will discuss within this chapter the breakdown of this contact with mental health services prior to incarceration. This discussion will be placed in the context of Penrose's law (1939). Hence in Ireland, similar to many other countries worldwide, the process of deinstitutionalisation led to a reduction in psychiatric hospital beds and an increase of mentally ill people within the criminal justice system.

An observation which is worthy of note from this study is the use of the word ‘asylum’ in the Trecín statement. The Oxford dictionary (1995) defines the word asylum as “a hospital where people who were mentally ill could be cared for, often for a long time”. In fact, one participant in this study referred to detention centres for young boys’, psychiatric hospitals and prisons as being one of the same thing, “I class all of them places [detention centres for young boys] as prisons anywhere that puts you behind locked doors. What else can you call it...?” (P10). Therefore it is not surprising that Konrad (2002)

refers to prisons as 'new asylums' to incarcerate mentally ill people. The importance of discourse with regard to mentally disordered offenders was clearly identified within the literature review as being extremely pertinent in how and where the mental health needs of this group should be provided for. The use of the word 'asylum' conjures up notions of the prison and the psychiatric facilities as being one and the same thing (Tuarascáil, Report 1966) - a form of power and social control (Foucault 1967, Nolan 1993, Jacob 2008). Indeed as Foucault (1977) remarked in 'Discipline and Punish', the technologies of social control may have changed over time from the public executions of the seventeenth century, to the disciplinary society of the nineteenth century and more recently to the carceral continuum of modern society.

However, the findings of this study reveal that the effects of institutionalisation on the individual have not changed. These findings can be understood in the context of Barton's (1959) theory on institutional neurosis and Goffman's theory on institutionalisation. One such example of this is a participant's description of becoming dependent on the prison system "they, [prisons] can't turn you away and they do look after you well" (P6). Indeed in some instances participants described life in prison as being better than life outside prison. For example "I'm not happy I'm in prison now.... but to be honest with you I am glad because it is a way of getting away from everything. I actually feel a lot better in here [prison]" (P1). However, another facet of the institutional environment is the use of coercive mechanisms often used as a form of control within prisons. Participants' in this study did refer to such experiences. For example, one participant referred to the fact that "you're locked in your room all the time, em padded rooms" (P 10). Another such example of this is evident in the following statement "I was one week on the landing but ended up spending 20 days in the seg [segregation] well it was for 40 days but they suspended 20 of them, I went in because I had a fight" (P 8). In fact, during the process of this research it was not unusual for me to be turned away or requested by a prison officer to come back another day to meet a potential participant due to the fact that the person I required to meet was in segregation.

However, despite these mixed experiences, a finding of this study suggests that mentally disordered offenders are gradually becoming reinstitutionalised within the criminal justice system. This finding is consistent to that of Priebe *et al.* (2008) who posit that a

trend of "reinstitutionalisation" into prisons is emerging. Yet to date there is limited research with regard to this. Underpinning this finding is the large number of participants who expressed a degree of satisfaction with the mental health care they received while in prison. This is evident in the extracts presented in section 5.3.5.3. (p. 133) from phase one of the study. This finding is further strengthened in phase two which found that (n=102, 88%) of participants reported that they were receiving help for their mental health problems while in prison. However, this finding must be considered in the context of the technique used in this study to recruit participants. This finding will be discussed in the context of the literature which is generally critical of the prison environment for mentally disordered offenders (WHO 2001, O'Neill 2006, European Committee for the Prevention of Torture, Amnesty International Irish Section report 2007).

A key aim of this study was to understand better the experiences of people with mental health problems within the Irish Criminal Justice System in accessing and maintaining links with mental health services prior to incarceration. This focus captured participants' experiences of mental health care within the community before entering the criminal justice system. In phase one of this study participants' description of their experiences of the mental health care received while in the community were predominantly negative. Examples of these experiences are clear from the following extracts from their interview transcripts, "He [doctor] never offered me anything other than medication..." (P 1), "I was very unhappy with how this whole thing [mental health problem] was managed I think they should have kept me in when I told them how I was feeling and I was so paranoid about the devil and that I should have been kept in" (P13). This experience resulted in some participants actually disengaging with mental health services for example, as one participant stated "what I didn't like was that the medication made me put on weight so that's why I stopped going to see the psychiatrist and stopped taking medication yeah a lot of weight."(P3). Similarly, phase two of this study found that a many as (n=68, 59%) of participants had disengaged with mental health services prior to entering prison. The literature review identified that for many people accessing and maintaining a link with mental health services can create many challenges (Goldberg & Huxley 1980, Lincoln & McGorry 1995, Boydell *et al.* 2006, Bhugra *et al.* 2004, Shaw 2007, Hayward & Moran 2007, Pilgrim 2011). This may be due to many factors such as personal preference,

mental health problems not being recognised within the primary healthcare system, or if recognised, appropriate services not being available or poor communication between agencies (Goldberg & Huxley 1980, Pilgrim et al. 2011). These findings are discussed in the context of this literature later in this chapter.

Another finding of this study suggests that certain individual circumstances may be substantial predisposing factors to future involvement with the criminal justice system. Among these are early terminations from the education system. This study found that the majority of its participants had lower educational attainments. Just less than half (n=52, 45%) of the participants in phase two of this study received an educational award and of these (28, 24%) received an award equating with level three on the national framework of qualifications (see Figure 6.5). Additionally, (n=49, 43%) were expelled or suspended from school at an early age. The qualitative phase of this study corroborates strongly with the finding of phase two on this issue. This finding is discussed in greater detail within section 7.2 below. This finding is consistent with other Irish research which contends that there is a greater prevalence of factors such as; early school leavers, being expelled or otherwise excluded from formal education or have had little or no meaningful engagement with the educational system among the offender population (O'Mahony 1997, ACJRD 2007).

A unique finding of this study concerned a change in the living circumstances of participants and the association with being the subject of a barring or protection order. This finding will be comprehensively discussed later in this chapter.

The majority of the people interviewed in the qualitative part of this study had been to prison at least once before. A critical finding of this study concerned participants' experiences of re-entering the community following release from prison. One of the views described by participants was a lack of confidence in mental health services in the community. This finding will be discussed in the context of the literature on former prisoners with experiences of accessing help after their release from prison (Durcan 2008, Howerton *et al.* 2007, Deane *et al.* 1999).

Hartwell (2004) refers to the notion of the triple stigma experienced by mentally disordered offenders in particular when they re-enter the community after involvement with the criminal justice system. This study describes participants' intense anxiety and

fear of how they might be treated upon re-entering the community following release from prison. This finding is in line with Cusack *et al.*'s (2003) Foucauldian perspective on stigma which shows not only how power can be seen to work, but also how it acts in a non-helpful manner. Indeed Campanelli *et al.* (2005) asserts that stigmatisation of offenders with mental illness is a risk factor for re-offending. With regard to this particular finding, participants described a sense of hopelessness about their future. A participant referred to the notion of a whirl pool effect as though there is no way of breaking the cycle of involvement with prison.

Finally, and perhaps most crucially, participants in this study reported that they would like to be involved in their treatment plan and needed to be able to talk about their problems not just receive medication. The majority of these participants expressed a wish for their treatment to be a combination of medication (if needed) as well as access to some form of talk therapy.

The remainder of this chapter will develop the above findings, and compare and discuss these in the context of pertinent and contemporary literature. As described in chapter four findings presented in chapters five and six are integrated within this chapter. Rauscher & Greenfield (2009) propose that integration remains one of the most important factors to consider in mixed methods research. In mixed methods research, integration can occur at the data collection, analysis, interpretation and results stages, or a combination of these stages. Yin (2006) emphasizes the importance of integrating mixed methods findings to produce a more complete account of the study findings. Therefore, if each method uses its own isolated procedures, the result could give rise to the appearance of separate studies using different methods. Furthermore, Bazeley (2002) contends that when a mixed methods design is used to gain a common understanding of a research problem then, regardless of whether they are used sequentially or concurrently, separation of the different components in reporting and interpreting those results is likely to lead to a report which is disjointed. Within this study the main process of integration occurred through the interpretation of the findings and is reported in this chapter. Both sets of findings are used to interpret, contextualise, and expand on the understanding of the overall findings. Therefore, integration throughout the process of interpretation allowed for a more complete understanding of the findings. This may not

be possible if the two sets of findings were interpreted separately. This process highlights the strengths of the mixed methods design utilised for this research allowing for findings to be clearly presented side by side. The integration of these findings allows for a comprehensive discussion of the central issues which were drawn from this research. It is intended that this will result in a more thorough unified mixed methods study.

The themes which emerged are used as a framework for the following discussion of these findings. These themes are: social circumstances, barriers to accessing community mental health services, re-institutionalisation, experiences with mental health services while in prison, and finally, experiences upon re-entering the community of those who had been in prison.

7.2 Social Circumstances

The findings of this study suggest that certain individual circumstances can be important predisposing factors to future involvement with the criminal justice system. Within this section several factors relevant to the experiences of this group with regard to accessing and maintaining a link mental health services are discussed. Some examples of these are socio-demographic factors such as gender, education, employment and living circumstances. Other factors include illness-related issues such as co-morbidity and level of insight and how these factors may impact on whether one seeks help for mental health problems or not. There are also issues concerning an individual's level of social support from family, community and professionals. Indeed this is a matter which causes an immediate concern for people following discharge from a psychiatric setting (Nolan *et al.* 2011). Pilgrim *et al.* (2011) refers to the concept of 'social networks' these are the links that exist among individuals within communities to help to explain and understand better help-seeking behaviours. Social networks are composed of four basic characteristics – socio-demographic, illness, illness history and social network (Pilgrim *et al.* 2011). Socio-demographic characteristics refer to background factors that help set the trajectory of the illness. Illness characteristics are issues pertinent to diagnoses. Illness history is concerned with issues regarding entrances and exits from the healthcare system based on diagnoses and remissions. Finally social network refers to issues relevant to the size and function of the individual's social network and his or her satisfaction with this support

(Bonin *et al.* 2007, p. 937). These four characteristics of the social network framework are used as a structure to present the findings within this section.

7.2.1 *Socio-demographic characteristics*

Gender: Of the 132 people who participated in both phases in this study (n=15, 11%) were female. In 2010 the number of female prisoners committed to Irish prisons stood at (n=157, 4%) (Irish Prison Service 2010, p. 14). The number of females committed to Irish prisons has increased by 0.6% since 2009 (IPS, 2010, p. 14). In Ireland, as is the case throughout Europe, women make up a small percentage of the overall prison population, on average constituting between 4.5% and 5% of the total prison population (Penal Reform International, p. 2). However, even though they are small in number the Social Exclusion Unit (2002) suggests that in general women prisoners have complex physical and health needs. Several of women in phase one of this study described experiencing domestic violence and abuse in their lives prior to imprisonment. For example, “when I was with my husband... well ex-husband now... [Silence]... he used to put me down all the time” (P 2). Furthermore, the quantitative phase of this study showed that practically all (n=11, 92%) the female participants were not in any relationship compared with a smaller percentage for male participants (n=81, 77%). This may indicate that female participants of this study are more susceptible to negative experiences due to their previous experiences with partners and limited social supports. Corston (2007) contends that women with histories of violence and abuse are over represented in the criminal justice system and can be described as victims as well as offenders. Furthermore, WHO (2009) note that the rates of self-harm and suicide are noticeably higher among female than among male prisoners. WHO (2009) observed that women in prison generally have more mental health problems than women in the general population. Furthermore, WHO (2009) profess that many women in prison did not receive adequate healthcare before incarceration.

United Nations General Assembly (2011) adopted the Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, otherwise known as the “Bangkok Rules”. These provide guidance for the treatment of women in prison and the management of women’s prisons on, *inter alia*, healthcare, safety and security, contact

with families, staff training, pregnant women and mothers with children in prison. According to Corston (2007) prisons are structurally setup with male prisoners in mind and are therefore inappropriate facilities for female prisoners. Corston (2007) asserts that men and women prisoners are treated the same within prisons. This arrangement creates injustice (Office of the High Commissioner for Human Rights, accessed 2011) and gender inequalities within prisons (The Inspector of Prisons report 2011, p. 6). An example of this, referred to previously, is that due to the small number of women prisoners these women are often accommodated far from home (The Inspector of Prisons report 2011, p. 6). Similarly this study found that the majority (n=8, 73%) of female participants reported that they were located in prisons which were not close to their home place. Another example of gender inequality is the fact that there is no open prison for women in Ireland whereas there are two such facilities for men in Ireland (The Inspector of Prisons report 2011, p. 5).

This study found that men more regularly sought help for mental health problems than women during their initial contact with services. However, this must be considered in the context of this study's limitations, for example limited number of women in the study and the limitations of selection process of participants. It is more generally accepted as Oliver *et al.* (2005) assert that women are more likely to seek help for mental health problems than men. Therefore, the finding of this study that men more regularly sought help for mental health problems than women may be understood better in the context of the WHO (2011) report. This report suggests that men are more likely than women to disclose problems with alcohol use to their healthcare provider. The majority of the males in this study referred to drug and alcohol misuse as their main problem and the reason why they looked for help in the first instance (section 6.6.2 Figure 6.6, p. 158).

Living Circumstances: An interesting finding of this study concerned a change in the living circumstances of participants. This study identified that practically two thirds (n=68, 59%) of the participants in phase two of this study reported that their living circumstances had changed. In phase one of this study the majority of the participants referred to experiencing difficulties at home which resulted in their leaving home and becoming homeless. Some examples of these experiences are; "I ended up getting barred from the house. Then eh with that everything just came down on me... I had no house... she had

the house everything was gone..." (P1). Another participant referred to sleeping rough or staying in hostels, "I ended up out on the streets more times and I'd stay in hostels and that sometimes.... And then I'd go home for a while but things weren't great there" (P6). Similarly, this participant spoke about becoming homeless and how this factor led to him ending up in getting involved with the CJS, "I left home at about 17[years]...ended up going to hostels for young offenders...got in with the wrong crowd and eh I ended up in [young offenders centre] and then I ended up in [prison]." (P3). Experiences such as these described in phase one of this study, led to the need to ask a question in phase two about living circumstances prior to imprisonment. This study found that (n= 43, 37%) of the participants were living with their family of origin at the time of onset of their current episode of psychiatric illness. A finding of this study showed that 50% of the women who participated reported that their living circumstances had changed. An example of such a change is evident from the following statement by a female participant. "It was when I came to [prison] about four and half years ago. This was the first time I made contact with [psychiatric services] I was in the [women's refuge centre]" (P2). Similarly, Corston (2007) found that 30% of women in prison lose their accommodation while in prison. Twenty four out of forty three participants in phase two of this study reported a change in their living circumstances following the onset of psychiatric symptoms. This resulted in them leaving the home of their family of origin. The next category whose living circumstances changed was of those who were living with their spouse or partner (n=13, 19%). This would suggest that those who were cohabiting were most regularly affected by a change in living circumstances at the time of the onset of psychiatric symptoms. Farrington (2008) claimed that many male mentally disordered offenders are detained specifically because of their perceived risk to women and children. Therefore, a question was posed in phase two of this study to assess if there was an association between change in living circumstances and being the subject of a barring or protection order. The Domestic Violence Act (1996) makes provisions for the protection of a spouse and any children or other dependent persons, or of persons in other domestic relationships, whose safety and welfare requires it. This legislation offers a number of options to victims of domestic violence such as barring orders, protection orders, safety orders and interim barring orders. A barring order is an order which requires the violent person to leave the family home. A safety order is a court order which prohibits the violent person from further violence or

threats of violence. It does not require that person to leave the family home. It also prohibits the violent person from watching or being near the family home in situations where the violent person does not reside in that home. A protection order is an order which has immediate effect. This order covers the period from when an application is made to the courts for a barring or a safety order and the date of court appearance for that application. It has the same effect as the safety order. Breaches of any of these orders granted by the courts are treated as criminal offences. The majority (n=71, 62%) of the participants in this study were the subject of a barring or protection order. All of these participants were male. This suggests that males with a mental health problem who are living with others are more likely to be the subject of a barring or protection order. It may be pertinent to ask if the Domestic Violence Act (1996), by the activation of a barring or protection order, is becoming a route to accessing psychiatric care. This finding may also suggest that participants from this study may be more susceptible to becoming homeless. Several studies have shown a relationship between homelessness and severe mental disorder (Nacro 1992, Zaph *et al.* 1996, Farrington 2008) as well as between homelessness and previous psychiatric history (Zaph *et al.* 1996). According to the DoH&C (2006) one of the barriers to accessing mental healthcare is homelessness which may be accompanied by a reduction in the support network of these people (p. 143). The Department of Environment, Heritage and Local Government (DoEH&LG. 2010) have made a commitment to the provision of housing for vulnerable groups, including those with disabilities and those who are homeless. In response to this a strategic plan was launched. This involves a cross departmental Team approach to consider issues such as Sheltered Housing, homelessness and Social Inclusion.

According to Shepherd and Murray (2001) housing should be at the centre of community psychiatry. Studies show that homeless mentally ill people are much more likely to be incarcerated than non-homeless people with mental illnesses (Crowley 2003, Duffy *et al.* 2003). Factors such as substance misuse (Kushel *et al.* 2005, Fischer 1988, 1992) and mental illness (Gelberg *et al.* 1988, Zaph *et al.* 1996 and Eynan *et al.* 2002) are commonly associated with offending among the homeless population. Some research evidence indicates that homeless individuals are more likely to be involved in minor offences (Fischer 1988, Constantine *et al.* 2010). However there is evidence of the involvement of the homeless population in serious crimes also (Gelberg *et al.* 1988, Blakely, 1992).

Seymour and Costello (2005) note, in their report on homelessness among people in custody that 25% of those sent to prison were homeless on committal. Of these one in three had been previously diagnosed with a mental illness and two in three had previously spent time in a psychiatric hospital. In addition, 90% of those homeless on committal were drug users, the majority with serious drug problems. These findings are interesting in the context of this current study. This study found that the majority of the participants were serving a sentence (n=96, 84%). The majority of these participants described being involved in minor offences, and having a history of mental health problems, drug and alcohol problems and homelessness. These factors may place many of the participants of this study at risk for future involvement with the Criminal Justice System.

The majority of the participants from the first phase of this study reported having previous involvement with both psychiatric and prison services and had experienced difficulties with securing suitable accommodation. According to Greenberg *et al.* (2008) the association of mental illness with homelessness among prisoners may be a reflection on the limited access to mental health services, particularly inpatient services. This issue will be discussed in more detail under the final theme of this chapter. The Social Exclusion Unit (2002) claims that the connection between crime and homelessness is particularly relevant because prisoners released without pre-arranged accommodation are more likely to re-offend. Vitelli (1993) posited that as many as 39% of prisoners were homeless upon release from prison. Furthermore he contested that this group were more likely to have mental illness, previous criminal records, and greater involvement with the mental health services and a higher incidence of violent and para-suicidal behaviours than did the domiciled.

Therefore accommodation is a key element in an offender's successful resettlement in the community and in rehabilitation (Nacro 2007, p. 4). Bhugra (1996) contends that the needs of this group are multifaceted and complex and need a closely coordinated approach.

Unemployment: almost half (n=52, 46%) of participants in this study were unemployed. Also those who were previously employed reported that the prospect of returning to work following imprisonment was non-existent. The finding of this study showed that

participants had lower level skills, poor employment histories, and high levels of unemployment. Of those who had employment prior to going into prison, the majority could not return to their employment following release from prison. Few had formal qualifications. Therefore low educational attainments may also be a barrier in exacerbating the difficulty of gaining employment. Phase one of this study corroborates the findings from phase two with regard to employment. In phase one of this study interview participants' made reference to the fact of having lower educational attainments as being a barrier to gaining employment, this is in line with the findings from phase two which suggests that this finding is a robust one. Participants' made several references to their experiences with regard to employment in phase one. For example, "I was 13 then I got a job I was labouring for 8 mths and that job just wound up you know I did a FAS [Irish National Training and Employment Authority] course then but I got kicked out of that because I stole something yeah yeah. So after that I was just hanging around stayed at home a lot in my room, I didn't have many friends I think people didn't like me or maybe they were afraid of me I don't know...." (P15). There are a number of factors which make gaining employment challenging for mentally disordered offenders, an example of which is having a criminal record (National Economic and Social Forum 2006) that can result in further discrimination and social isolation.

Work can be described as a socially integrating force that is highly valued. It is the key social activity which gives people a sense of self-worth and social identity (Stuart 2006, Auerbach & Richardson 2005). Work and family roles are described as being the cornerstones of a general law-abiding adult citizen's identity construct (Uggen *et al.*, 2004 p. 263). Despite this, the OPCS Psychiatry Morbidity Study in Great Britain in 1995/1996 showed that mental health service users had the highest rate of unemployment of any disabled group (Office for National Statistics, 1996). Only 24% of adults with long term mental illness are in employment (Office for National Statistics, 2003). Also people with mental health problems are nearly three times more likely to be in debt, and are more than twice as likely to lose their job as compared to people who do not have a mental illness (Office for National Statistics, 2003). Indeed, Whelan *et al.* (2004) showed a cumulative link between unemployment and poverty and family burden. Daly *et al.* (2003) found that there was an eight-fold difference in the number of psychiatric

admissions between professional and unskilled workers in Ireland. However, the contradiction is that being in employment can reduce the level of relapse among people with mental health problems (Social Exclusion Unit 2004). Secker & Membrey (2003) posit that employment is an important factor with regard to the re-integration of people with long-term mental health problems back into the community.

Employment is identified as a key element in an offender's successful resettlement in the community and rehabilitation (Nacro 2007, p. 4). Rhodes (2008) claim that social ties are the most effective and predominant means of finding paid employment for ex-offenders. Furthermore Niven and Stewart (2005) emphasised the importance of social networks for ex-offenders when entering employment, training or education programmes following release from prison. However, Gillis (2000) points out that structured aftercare services and support are also required for ex-prisoners to gain and maintain employment. Furthermore, as Niven & Olagundoye (2002) suggest, accommodation is a critical factor if prisoners get into paid work following release from prison. Gadd & Farrall, (2004) note the importance of the interaction between employment, self-identity and the social relationships of ex-offenders. Having a criminal record is identified as a barrier to accessing employment (National Economic and Social Forum 2006, p. 129). Consequently, unemployed ex-prisoners are twice as likely to re-offend as those in full or even part-time employment (Law Reform Commission 2007, p26).

Education: Findings from this study showed that the majority of participants achieved low educational attainments and were often either suspended or expelled from school at an early age. From phase one of this study eleven of the fifteen people interviewed stated that they either left school early or were expelled as a result of bad behaviour while attending school. Examples of some of the experiences of these participants with regard to education are; one participant described the lack of education as being the norm particularly within a rural setting, "I had a very ordinary life lived on a farm in a country area nothing unusual or that. Didn't get much schooling but that was the norm you know."(P2). However most participants described being expelled from school because of behavioural problems, "eh I went to school me mother kept me in school but eh I got into a fight when I was 15 and then I was thrown out of school I was very close to doing my junior cert but I didn't get to do it. I really wanted to do my junior cert I wanted to have

trade or something like that you know. But as I say I got into a stupid fight and eh the headmaster just took it into his head that I was the cause of it so then I was expelled you know" (13), similarly, "I was always in trouble I got kicked out of school load of times so I didn't get much of an education." (P3). This finding is strongly supported by those from phase two of this study. These showed that (n=52, 45%) received an educational award. However, of these the majority (28, 24%) received an award equating to level three on the national framework of qualifications fan (see Figure 6.5). Additionally, (n=49, 43%) were expelled or suspended from school at an early age. This is consistent with other Irish research which shows that a high number of offenders are early school leavers, have been expelled or otherwise excluded from formal education or have had little or no meaningful engagement with the educational system (O'Mahony 1997, ACJRD, 2007). Morgan & Kett (2003) say that "poor literacy skills restrict a range of life choices (particularly employment), and thus become a pre-disposing factor in criminal activities" (p. 10). Educational disadvantage is a critical factor in all forms of social exclusion and one of the strongest risk factors associated with imprisonment. Two key factors of literacy and school completion directly impact on life chances (IPRT, 2010, p. 11). Mental illness is associated with lower levels of educational attainments (Waghorn & Lloyd 2005, King *et al.* 2006). Also according to Farrington (2008), mentally disordered offenders have a lower level of educational and vocational attainment and have higher levels of school expulsion as compared with the general psychiatric population. Green *et al.* (2005) posit that one in every ten (10%) children aged 5-16 years have a clinically diagnosable mental health problem. Richards *et al.* (2009) remark that childhood and adolescent mental health problems have an impact on adult life chances, with major cost implications for individuals, for government, and for society. Odgers *et al.* (2008) reported that men with extreme antisocial problems in childhood and adolescence were at a higher risk of offending, and were more likely to commit violent crimes such as assault and robbery. They also had lacked educational qualifications, were likely to be in unskilled employment, and to engage in substance abuse.

Richards *et al.* (2009) assert that early intervention and prevention strategies for emotional support for those at risk of early school leaving is vital. Similarly, one participant in this study claimed that "If my mental health problems were picked up

earlier I think this would have made a big difference... yeah big time" (P3). Indeed, Friedli & Parsonage (2007) assert that if intervention was provided earlier to prevent conduct disorder, costs with regard to crime would be greatly reduced. Consequently as another participant commented "I think if I had of got help sooner I think that a lot of things would have been different for me ... I have no doubt that the offence wouldn't have happened no definitely not no... If I had got drug and alcohol awareness and if I had taken it seriously ... if I had of got it or was offered it" (P14).

7.2.2 *Illness characteristics*

Co-morbidity is a common factor with conditions such as personality disorder, alcoholism and drug dependence. According to Yourstone *et al.* (2009), women were more likely to be diagnosed with personality disorder than men. Kennedy (2007) observed that the Mental Health Act (2001) excluded personality disorder in its definition of mental disorder. Wright *et al.* (2006) found in a study among Irish female prisoners that 51.4% (37 of 72) had a diagnosis of a personality disorder. A considerable proportion of these had a co-morbid mental disorder, substance misuse or harmful behaviour. Furthermore, according to the WHO (2009) many women in prison have a history of sexual and physical abuse and violence. The implications for this in Irish prisons may be that women prisoners with a diagnosis of personality disorder or dual diagnosis may find it more difficult to be identified as needing psychiatric treatment by prison staff. Boardman *et al.* (2010) maintain that female mentally disorders offenders have more complex problems and have a higher risk of social exclusion due to a history of domestic violence and the ensuing implications of poverty, social interactions and mental and physical health.

The qualitative component of this study found that some participants were diagnosed with a range of mental disorders such as schizophrenia or bipolar disorder. Some examples from the transcripts are included here "I have been diagnosed as schizoid affective disorder (P14), "He [doctor] told me that I was schizophrenic... (P6), "So that's when I got diagnosed with bipolar" (P1). This finding was corroborated by the frequency with which participants referred to symptoms of major mental disorders such as major mood swings, hearing voices, and paranoia. In this study Question C3 of the quantitative data collection instrument asked participants to state their main mental health problem

which caused them to seek help. The main mental health problems referred to ranged from feelings of anxiety\panic attack, sleeplessness, feeling suicidal, depression, mood swings, hearing voices, paranoia, dependency on drugs and alcohol. Often a combination of problems was described such as anxiety and depression or drug and alcohol misuse and psychiatric symptoms (see Figure 6.6). However, of all the symptoms referred to, paranoia and hearing voices were the most regularly mentioned (n = 36, 32%).

An interesting point from the response to this question is that the majority of the participants did not refer to a diagnostic label but rather referred more to actual feelings such as feeling low, being a bit high, hearing voices or moods being up and down. This finding suggests that this group may be influenced by the label attached to them. Interestingly, participants in phase one of this study stated what they were told by a mental health practitioner with regard to their diagnosis. Whereas, in phase two participants' were asked to give their subjective view of their main mental health problem for which they sought help. According to Lai *et al.* (2000), receiving a diagnosis of mental illness can often be associated with having the additional burden of a negative label. Consistent with Lai *et al.* one participant in phase one stated, "Well to be honest with you I think it was the male pride... I didn't want to be taken any tablets you know. I didn't want to be diagnosed with anything" (P1). This comment may be better understood in the context of Wallcraft *et al.* (2011) suggestion that receiving a diagnosis of mental illness incurs loss of social status and employability, a fact that actually discourages seeking help. Consistent with many studies (Allwright *et al.* 2000, Linehan *et al.* 2005) this study showed a marked occurrence of drugs and alcohol misuse/abuse among this population. There were several references to misuse/abuse of drugs and alcohol in phase one of this study. For example "I got into taking drugs and eh I could see no other way of getting up [feeling normal] I was low.... Low low low all the time (P1). Another participant associated their substance abuse with becoming involved with the CJS, for example, "But before that there was a spiral of events that led to my involvement with the CJS [young offenders centre]- drinking, drugs, barring order and homelessness at one stage."(P5). This finding was further corroborated in phase two of this study (see section 6.6.2 Figure 6.6 p. 158). Duffy *et al.* (2003) argues that drugs and alcohol dependence and their harmful use were by far the most common problems, present in between 61% and 79% of prisoners. The

influence of substance abuse on offenders with mental health problems is documented in previous studies (Menezes et al. 1996, Kushel et al. 2005, Seymour and Costello 2005, Linehan et al. 2005). Consistent with these studies this research shows the presence of mental illness, substance misuse and offending behaviour among this group.

7.2.3 *Illness history*

In the qualitative phase of this study eleven of the fifteen participants had made varying degrees of contact with mental health services before they became involved with the CJS. A typical description of the contact is provided in this comment “Yeah I felt I needed to get help for my mental health problems. I tried to get help for it once yeah once I went to psychiatrist in the [psychiatric hospital]; I was referred to another service” (P3). This finding was corroborated by the quantitative phase of this study. Practically all (95%) of the participants had made some contact with mental health services prior to imprisonment. Interestingly, thirteen participants in the qualitative phase of this study expressed negative views about how their mental health problems were provided for, prior to becoming involved with the CJS. These negative experiences ranged from an over reliance on medication and the use of repeat prescriptions, G.P. not ‘hearing’ problems – unwillingness to talk about problems, absence of services to be referred on to, or services not being inclined to admit a person to an in-patient setting. An example of this negative experience can be shown in the following interview extract; “He [doctor] never offered me anything other than medication... he never offered me a psychologist or anything. And he knew about me sister and me father and the history of depression in the family and all that...I just went back for another prescription you know. He never asked to see you like, just a repeat prescription. But they just weren’t working I was more down all the time you know what I mean than up.” (P1). The literature review showed that mentally disordered offenders are usually known to mental health services prior to imprisonment (James 2002, O’Neill 2006, Linehan *et al.* 2006). This suggests that participants disengaged with mental health services prior to imprisonment. Similarly, Farrell *et al.* (2006) observed that the majority of prisoners with mental health problems were not able to get help from mental health services in the year before coming to prison. Similarly, a participant in phase one of the study stated, “Yeah well as I say I was in [psychiatric hospital] as an

outpatient but I never bothered staying there... they were useless.... I ended up out on the streets more times and I'd stay in hostels and that sometimes.... And then I'd go home for a while but things weren't great there" (P6). Furthermore Durcan (2007) suggests that prisoners in his study described the feeling of being let down by community services prior to incarceration. Howerton *et al.* (2007) suggest that socio-demographic factors may contribute to this breakdown. In addition, Howerton *et al.* (2007) contend that mentally disordered offenders are predominantly more likely to be associated with the lower socioeconomic status, increased level of impulsivity, limited coping skills, social isolation and a history of self harm and attempted suicide. They are more likely to be homeless (Crowley 2003, Duffy *et al.* 2003) and have a history of substance abuse (Duffy *et al.* 2003). Similarly, participants in this study were regularly the subject of a barring or protection order which may increase the possibility of being homeless. Also participants in this study were commonly unemployed, on benefit allowance which may mean they may be exposed to greater levels of poverty, and had lower levels of educational attainments.

7.2.4 Social Network

This study revealed that individuals experienced varying levels of social encouragement on their pathways to mental healthcare. For example, for their first contact sample, 47% reported that a family member or friend persuaded them to seek help for their mental health problems. Others (15%) were persuaded by either Gárdaí or prison staff and some were persuaded by their employers or by the education system. However by the fourth contact the type of social support changed completely for participants in this study. Just about half (49%) of seventy-two participants reported that social support was from the criminal justice system and the least was from family members or friends (3%). According to Tedstone Doherty *et al.* (2010) social support is one of the factors which influence help-seeking behaviours. The change in social support described by participants in this study may impact on the quality and source of help accessed following release from prison. The qualitative data gathered for this study indicates that many people experienced negative attitudes towards them due the fact that they had been in prison. These will be discussed in more detail in the following section.

7.3 Barriers to accessing mental health services in the community

The literature review identified many of the barriers experienced by people when attempting to access mental healthcare in the community (Goldberg & Huxley 1980, Pilgrim *et al.* 2011). This study identified many critical barriers experienced by its participants when trying to access mental healthcare in the community. Participants described these experiences from two perspectives. The first is of those who had never been in prison before and the second of those who had been to prison before so were re-entering the community with a criminal record. The barriers identified were stigma - negative attitudes or perceptions about mental services from health professionals, misdiagnosis, over reliance on medication, lack of services and lack of support. Participants described the stigma of being labelled mentally ill as the biggest barrier to accessing mental healthcare. For example from phase one a participant commented that “some of them [society] didn’t want to know me when they realised that I had a mental illnessbecause of the stigma they just didn’t want to know me. You know.” (P11). In fact another participant stated that there is no change in the level of stigma experienced despite the efforts to reduce it “You know there is still a huge stigma about them I don’t care what anyone says. It is still alive and well.” (P14). However on the other hand participants described the experience of being labelled not only society but also from within the services which they attended for their mental health problems. One example of stigma by health professionals is clear from this statement “The services don’t want to know you....once they hear that you were in prison or the [forensic services]” (P5). In Ireland in 2010 a new programme was launched to address the issue of stigma in our society. Reducing stigma is one of the major policy approaches proposed to reduce the discrimination associated with mental health problems (See Change - National Stigma Reduction Partnership, 2010). According to Vogel & Wade (2009) one of the more common reasons why people do not seek help for a mental health problem is because of the perceived stigma associated with it. Corrigan (2004) asserts that stigma can lead to a delay in seeking help for mental health problems in an attempt to reduce the negative consequences associated with stigma. Similarly this study identified considerable delays experienced by participants in accessing mental health care. Indeed, one participant stated that “I was ok for a while but then I got bad again and the psychiatrists wanted me

to go back to the [forensic services] again, but then I didn't want to go back there I refused because of my family, they didn't like the last time that I was there they slag me and stuff they would call me ... a mad bastard ... your only a psychopath... you're no good to anybody you know it's a stigma" (P10). For this study the delay in seeking mental health care was calculated by subtracting the answer to question C 5 'How long ago did person's main mental health problem begin?' from the answer to question C 6 'How long is it since you first saw somebody about this problem?' Considerable delays in seeking mental health care were reported in phase two of this study. A delay of up to one year was reported by (n=42, 36%) participants. A further (n=32, 27%) experienced a delay of just over one year to three years. The remainder (n= 43, 43%) experienced a delay of over three years. However, Golberstein *et al.* (2008) argue that there is limited empirical evidence that stigma actually affects the use of mental health services. They suggest that other facets of stigma apart from the perception of public stigma may affect help-seeking. In contrast to the public stigma, an internal form of stigma, that of self-stigma has been described. This happens when a person labels oneself as unacceptable because of having a mental health concern (Corrigan 2004, Vogel *et al.* 2006) or when they have a sense of being powerless over the negative association with mental health problems (Corrigan *et al.* 2009). Vogel & Wade (2009) point out that self-stigma is related to cultural and gender-role norms. The concept of self-stigma may be very relevant with regard to participants of this study. As described in section 7.2.1 above, participants in this study experience many social problems which may impact on their self image, such as homelessness, unemployment, poverty, poor education, life trauma and criminal involvement. One participant described how he tried to maintain his principle of staying independent and how this impacted on his life "I was homeless for a while and I had a principle of not wanting to go on the dole but I would run out of money and it was a crazy time I was going from Billy to jack but em I should have looked for help yeah definitely" (P11). Another participant referred to how one problem escalated to the next eventually leading to involvement with the CJS "But before that there was a spiral of events that led to my involvement with the CJS [young offenders centre] - drinking, drugs, barring order and homelessness at one stage."(P5).

This study also found that some participants experienced stigma from the services they were attending e.g. within the prison system or from the Gardaí. One example of a person feeling stigmatised was by a homeless service, this was based on the crime which they had committed, “I won’t even get into a hostel now... now that I’m in for arson... they won’t let you in if you done that... so I don’t know.... At least prison can’t turn you away and they do look after you well.” (P6). Another participant stated that they felt stigmatised by prison personnel, for example “Officers slag me because I talk to [voices] you knowsimple bastard ...you mad man not all of them certain ones you know.” (P10). According to Byrne (2000) there is no stereotypical stigmatiser. They can come from all creeds and classes – from the legal profession, health professionals, education and prison workers. Heflinger & Hinshaw (2010) assert that health professionals from an array of health fields stereotype psychological disorders. Corrigan (2005) suggests that the dehumanizing effects of stigma by mental health professionals are bolstered by evidence from “consumer narratives.” Corrigan (2005) “point out that in the course of doing ‘good,’ many professionals may hold pejorative attitudes toward consumers that are enacted in paternalistic and coercive treatment strategies” (p. 75). Schulze (2007) states that anti-stigma campaigns are sometimes driven by health professionals who may themselves be responsible for creating some of the stigmatisation and so are less successful in beating stigma and discrimination. These same professionals have been criticized by Schulze (2007) for being largely uninformed by the lived realities of people with mental illness and their families.

A Health Research Board (HRB) report (2009) found that one of the most frequently identified barriers to attending a GP was embarrassment, or feeling awkward (p. 27). Participants in this study similarly believed their GPs would not understand or act empathically towards them about their mental health problem. For example, one participant claimed that on return visits his GP did not ask to speak to him and that a repeat prescription was left for collection, “He [GP] never asked to see you like, just a repeat prescription” (P1). As a result they described avoiding their local GP or declining to return due to a bad experience while on a previous visit. Some examples of these experiences are presented in the following extracts, “I was once prescribed Prozac by my GP [about 5 years ago]. He [GP] knew I didn’t like taking tablets.....yeah I went back a

couple more times he [GP] wanted to give me a mild sedative or a sleeper but I said no I don't see the point in taking medication, So when I go off the tabs the problems still exist that's how I feel you know" (P7). Another participant described a level of dissatisfaction with the service provided by their GP claiming that the GP didn't listen to his views, "Also over the years I used to go to my GP and sometimes when I went to see him he would just give me some relaxing tablets you know. I would of said to him what me problems were but all I could get were the relaxing tablets but they were no good" (P13). Again, another example of a participant's view about attending their GP, this participant felt that the GP was not even concerned about their mental health problem. However, he seemed more interested in the patient's family circumstances alone, "No he never referred to anything like that no no. I think they were more concerned about the kids and everything else. So no he (GP) never asked anything about that [mental health]" (P2). Such dissatisfaction with GP's is particularly important considering that this study found that just over half of the participants (n=62, 53%) reported that the GP was their first point of contact. This fact is further complicated for this group due their association with the criminal justice system.

Being misdiagnosed was identified as a substantial barrier for participants with regard to maintaining a link with their health provider. In phase one of this study, six participants made multiple references to the fact that they were misdiagnosed. Consistent with this, Goldberg & Huxley (1980) assert that one of the barriers to effective treatment of mental illness is lack of recognition of the seriousness of mental illness by health professionals. Paykel *et al.* (1998) suggest that one of the main reasons people may not go to their GP is that they feel that their GP does not have the skills to help them. One such example of this from a participant extract is, "How it all started I had depression for year but I was wrongly diagnosed I have bipolar depression they just said it was depression [doctors] I always new ...well I didn't if you know what mean." (P1). A further two participants' claimed that it was several years before they were accurately diagnosed, "But it was a long while afterward that they [doctors] found schizophrenia and I didn't suffer from depression you know" (P3), "Yes and when I was younger I was diagnosed as a schizophrenic but that was it that was wrong" (P15). This finding is not surprising considering Coptly & Whitford (2005) finding of deficiencies in mental health training for

general practitioners and deficiencies in protocols for the delivery of mental healthcare in the community. In response to this the Health Service Executive (HSE) launched a resource pack 'Mental Health in Primary Care', for the delivery of mental healthcare at primary care level. However the DoH&C (2006) draw attention to the fact that Education in psychiatry is not formalised (p. 191). Furthermore, it is recommended that "The GP training body and the psychiatry training bodies should jointly review all issues in relation to mental health training for GPs (Recommendation 18.14, p. 191).

The majority of the participants in the qualitative part of this study reported that they only received medication and repeat prescriptions when they attended a GP about their mental health problems. For example, "He [GP] never asked to see you like, just a repeat prescription" (P1). This finding was corroborated in the quantitative part of the study. A considerable difference was noted between treatments provided by the various contacts accessed. This study found that the GP regularly prescribed a sedative or sleeping tablet. The second most common treatment offered were antidepressants (n=26, 37%). This finding is consistent with the Department of Health and Children who expressed concerns about the perceived 'over-reliance on medication' in dealing with mental health problems (DoH&C, 2006). This was seen to be the case not just for secondary level mental health services but also for GP provided care (DoH&C, 2006). Also a survey of GPs by the Mental Health Foundation found that 72% of GPs agree that a non-pharmacological approach might be beneficial for the treatment of depression but most of them reported prescribing mainly medication (Mental Health Foundation, 2010). An Oireachtas report drew attention to the inappropriate use of psychopharmacology, lack of training and education on psychopharmacology for practitioners, the conflict of interest due to the major role that the pharmaceutical companies play in the training and education of practitioners and the promotion of medication (Joint Committee on Health and Children 2007). Beresford (2005) refers to the notion of pharmacological dominance due to the mental health system's over-reliance on drugs and their crude usage in practice (p. 87). Furthermore Conrad (2007) argued that problems are becoming increasingly controlled by medication and alluded to the notion of a 'pill for every ill'. Chew-Graham *et al.* (2002), in a qualitative study with GPs, suggest that GPs working in socio-economically deprived areas describe patients with depression as actively seeking medication. However there is

little research available to support or refute this notion as yet. Also it must be pointed out that medication has been shown to be beneficial for the treatment of mental health problems (Ludwig *et al.* 2007). However Tedstone Doherty (2009) notes the negative consequences of prescribing medication without also considering other modes of treatment (p. 68). Findings from this study showed that participants' reacted very negatively to only receiving medication for their mental health problems. These reactions included not taking prescribed medication for example "stopped taking prescribed medication" (P15), self-prescribing for example "I got into taking drugs and eh I could see no other way of getting up [feeling normal]" (P6), misuse of prescribed medication for example "Tablets you know with the prescription ye just tell the Doctor what you want and he writes it out for you." (P9). As mentioned earlier these experiences are extremely relevant in the context of the high level of disengagement (n=68, 59%) with mental health services found in phase two of this study. Interestingly, Happell (2008) points out that many service users view medication as helpful but only when their concerns and preferences are taken into consideration as well. Participants' in this study were emphatic with regards to their view on where medication fits into their treatment regime. There were nine references to this issue in phase one, for example "I need to be able to talk about me problems and be on the proper medication." (P4).

Another key barrier identified in this study was the perceived lack of services available. An Oireachtas report highlights the lack of alternative treatments available, including the need for more psychologists and counsellors (Joint Committee on Health and Children 2007). HRB (2006) note that few, if any, general practitioners have direct access to counsellors and psychologists within the primary care service. Some participants reported that they were from rural areas in Ireland where there were no services. For example one participant described living in a rural area and the nearest mental health services being miles away "Well anyway I had no access to them anyway... how do you mean? [Prompt by the researcher]... the mental health services are in [city]... that's a good bit away. I'm not living near [city] no no" (P5). DoH&C (2006) note rural disadvantage as an issue for concern in parts of Irish society. To date, no research in Ireland has identified treatment options available for those with mental health problems in the primary care setting. Experience suggests that the range of treatment options are

narrow and access to allied health professionals limited (Department of Health and Children 2006).

Many participants in this study referred to having several health-related problems such as substance abuse and mental health problems. An example of this from phase one is “So basically at the age of 39 [years] I smoked hash became sick and ended up here [prison]. No eh I would have smoked it before when I was about 18 [years] for about a 6 months period but I went back to it at a period in my life were I smoked it again....” (P14). This finding is strengthened by the combination of problems frequently described by participants’ in phase two of the study. These combinations ranged from anxiety and depression or drug and alcohol misuse and psychiatric symptoms (see Figure 6.6 p. 158). MacGabhann *et al.* (2004) assert that the term dual diagnosis is recognised in the Irish healthcare context. However there is no development in relation to dual diagnosis specifically and how the issue should be addressed. Consequently, there is neither, formal recognition of the prevalence of dual diagnosis, nor any impetus for service provision (MacGabhann *et al.* 2004, p. 14).

Many participants reported the lack of support as being a barrier to accessing and maintaining a link with mental health services. For example this participant described the experiences of “being discharged too soon and not having support you’re just left out to fend for yourself really” (P12). A HRB survey (2009) conducted by Tedstone Doherty *et al.* which asked people if they had a mental health problem and, if so, what supports would they prefer. The most frequently preferred supports were family and friends or their GP. This was followed by psychiatrist, counsellor and psychologist, but to a much lesser extent. These findings highlight the importance of family and friends as informal supports for people with mental health problems as well as the formal support of the GP (HRB 2009, p. 68). This finding is consistent with findings from the quantitative phase of this study which found that the majority of the participants identified a family member as the person who suggested that they needed to seek help for their mental health problem before self referral. However this finding is challenged in by the findings in the qualitative phase of the study. For example six out of eleven participants who made contact with services self initiated their first contact regarding their mental health problems. “No I went of my own accord... nobody told me to go and see him. I’ll never forget the day...one

day I was just out in the garden fixing the lawnmower and then I don't know what happened...I just went bonkers....I don't know what it was so I said I'm going to go see somebody... myself I said." (P1). Also the GP was the most frequently utilised form of support by the participants. However this study highlighted a difference between a family members' choice of support to access help to that of those who self-referred. Of those who self-referred, (n= 21, 70%) went to a GP and only (n=1, 3%) went to psychiatric services. However of the family members who suggested a participant should seek help, (n=33, 64%) suggested visiting a GP. Interestingly, a comparison between referral choices of family members with those who self referred showed that a family member suggested going to psychiatric services first (n= 10, 19%) more regularly than those who self referred (n=1, 3%). According to the Dept of Health & Children (2006 p. 106) if people with mental illness are living with relatives, the effects of their disorder may place considerable burden on their carers. Some people with mental health problems may never have been admitted to hospital and are particularly at risk of becoming homeless or spending time in prison. This is clearly evident in some of the remarks made by participants' in phase one of this study. For example, "I was nearly 14 yrs when I got 12 months in [a detention centre for young offenders] for robbing cars mainly you know..." (P9). "But before that there was a spiral of events that led to my involvement with the CJS (young offenders centre) - drinking, drugs, barring order and homelessness at one stage."(P5). Participants in this study reported that their support system changed drastically by the time of their third and fourth contacts. At this stage their most frequently referred to contact was that of the prison psychiatric services. This and the change in living circumstances as discussed earlier suggest that participants may have limited supports available following release from prison. Vitelli (1993) opines, with reference to the homeless, that there is a risk that dependency on the criminal justice system may develop in order to gain access to health care.

7.4 Re-institutionalisation

The process of de-institutionalisation within the mental healthcare system has majorly, if not radically, improved the care for and the lives of mentally ill people in countries that have conducted psychiatric reforms (Salize *et al.* 2008, p. 527, European Commission, 2005). The aim of the Irish newly constructed mental health system is to deliver a range

of activities to promote positive mental health in the community. It should intervene early when problems develop and it should enhance the inclusion and optimal functioning of people who have severe mental health problems (DoH&C, 2006. p. 14). Yet, interestingly, a substantial amount of participants from this study expressed a degree of satisfaction with how their mental health problems were managed and the treatment provided once they entered the prison system. For example one participant made a comparison between the mental health care they were receiving in prison as opposed to the care received when in mainstream mental health services, "Well it [prison] is good really I am on tablets and I get to see a counsellor [psychologist] about my problems as well. I think this is good because when I was in the mental hospital all I got was tablets nobody talked about the problems" (P12). Such experiences raise the question, 'are mentally disordered offenders becoming re-institutionalised?'

Munk-Jorgenson (1999) argued that the process of deinstitutionalisation in mental healthcare has actually contributed to the causation of many other problems, such as increased suicide rate among psychotic patients, an increase in coercive 'activities' in psychiatric hospital wards, the increasing rate of occupancy of psychiatric beds, the increase in the rates of acute or emergency admissions, and the increase in the number of criminal offenders among the mentally ill. Furthermore, Murphy (1992) contested that the process of deinstitutionalisation and the reluctance among general psychiatrists to accept high-risk prisoners from the criminal justice system has contributed to an increase in mental health problems being dealt with in the prison system. In fact, with regard to the latter, Konrad (2002) refers to the imprisonment of the mentally ill as a type of "new asylum". Furthermore, Swartz & Lurigio (2007) remark that prison is now being referred to as 'the de facto major providers of mental health services' (p. 582). Priebe *et al.* (2008) posit that a trend of 'reinstitutionalisation' is emerging. Indeed almost twenty-five years ago Elpers (1987) expressed concern about a possible relapse to re-institutionalisation. Priebe *et al.*'s. (2008) study was a follow-on from Priebe *et al.* (2005) which explored if 'reinstitutionalisation was occurring in mental healthcare. Priebe *et al.* (2008) showed that there was an ongoing trend toward increased provision of institutionalized mental healthcare across Europe. It has been claimed that the number of forensic beds increased in many European countries. At the same time, it is also claimed that this did

not happen in Ireland (Priebe *et al.* 2008, p. 571). However in late 2008 and early 2009 ten additional beds were made available at the Central Mental Hospital Dublin aimed at addressing the waiting lists for prisoners in need of mental health care (IPS 2009, p. 42).

A finding of this study suggests that mentally disordered offenders are gradually becoming reinstitutionalised within the criminal justice system. This finding is consistent to that of Priebe *et al.* (2008) who posit that a trend of "reinstitutionalisation" into prisons is emerging. Many of the experiences described by participants in this study with regard to their mental health care while in prison could be better understood in the context of the process of 'institutional neurosis' (Barton 1959) and 'Institutionalisation' (Goffman 1961). Goffman's (1961) assertion was that individuals develop behaviours that aid them to survive institutional life (pp. 61-64). Barton (1959) explains the process of institutionalisation as being the result of factors such as loss of contact with the outside world, enforced idleness, brutality and bossiness of staff, loss of friends and personal possessions, poor ward atmosphere and loss of prospects outside the institution. The behaviours described by participants in this study included several of these factors. For example withdrawal and bossiness of staff, requesting to go to the 'pad or solitary confinement' rather than interact with fellow prisoners, One participant referred to the fact that "But people [prison staff] don't understand in prison and then they put you into a padded room with a bookthis just makes you worse and then the voices get worst... but if you are in the cell at least you have a telly that's something." (P10). Also an example of being intimidated by prison staff as described by one participant in the qualitative phase of this study "Officers slag me because I talk to [voices] you knowsimple bastard ...you mad man not all of them certain ones you know." (P10). Conversely, this behaviour may also be regarded as a form of fighting the system, which is also used as a way of withdrawing from other inmates. In this instance the request to go into segregation is by prisoners themselves. Describing life in prison as being more desirable than life outside the prison, indeed in some instances, participants described life in prison as being better than life outside prison. For example "to be honest with you I am glad because it is a way of getting away from everything. I actually feel a lot better in here [prison]" (P1). Further, compounding this finding is the large number of participants who expressed a degree of satisfaction with the mental health care they received while in prison. This is evident in the extracts presented in

section (5.3.5.3) from phase one of the study. This finding is strengthened further in phase two which found that (n=102, 88%) of participants reported that they were receiving help for their mental health problems while in prison. However, this particular issue of satisfaction with prison health care provision may be considered in the context of, Gately *et al.* (2006) hypothesis. That is, that the structured prison regime allows prisoners' time to regain control over previously chaotic lifestyles. Therefore this may make prison appear better than it actually is. Also according to Durcan (2008) prison may 'acted as a stabiliser' for some prisoners (p. 31). For example one particular participant stated that "Well let's face it, there is a recession out there... at least I have no worries in that way in here." (P1).

7.5 Experiences of mental health services in prison

It has been well documented that many factors about prisons can have negative effects on prisoners' mental health. These include overcrowding, various forms of violence, enforced solitude or conversely, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about future prospects (work, relationships, etc), and inadequate health services, especially mental health services, in prisons (WHO 2001, p. 1). O'Neill (2006) describes prisons as 'toxic and inappropriate environments' (p. 87) in which to manage people with major mental illnesses. Furthermore the quality of mental health care provided in prisons has been criticized. The European Committee for the Prevention of Torture, Amnesty International Irish Section Report (2007) reiterated its serious concerns about how Ireland's criminal justice system provides for the needs of prisoners with mental health problems. Indeed, Knight and Stephens (2009) contend that the prison ethos conflicts with the principles of healthcare provision which emphasises self-determination underpinned by a philosophy of recovery. Durcan (2008) found that the prison itself is a risk factor for emotional distress as well as having a disproportionate population composed of people from disadvantaged backgrounds with a history of trauma, loss and low resilience to distress. A mere ten years ago Irish Penal Reform Trust (2001) report 'Out of sight, out of mind' highlighted the fact that 78% of mentally ill prisoners had been held in solitary confinement (p. 9). Coyle (2005) remarks that it is hardly surprising that the incidence of suicide and self-injury is so high among those

individuals who are possibly already emotionally highly charged, or even mentally disturbed upon entering a prison.

Considering these facts about the prison environment it is difficult to understand why so many participants in this study might be satisfied with prison mental healthcare. This finding was corroborated by the finding from phase two of the study which found that the vast majority of the participants (n=102, 88%) reported that they were receiving help for their mental health problems while in prison. However this finding must be considered in the context of the methodological design used to recruit participants for this study. Participants for this study were selected from the prison mental health in-reach clinics. Hence they have been identified by the prison system as needing help with mental health problems. There are many prisoners within the prison system, whose mental health problems are not recognised (DoH 2000). Several participants in phase one of this study suggested that they were getting a combined approach to address their mental health problems while in prison. They made it very clear that they found this quite approach beneficial. For example "Well it [prison] is good really, I am on tablets and I get to see a counsellor [psychologist] about my problems as well (P12). Also another participant refers to benefit of being able to talk about this problems "In here, I see a counsellor and go to meeting, this is the first time that I done that and I find it good... just to get things off your chest you know" (P6). The reason for this may be because many prisoners who are attending the in-reach service have been transferred to the Central Mental Hospital for assessment and treatment. The combined approach to treatment consisted of medication together with seeing a psychiatrist or nurse from the Central Mental Hospital or a psychologist from the prison service or attending GROW, Narcotics Anonymous, AA, Al-anon meetings.

An important consideration to make with regard to this finding is recent policy and practice developments which have occurred within the Irish Prison Service in relation to mental health care. Currently, health policy in Ireland aims to align and integrate prison health services and practices with those of the primary mental healthcare system. The Mental Health Commission (2011) asserts that mental healthcare must be a key component of the overall prison healthcare system. DoH&C (2006) recommends prison health services should be

“integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care. Efforts should be made to improve relationships and liaison between forensic mental health services and other specialist community mental health services. ” (A Vision for Change, Recommendation 15, 1.5, p. 140)

The MHC (2011) expands further by emphasising the need to develop a multi-agency approach to healthcare within the prison systems (MHC, 2011, p 21). IPS (2009) reports the objective of healthcare within prisons is based on the principle of providing care that is equivalent to that available in the community. This principle of equity of treatment is a moral issue (Brooker *et al.* 2009, p. 5). Morgan *et al.* (2007) noted that increasing numbers of mentally ill offenders in prisons should result in the need to employ a range of mental health professionals. According to Morgan *et al.* (2007) this did not occur. However it could be argued that many developments have occurred within the Irish criminal justice system to improve the mental healthcare of prisoners albeit not completely reaching its target. The IPS (2010) asserts that the provision of mental health services continues to improve in all Irish prisons (p. 30). In December 2010 a Vulnerable Persons Unit (VPU), which is a nine-bedded facility, opened in the Medical Unit in Mountjoy Prison. This unit provides expert, supportive, short-term care for prisoners who are in an acutely disturbed phase of a mental illness. The VPU provides a more controlled and supportive environment for a vulnerable prisoner as a short term intervention (IPS 2010, p .31). In March 1999, the first cadre of Nurse Officers was recruited to the Irish prison service (IPS 1999-2000, p. 14). Also the Central Mental Hospital Forensic Mental Health Service provides twenty consultant led in-reach sessions weekly by arrangement at all Dublin prisons and also at Portlaoise and the Midlands Prisons. Specialist in-reach services are in place for consultant-led mental health sessions in the remaining prisons (IPS, 2010, p. 30). The DoH&C (2006) recommended the introduction of court diversion schemes and that legislation should be introduced to allow this to take place. O’Neill (2006) defines diversion as the transfer of persons with mental illness from the criminal justice system to locations where they can receive appropriate treatment. However the Mental Health Commission (2011) remarks that there is no universally agreed definition or model of diversion. Since 2006 diversion has been taking place from Irish remand centres in the absence of specific legislation (O’Neill 2006,

p. 27). The success of this scheme has been spectacular to date with over 700 detailed assessments being carried out by the research team and in excess of one hundred people diverted to more appropriate mental health services (Irish Medical Times 2011).

A finding from this study indicates that participants considered that they were more likely to receive a more accurate diagnosis for their mental health problem only upon entering the prison system. Six participants in phase one of this study stated that an accurate diagnosis was made either within the prison system or while they were assessed in the Central Mental Hospital. Some examples of relevant comments on this issue are as follows; "So eh when I got into trouble with the police my solicitor got me assessed by a psychologist...so that's when I got diagnosed with bipolar." (P1), "they [mental illness] were only picked up this year while I in prison this time" (P3), "When I was in [prison] for the first time I was told that I had schizophrenia." (P10). This finding is consistent with a study by Rautanen & Lauerma (2011) which found that the majority of offenders were more likely to be accurately diagnosed while in the prison hospital rather than in the community. Furthermore Rautanen & Lauerma (2011) assert that subsequently the group in their study experienced a long delay in receiving a diagnosis when compared to the community comparison group.

Frazier (2011) wrote in a US newspaper about a man called James Verone who robbed one dollar from a bank so he could go to prison to receive the needed medical treatment. According to Frazier (2011) people who may be marginalised within society - the homeless, the addicted, and the mentally ill — have for years treated jails and prisons in much the same manner as northern snowbirds treat their Florida condos... a nice warm place to spend the winter (p. 1). Furthermore, the American psychiatrist Moffic (2010) claims that prisons are better in terms of easier access to mental healthcare as it is not dominated by health insurance. There is also a greater chance of mental health problems being recognised in prison due to the close observation of inmates. Gately *et al.* (2006), in an exploration of the prisoners' perceptions of the barriers and opportunities for managing long-term general medical conditions in a prison setting, found that in some cases, the structured prison regime helped to improved their health once in prison, as their previously chaotic lifestyles ceased. Blitz *et al.* (2006) posit that prisoners' ability to gain access to treatment is likely to be improved in prison, in part because individuals in

prison have a constitutional right to medical and mental health treatment and in part because financial, organizational, and transportation barriers in the community are considerably less challenging. Surprisingly, Brooker *et al.* (2009) note that the criminal justice system could be seen from a public health perspective as an opportunity for early mental health intervention. However, I would argue and it is the contention of this research that mental problems are better treated within mainstream mental health services. I consider prisons inappropriate environments for prisoners with mental health problems this view is consistent with many others contributing to this field of research (Irish Penal Reform Trust 2001, WHO 2001, Coyle 2005, O'Neill 2006, Corston 2007, WHO 2007, Durcan 2008, Bradley 2009, Knight & Stephens 2009).

7.6 Experiences of accessing mental healthcare following release from prison

The majority of the people interviewed in the qualitative part of this study had been to prison at least one before. IPRT (2010) points out that there is no statutory duty in relation to reintegration or a duty of statutory agencies to co-operate. This continues to have a negative impact on society's response to the needs of prisoners and ex-prisoners. This is most acutely felt in relation to provision of accommodation by local councils, and the provision of medical treatment, including addiction and mental health treatment, upon release (IPRT, p. 1). The DoH&C (2006) recommended that linkages should be established with the Probation Services. However little progress has been made and where a linkage is established it may only be on a local arrangement. A report by the National Economic and Social Forum (NESF) on Mental Health and Social Inclusion highlighted the shortcomings in services to meet the mental health needs of ex-prisoners (NESF 2007).

A key finding with regard to participants' re-entry back into the community was the lack of confidence in mental health services. For example, one participant claimed that "there should be proper links made for when you go out not just when you get out but it should be set up well before that you know like better planned and that. But they never materialise these should be ready well before you get out" (P10). Another participant referred to feeling that upon leaving prison that he will not be able to access services due to his criminal and psychiatric history "The services don't want to know you....once they

hear that you were in prison or the [forensic services]" (P5). Another participant described a very grim view of his future involvement with mental health services "I would like to have a say into how and what treatment I get and for that matter if I even need treatment I don't think that happens now nobody took on board my views yet so I don't think they will start now. You are at their mercy they [psychiatrists] have the power" (P15). The literature identified that ex-prisoners with mental health problems distrusted and had a lack of confidence in primary mental health professionals that discouraged them from seeking help (Howerton *et al.* 2007). They often found it difficult to establish a therapeutic alliance (Deane *et al.* 1999). Vitelli (1993) asserts that, due to the lack of available services in the community, prisoners, particularly homeless ones, may develop a dependence on the criminal justice system to gain access to healthcare. However Grant (2007) says that while in prison negative attitudes about mental disorders held by correctional staff, health professionals, and the culture among other inmates may deter people from seeking help. This may result in people being untreated and having a poorer prognosis.

The matter is compounded by the finding reported by participants of feeling afraid about how they may be treated by society and services once they leave prison. DoH&C (2006) note that negative perceptions of this group take the form of denying equity of medical care, equity of housing provision and of a range of other elements of 'citizenisation' enjoyed by the 'normal' community (p. 137). As discussed earlier stigma is a major barrier. In circumstances where there is previous involvement with the criminal justice system this may be even more problematic. Hartwell (2004) refers to the notion of triple stigma experienced by mentally disordered offenders in particular and their re-entry into the community after involvement with the criminal justice system. Subsequently according to Harwell (2004) being labelled as a mentally disordered offender further separates and stigmatises them from the community. Edwards (2000) describes how stigmatisation might affect ex-convicts in terms of finding a job and social acceptance after serving their sentence. Indeed as Campanelli *et al.* (2005) assert, stigmatisation of offenders with mental illness is a risk factor contributing to re-offending.

Participants in this study reported that they would like to be involved in their treatment into the future, needed to be able to talk about their problems and not just receive

medication. The majority of these participants expressed a wish for their treatment to be a combination of medication and talk therapy. For example “I would like to attend my GP when I get out of here [prison] and have regular checkups with the psychiatrist and to stay on my medication. I would like to have therapy as well for the drugs I want to stay off them” (P4). Another participant expresses that he shouldn’t be labelled by his past and if he is to manage his problems that he would need a mixed approach to his treatment “I do feel remorse and I do feel guilty, and what I done was very out of character for me I never did anything wrong before. To be honest I’m just not a criminal you know. So if I had the support of my family and the right people [professionals] I think I would be able to manage this illness.” (12). This finding is consistent with Howerton *et al.* (2007) who reported that offenders wanted their GP to listen to them, treat them with respect, provide appropriate information, and to treat them with compassion. Medical intervention can help but may often need to be combined with other treatment approaches. Tedstone Doherty *et al.* (2008) acknowledge the need for a more integrated approach for the treatment of mental health problems (p. 53). This study found that the majority of participants not only had mental health problems but also commonly abused drugs and alcohol and experienced a range of social problems. This finding is similar to other studies among prison populations (Duffy *et al.* 2003, Singleton *et al.* 1998). IPRT (2010) assert, with regard to prisoners experiencing multiple problems, that there is a lack of diagnostic services. Many of them are not supported in the prisons, and there are almost no services in the community to address their needs upon release (p. 42). Mezey (2007) suggests that strategies to enhance social inclusion for offenders are as important as medical interventions. Examples of such strategies are housing support, education, access to work, and specialist input from probation services and the voluntary sector. Another finding from this study concerned issues of continuity of care and the need for ongoing support to help participants cope with the many challenges involved. NESF (2007) recommended that additional resources should be available to treat mental ill-health in prison, to improve the availability of one-to-one support for ex-prisoners with mental ill-health, and to address the issue of long-term accommodation for people leaving prison.

7.7 Summary of Key Findings

This section re-emphasises some of most key findings from this study. The main themes emerging from this study are:

- social circumstances,
- barriers to accessing community mental health services,
- re-institutionalisation and experiences with mental health services while in prison,
- experiences of those who had been in prison upon re-entering the community.

This study identified several barriers reported by participants to accessing and maintaining links with mental health services prior to incarceration for this population. Among these are lack of recognition of mental illness by participants and health professionals, limited referral options, over-reliance on pharmacological interventions to manage mental health problems, stigma and lack of social support, and limited professional support. These factors in conjunction with particular individual circumstances are shown to be important predisposing factors to future involvement with the criminal justice system. Included within these factors are difficulties while in the educational system and being the subject of a barring or protection order.

The process of de-institutionalisation results in an increase in the number of mentally ill people in the criminal justice system (Penrose 1939, Brennan 2006, O'Neill 2007, WHO 2007). The findings from this study suggest that mentally disordered offenders are gradually becoming re-institutionalised within the Irish criminal justice system. Subsequently, the finding of this study support the WHO's prediction within the Trecín statement that prisons 'will' become twenty-first century asylums (WHO 2007, p. 5) when in reality they are the twenty-first century asylums.

Of the participants who had a previous conviction, re-entry into the community and subsequent re-engagement with mental health services and supports was often fraught with challenges. The process of re-integration was complicated by participants' lack of confidence in mental health services in the community as well as their feeling of being extremely stigmatised by society and health professionals. These experiences along with feelings of hopelessness and having no prospect for the future lead to a very grim expectation for the future by this sample. However, participants were unambiguous in

how they would like to be treated and how they would like their mental health problems managed. They wanted a combined approach in which they would be involved.

This research provides a better understanding of the experiences of this group and generates evidence that impacts on the quality, structure of services and resources for this population. Figure 7.1 below provides an overview of the key issues pertinent to factors influencing involvement with the CJS based on the findings of this study.



Figure 7.1 Key issues concerning the group

CHAPTER EIGHT - CONCLUSION

“I never want to end up in prison again I just need a chance I know I could do it with the right help all I need is that chance.” (P10)

8.1 Introduction & Contribution to Extant Knowledge

It is fitting that this thesis should conclude with a poignant statement by one of its participants. The above statement sums up the desperation and sense of hopelessness felt by many people who agreed to get involved in this study. This research set out on a quest to explore and provide a forum through which prisoners with mental health problems could tell their own stories about a very pertinent issue, that of, accessing and maintaining a link with mental health services prior to incarceration. The fact remains that the majority of the people with mental health problems within the Irish CJS had made contact with mental health services prior to being incarcerated (Linehan *et al.* 2005, O'Neill 2006, WHO 2007). This is particularly noteworthy because this study found that a substantial proportion of the participants had disengaged with mental health services prior to being imprisoned. Gater *et al.* (2005) point out that an understanding of people's experiences of help-seeking for mental health problems is imperative in order to plan appropriate mental health care. This research does provide a better understanding of this issue. It does this from a unique and essential perspective and therefore contributes substantially to the existing body of knowledge in this field. This research reveals many of the salient points on this issue, allowing for a profound understanding of participants' experiences in trying to access and maintain a link with mental health services prior to their incarceration in prison. This chapter offers suggestions for future practice development, improvements in policy, protocol and legislation, and essential future research and education pertinent to this field.

8.2 Implications for future research

There is limited Irish research on this topic particularly from a service user's perspective as identified in the literature review. Indeed, this is similar to many other European countries in this regard. Much of the existing research focuses on service utilisation and referral rates of people who are engaged with the health system or on prisoners' experiences of prison mental health services. However, future research on the issue of help-seeking behaviours needs to consider why people disengage with a health system. This study focused on prisoners' experiences with regard to the issue prior to incarceration. However, there are many other perspectives from which pathways to care need consideration, such as child adolescent and family mental health, social and cultural factors influencing access, co-morbidity, personality disorders, and delays in accessing mental health care, untreated illnesses and from an educational systems focus. Future research needs to explore experiences of accessing and maintaining links with mental healthcare within primary mental health care settings, experiences of mental health care post discharge from a psychiatric and experiences of mental health care post discharge from prison. A key component of future research on this issue needs to concentrate on the development of a reliable and valid measure of pathways to care.

With regard to prisoners' experiences on this issue, future research should be conducted collaboratively with European counterparts among prisoners with similar mental health problems. This present study found that barring or probation orders are regularly utilised to manage instances of domestic problems involving people with mental health problems. Future research needs to closely examine this issue in more depth. This should involve people who applied for a barring/probation order in such research.

8.3 Recommendations

8.3.1 Practice development

- Prisoners with mental health problems are often homeless following release from prison. This is considered a contributing factor in the cycle

of re-offending among this group. Therefore, various models of supported accommodation need to be available for this group for example, case/care management model.

- Findings of this study indicate people often present with needs which are multifaceted. For example, psychological, physical, emotional and social. Therefore, a clear emphasis on interdisciplinary and inter-agency best practice is to be recommended.
- A considerable number of participants in this study described a process of disengagement with mental health services prior to becoming involved with the CJS. Therefore, greater links between primary healthcare and mental health services need to be coordinated and systematically reviewed to ensure that people do not 'fall between the cracks'.
- Finding of this study is that there is instance of co-morbidity with drugs and alcohol. Therefore there is a need for a comprehensive evaluation of the scale of this problem initially. Services could then be established based on the outcome of this evaluation.
- This study suggests that women in Irish prisons are provided for differently to their male counterparts. Improved service options need to be made available for female prisoners with mental health problems. These options should be of an equal standard to those provided for their male counterparts.
- This study found that many participants found that professional services were not there, where and when they needed them. Hence, shortfalls in professional services in areas of psychology, social work, addiction need to be addressed.
- Participants in this study regularly referred to the difficulties experienced when re-entering the community following release from prison. Therefore, pre-release planning procedures need to be established. This could be facilitated by relevant services collaborating

to fund a case/mental health liaison worker to engage individuals with necessary services, supports and families in the lead up to and following their release from prison.

- Participants in this study were often the subject of a barring or protection order. This may lead to an individual experiencing many problems among these are, homelessness, unemployment, limited social supports, poverty or involvement in criminality. A more comprehensive assessment is required to determine the extent of this problem.

8.3.2 Improvements in policy, protocol and legislation

- An analysis of prisoners' mental health needs should be conducted in every prison to establish their mental health and service needs.
- The majority of these participants in this study described being involved in minor offences, and having a history of mental health problems, drug and alcohol problems and homelessness. These factors may place many of the participants of this study at risk for future involvement with the Criminal Justice System. Therefore, it is imperative to evaluate protocols and policies between primary healthcare systems and access to specialist services in order to identify strengths and weaknesses, particularly with regard to referral and discharge.
- This study found that the majority of participants had lower educational attainments and were often either suspended or expelled from school at an early age. Hence, early Intervention Services (EIS), currently provided by the Health Service Executive (HSE), need to be evaluated to determine their effectiveness.
- The only place to which prisoners with mental health problems can be transferred at present is to the National Forensic Mental Health Service. However, this service is a high-secure facility and not all prisoners with mental health problems require such a level of security. Changes in

legislation and policy need to acknowledge this anomaly in service provision.

8.3.3 *Research and education*

- The general practitioner (GP) is considered the first point of contact for people with mental health problems. Participants in this study regularly referred to their mental health problems not being recognised by their GP. Therefore, appropriate and accessible mental health training for GP's should be made available. Also this training should be made mandatory for this group.
- Stigma is a considerable issue of concern for this group, as identified within this study. This was experienced both at a societal and a professional level. Therefore, training on attitudes to mental illness needs to be provided at a community level as well as to relevant health professionals for example, mental health workers, GP's, Gardai, probation and prison staff.
- Prisoners with mental health problems are more likely to have an encounter with someone without training in health for their mental health problem while in prison. Therefore, in-service training courses should be provided to all prison staff at regular intervals during their employment. This training should be provided in association with the National Forensic Mental Health Service. Forging stronger inter-professional collaboration between agencies addressing the needs of prisoners with mental health problems would facilitate this.
- Participants in this study regularly described a lack of confidence in mental health care following release from prison. Therefore, it is necessary to provide training for health professionals involved in post-prison mental healthcare of this group to dispel myths regarding them.

8.4 Reflections on Ph.D.

This research set out to gain an understanding of the experiences of people with mental health problems within the Irish Criminal Justice System of accessing and maintaining links with mental health services prior to being imprisoned. The thesis commenced with a general introduction to some of the wider issues and fundamentals of this study. However, a central and I believe a critical component at the outset of this study was to situate myself, academically, professionally, and personally. I found this process challenging on many levels. I acknowledge that I am familiar with the proposed field of enquiry in terms of the environment, which I believe is a relevant factor to getting this type of research (prison) done. Notwithstanding this it became apparent as I broached this study the necessity for me to acknowledge my personal limitations and possible preconceived notions with regard to the research problem and to conducting prison research. Some examples of these are on a personal level, did I truly understand prison culture from the perspective of the prisoner or even that of the prison authorities? Or because of my professional background could I be considered as being in a position of power by the people participating in the research? Or on a practical level accessing study sites to conduct this research was not in my control. By raising such questions an opportunity was created to explore and acknowledge, if left unaddressed the possible impact these issues could have on the outcome of this research. Thus exploring these issues proved to be a worthwhile process in the development of my academic, professional, and personal attributes required to conduct this research. For instance I became acutely aware at an early stage in the research process that I needed to be pragmatic in my methodological approach to this form of enquiry. Also I needed to acknowledge the usefulness strategically, of my professional position and those of my supervisors when gaining access to study sites. Nevertheless it was imperative to address the possible power implications of this very fact. This particular issue was managed by devoting meticulous attention to ethical matters pertinent to this form of enquiry. These

challenges were embraced and eventually overcome by acknowledging my personal limitations in understanding the experiences of potential participants on this issue from their perspective. Possibly the most challenging aspect of this study was the process of gaining access to an untypical research environment (Irish Prison System) and its population. This was particularly due to the fact that I was entering the prison system as an outsider. Nevertheless, in order to conduct this particular study it was necessary to gain access to prisons throughout Ireland. This was fundamental to the aims and objectives of this research. There were many factors which aided the process of gaining access to prisons and its population to conduct this study, among these are: previous experience and knowledge of the researcher, credentials of research supervisors, achieving ethical approval from Trinity College, Dublin and the Prisoner Based Research Ethics Committee (PBREC), Strategic planning – establishing links with key prison personnel and finally and most importantly, respect. Therefore gaining an understanding of the prison environment and those in it was paramount. This required a comprehensive review of the literature pertinent to this matter. This provided an opportunity to not only understand environmental issues but also to consider prison from a human rights and a legal perspective. This situated the unique and untypical environment and population in which this research was conducted. This process was guided by the seminal works of Foucault, Goffman, Penrose, and Barton.

In spite of the many challenges outlined and referred to within this thesis with regard to conducting prison research. I believe that it was essential to include the people who actually experienced the problem in order for them to tell their story from their perspective. Two particular factors influenced this decision. Firstly, to provide new knowledge on an issue for which there is currently limited information available, specifically from the perspective of those who actually experienced the problem. Secondly, in order to address some of the methodological limitations of earlier studies on pathways to mental health care. These factors influenced the exploration of issues relevant to this study from a sociological theoretical perspective. This perspective provided a more complete

understanding of the issue under investigation. Most importantly it considered the cultural and environmental context in which mental illness is experienced. This part of the enquiry was largely influenced by theorists such as Goldberg & Huxley, Goffman, Pescosolido, and Dewey.

This research required a thorough examination of the differing and changing worldviews which form the foundations of research. This exhaustive examination provided a forum through which I could acquire a deep understanding of the dominant worldviews of positivism and post positivism, constructivism and interpretivism, transformativism and pragmatism which exist within contemporary research practice. A critical learning curve for me in this research project was with regard to locating this study within the transformative or pragmatic philosophical worldview. This issue was influenced by my understanding of issues regarding the target population for this study. The review of the literature revealed that mentally ill people within the criminal justice system are an extremely marginalised and discriminated group (Brett 2003). The very places (prisons) in which they are located signifies a power imbalance (Crewe 2007), human rights violations (Knight and Stephens 2009) and are widely associated with depravity and inhuman standards of care (Coyle 1997, O'Neill 2006, WHO 2001, 2006, 2008, 2011). These factors suggested to me that this research should have a social justice agenda. The situation created a quandary for me as a researcher. Personally as this dilemma was unfolding I felt overwhelmed and confused. This was such an important issue for me that it prompted me to seek advice from two key proponents of transformative and pragmatic paradigms, Professor Donna Mertens and Professor John Creswell respectively. Following this I managed to appropriately locate this study within a pragmatic philosophical foundation. There were two reasons for this decision. Firstly, I needed to stay focused on the actual research question for this study. Secondly, I needed to acknowledge that this study may not bring about direct change for participants. This is the central principle of the transformative paradigm. As a researcher I learnt a considerable amount in terms of the importance of forming the most appropriate philosophical base for a research

study. The writings of philosophical pragmatists such as Pierce, James, Dewey, Mead, Bentley and Rorty enormously influenced this work. This study utilised a pragmatic exploratory sequential mixed methods approach. This approach allowed me as a researcher to take cognisance of two very important factors with regard to this research. Firstly, on a philosophical level it provided a realist foundation for this research. It provided an opportunity to consider human life as a form of evolution for example being subject to change or how it may be influenced by environmental factors. It allowed me to be more open minded epistemologically. Finally, and particularly relevant to the focus this research it emphasised the social component of human life. This particular aspect is influenced by the writings of Dewey on social and community values and people being part of a democracy. Secondly, on a practical level the mixed methods approach provided an opportunity to address some of the many environmental constraints of conducting research within a prison. The research approach utilised for this study ensured that a larger sample could be recruited. Therefore, the findings are more useful and generalisable to the overall population. It must be emphasised that this is particularly relevant when conducting research within a prison environment due to the many constraints encountered. There are several challenges to using a mixed methods approach in research. Among these is researchers' ability to use different approaches effectively, managing large amounts of data and interpreting two sets of data within a single study. In mixed methods research the issue of integration is fundamental. This research is effectively integrated at three points within the study. One of the criticisms of mixed methods studies is that they can if not adequately integrated appear like two separate studies within the one project (Hanson *et al.* 2005; Bryman 2007; Creswell and Plano-Clark 2007). Therefore in order to address this particular issue a concerted effort was made to integrate both sets of findings within the discussion chapter of this thesis. In my view this process demonstrated the strengths of the mixed methods approach utilised to conduct this research.

On a professional level conducting this doctoral study provided me with the necessary skills to advance my research activity in this area. This provided the prospect of considering either singular or mixed methodologies for future research. It is my intention to make these skills available to others. This can be facilitated by providing expertise and support to fellow researchers, to professional colleagues from both a nursing and an interdisciplinary perspective and to related voluntary agencies such as homeless services. This will lead to a greater contribution to the extant body of knowledge in this field.

This study illustrates the importance and clearly places the issue of pathways to mental health care for this population within a sociological perspective. The major findings from this study are: social circumstances, barriers to accessing community mental health services, re-institutionalisation and experiences with mental health services while in prison, experiences of those who had been in prison upon re-entering the community.

Personally, while conducting this study I experienced emotional responses which I often found to be extremely upsetting. One would imagine that I shouldn't have been so shocked by these stories considering my past experience of working in a forensic mental health setting. On reflection I believe that I had become desensitised to the very real issues for these people. On a personal level I consider this to be a very important lesson to have learnt. The experiences and views described by participants in this study were often harrowing and brutally honest, particularly in regard to feeling let-down by services and by society in general. Examples of some of these experiences and views were traumatic life events, people not believing that they were part of society, feeling worthless and feelings of hopelessness about their future. I felt privileged that this group of people shared their very personal life stories with me. Therefore, it is my responsibility, I believe, that the experiences and views presented by participants on this issue are disseminated to key services and stakeholders among whom are service users (prisoners) and the service user advocacy networks, mental health professionals, prison authorities, professional bodies from both the voluntary and public sectors, relevant Irish

Government bodies and agencies such as the Department of Health & Children, the Department of Justice and Law Reform, the Association for Criminal Justice Research and Development (ACJRD) and the Irish Penal Reform Trust (IPRT).

On a final note I consider education as a lifelong process. Such a process provides the knowledge and skills necessary to inform best professional practice and ultimately to the changing needs of our society. Dewey emphasised the active nature of learning involving two parts. The first consists of the experience itself, and the second involves the thought and consideration of what this experience meant. He stated that

“...we do not learn by doing...we learn by doing and realising what came out of what we did”.

(John Dewey 1933)

This shall remain my philosophy for my professional and personal development going into the future.

REFERENCES

- Abowitz D. A. & Toole M. T. (2010) Mixed methods research: fundamental issues of design, validity, and reliability in construction. *Research Journal of Construction Engineering and Management* Volume **136**; (1), 108-127.
- Abram K. M. & Teplin L. A. (1991) Co-occurring Disorders among Mentally 111 Jail Detainees. *American Psychologist* **46**, pp 1036-1045.
- Aday L.A. & Andersen R. (1974) A framework for the study of access to medical care. *Health Services Research* **9**, pp 208-220.
- Aderibigbe Y. (1996) Deinstitutionalisation and Criminalization: tinkering in the interstices. *Forensic Science International* **85**, 127-134.
- Allwright S., Bradley F., Long J., Barry J., Thornton L. & Parry J. V. (2000) Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross-sectional survey. *British Medical Journal* **321**, 78-82.
- An Bord Altranais (2000) *The Code of Professional Conduct for each Nurse and Midwife*. Dublin Stationery Office.
- Andersen R. M. (1995) Revisiting the Behavioral Model and Access to Medical Care: Does it Matter. *Journal of Health and Social Behavior* **36**, pp. 1-10.
- Anderson O.W. (1963) The Utilization of Health Services. In *handbook of Medical Sociology* (Freeman H.S., Levine S. & Reeder G.L.) Prentice Hall Englewood Cliffs New Jersey.
- Andrew S. & Halcomb E. J. (2006) Mixed methods research is an effective method of enquiry for community health research. *Advances in Contemporary Nurse* **23**(2), 145-153.
- Aneshensel C. S. & Phelan J, C. (1999) *Handbook of the Sociology of Mental Health*. Kluwer Academic, Plenum Publishers, New York.
- Appleton J.V. (1995) "Analyzing Qualitative Data: Addressing issues of validity and reliability". *Journal of Advanced Nursing* **22**, 993-997.
- Arsenault L., Caspi A., Moffitt T. E. (2000) Mental disorders and violence in a total birth cohort. *Archives of General Psychiatry* **57**, 979-986.

- Atkinson J. (2007) 'Protecting or empowering the vulnerable: Mental illness, communication and the research process'. *Research Ethics Review* **3**(4), 134–138
- Auerbach E.S. & Richardson P. (2005) The long-term work experiences of people with severe and persistent mental illness. *Psychiatric Rehabilitation Journal* **28** (3), 267-273.
- Barkley C. (2000) Treatment resistance. In *Forensic Mental Health Care: A Case Study Approach*. (Mercer D., Mason T., McKeown M. & McCann G., eds.), Edinburgh: Churchill Livingstone.
- Barton W. R. (1959/1976) *Institutional Neurosis*, Bristol: Wright & Sons.
- Bazeley P. (2002) Issues in Mixing Qualitative and Quantitative Approaches to Research. In *Applying qualitative methods to marketing management research* (eds). Buber R., Gadner J. and Richards L. (2004) Palgrave Macmillan, UK, pp141-156.
- Beauchamp T. L. & Childress J. F. (1989) *Principles of Biomedical Ethics*, 3rd edn. Oxford University Press, Oxford.
- Bebbington P. E., Meltzer H., Brugha T. S., Farrell M., Jenkins R. & Ceresa C and Lewis G. (2000) Unequal access and unmet need: neurotic disorders and use of primary care services. *Psychological Medicine* **30**, 1359 –1367
- Beckett J. C. (1966) *The Making Of Modern Ireland 1603-1923*. London: Faber.
- Belcher J. (1988) Are jails replacing the mental health system for the homeless mentally ill? *Community Mental Health Journal* Volume **24** (3) 185-195.
- Beresford P. (2005) Where would we be without the pharmaceutical industry? – A service user's view. *Psychiatric Bulletin* **29**, 86-87
- Berg B. (2004) *Qualitative research for the social sciences* (5th ed.). Boston: Pearson Education, Inc.
- Bhugra D. (1996) *Homelessness and Mental Illness*. Cambridge University Press.
- Bhugra D., Harding C. & Lippett R (2004) Pathways into care and satisfaction with primary care for black patients in South London. *Journal of Mental Health Nursing* **13**(2), pp 171-183.
- Biddle L., Gunnell D., Sharp, D. & Donovan J.L. (2004) Factors influencing help seeking in mentally distressed adults: a cross-sectional survey. *British Journal of General Practice*, **54**, 248 –253

- Biles D. & Mulligan G. (1973) Mad or bad? The enduring dilemma. *British Journal of Criminology*, **13**, 275-279.
- Bilton T., Bonnet K., Jones P., Skinner D., Stanworth M. & Webster A., (1996) *Introductory Sociology 3rd edn*. Macmillan: London.
- Birmingham L, (2003) The mental health of prisoners. *Advances in Psychiatric Treatment* **9**, pp 191–199
- Birmingham L. (2004) Mental disorders and prisons. *Psychiatric Bulletin* **28**, 393-397.
- Birnbaum, M & Sharif Z. (2008) Medication adherence in schizophrenia: patient perspectives and the clinical utility of paliperidone ER. *Patient Preference and Adherence* **2**, 233–240.
- Black D., James M., Evans, R. & Rogers, P. (2007). The association between a self reported history of mental health problems and a history of parasuicide in a sample of UK male prisoners. *International Journal of Nursing Studies* **44**, p 427-434.
- Blackburn R. (2001) *The Psychology of Criminal Conduct: Theory, Research & Practice*. Wiley and Sons Blackwell Publishing Ltd.
- Blakely E. J. (1992) Characteristics of homeless jail inmates: implications for social work. *Journal of Social Distress and the Homeless* **1**, 145–155.
- Blitz C.L., Wolff, N. & Paap, K. (2006) Availability of behavioral health treatment for women in prison. *Psychiatric Services* **57**(3), 356–360.
- Boardman J., Currie A., Killaspy H., & Mezey G. (2010) *Social Inclusion and Mental Health*. London: Royal College of Psychiatrists Publications.
- Bogdan R.C. & Biklin S.K. (1998) *Qualitative research for education: An introduction to theory and methods*. (3rd ed.) Boston: Allyn and Bacon.
- Bonin J. P., Fournier L. & Blais R. (2007) Predictors of mental health service utilization by people using resources for homeless people in Canada. *Psychiatric Services*, **58**, 936-941
- Bookle M. & Webber M. (2011) Ethnicity and access to an inner city home treatment service: a case–control study. *Health & Social Care in the Community*, **11**(3), 280-288.
- Boote D. N. & Beile P. (2005) Scholars before researchers: On the centrality of the dissertation literature review in research preparation. *Educational Researcher* **34** (6), 3-15.

- Bosworth M., Campbell D., Demby B., Ferranti S. & Santos M. (2005) Doing prison research: views from inside. *Qualitative Inquiry* volume **2**, 249-264
- Bowen R. A., Rogers A., Shaw J. (2009) Medication management and practices in prison for people with mental health problems: a qualitative study. *International Journal Mental Health Systems*, **3**(1), 24.
- Boydell K., Pong R., Volpe T., Tilleczek K., Wilson E. & Lemieux S. (2006) Family perspectives on pathways to mental health care for children and youth in rural communities. *Journal of Rural Health*, Volume **21** (2), 182-188
- Bradley E. H., Curry L. A., & Devers, K. J. (2007) Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research*, **42**(4), 1758-1772.
- Brennan D. (2006) *A Sociology of Institutionalisation of the 'Mentally Ill' in Ireland*. Unpublished PhD Theses. Trinity College, Dublin
- Brennan P. A., Grekin E. R. & Vanman E. J. (2000) Major mental disorders and crime in the community. In *Violence among the Mentally Ill*. (Hodgins S., ed), Dordrecht: Kluwer Academic Publishers.
- Brett A. (2003) Psychiatry, Stigma and Courts. *Psychiatry Psychology and Law* **10**(2), 283-288.
- Brett Davies M. (2007) *Doing a Successful Research Project*. Palgrave Macmillan.
- Bringer J.D., Johnston L.H. & Brackenridge C.H. (2004) Maximising transparency in a doctoral thesis: The complexities of writing about the use of QSR*NVIVO within a grounded theory study. *Qualitative Research* **4**(2) pp 247-265.
- Bronniti S. & McSherry B. (2001) *Principles of Criminal Law*. Sydney: Law Book Company.
- Brooker C., Ullmann B. & Lockhart G. (2009) Inside Out: solutions for mental health criminal justice system. Retrieved from www.policyexchange.org.uk on December 2010.
- Brunet K., Birchwood M., Lester H. & Thornhill K. (2007) Delays in mental health services and duration of untreated psychosis. *Psychiatric Bulletin*, **31**, 408 – 410.
- Bryman A (2008) *Social Research Methods (3rd ed)*. Oxford: Oxford University Press.
- Bryman A. (1984) The debate about quantitative and qualitative research: A question of method or epistemology? *British Journal of Sociology*, **35**, 78–92.

- Bryman A. (2004) *Quantity and Quality in Social Research*, 2nd edn. London: Routledge.
- Bryman A. (2006) Integrating quantitative and qualitative research: how is it done? *Qualitative Research* **6**(1), 79-113.
- Bryman A. (2007) Barriers to integrating quantitative and qualitative research. *Journal of Mixed Methods Research*, **1**(1), 8-22.
- Bulbulbia J. (2005) Mental Health Act 2001. [The Bar Council, Bar Review](http://www.lawlibrary.ie/documents/publications/Feb05.pdf). Retrieved from www.lawlibrary.ie/documents/publications/Feb05.pdf on January 2008, pp 8-12.
- Burke-Johnson R. & Onwuegbuzie A. J. (2004) *Mixed methods research: a research paradigm whose time has come*. *Educational Researcher* **33**, 14-26
- Burns N & Grove S. K. (1997) *The Practice of Nursing Research: Conduct, Critique and Utilization* 2nd edn. W.B Saunders & Co, Philadelphia.
- Burns N. and Grove S.K. (2005) *The Practice of Nursing Research: Conduct, Critique and Utilisation* (5th edn). Elsevier Saunders, St.Louis.
- Byrne P. (2000) Stigma of mental illness and ways of diminishing it. *Advances in psychiatric Treatment* **6**, 65-72
- Cameron R (2009) 'A sequential mixed model research design: design, analytical and display issues'. *International Journal of Multiple Research Approaches* **3**(2), 140-152.
- Campanelli P.C., Cleek E.N., Gold P.B., Lieberman H.J., Nakagawa A. & Skoraszewski M. (2005) Screening offenders with histories of mental illness and violence for supportive housing. *Journal of Psychiatric Practice* **11**, 279–288.
- Canadian Mental Health Association (1963) *More for the Mind "A Study of Psychiatric Services in Canada"*. Toronto: Canada.
- Capra F. (1986) The Concept of Paradigm and Paradigm Shift. *Re-Vision* **9**(1), pp 3.
- Caracelli V. J. & Green C. (1997) Crafting Mixed-Method Evaluation Designs: The Challenges and Benefits of Integrating Diverse Paradigms. In *Advances in Mixed Method Evaluation Designs*. (Green J. C. & Caracelli V. J., eds), Jossey-Bass, San Francisco, pp. 19-32.
- Caracelli V. J. & Greene J. C. (1993). Data analysis strategies for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis* **15**, 195–207.

- Castel F., Castel R & Lovell A. (1979) *La Société Psychiatrique Avancée: Le Modèle Américain*. Paris: Bernard Grasset.
- Cherryholmes C.H. (1992) Notes on pragmatism and scientific realism. *Educational Researcher* **14**, pp 13-17.
- Chew-Graham C. A., Mullin S., May C., Hedley S., & Cole H (2002) Managing depression in primary care: another example of the inverse care law? *Family Practice* **19**, 632 -637.
- Clarke J. B. (1991) A View of the Phenomenon of Caring in Nursing Unpublished BSc study, Bournemouth. In *Qualitative Research for Nurses*. (Holloway I. & Wheeler S. eds) Blackwell Science Ltd.
- Clemmer D. (1940) *The Prison Community*. New York: Holt, Rinehart & Winston.
- Coffey M. (2006) Researching service user views of forensic mental health services: a literature review. *Journal of Forensic Psychiatry and Psychology* **17**(1), pp 73-107
- Cohen E. F. & Morley C. P. (2009) Children, ADHD and citizenship. *Journal Medicine and Philosophy* **34**(2), 155-180
- Cohen L., Manion L., & Morrison K. (2000) *Research Methods in Education*, 5th ed. London: Routledge Falmer
- Coid J, Maden T. (2003) Should psychiatrists protect the public? *British Medical Journal*; **326**(7386):406–407.
- Colaizzi P. (1978) Psychological Research as the Phenomenologist views it. In *Existential Phenomenological Alternatives for Psychology*. (Valle R & King M. eds), Oxford University Press, New York, pp. 48-71.
- Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), par. 1. *Community Mental Health Journal* **24** (3), 185-195.
- Conrad P. (1992) Medicalisation and social control. *Annual Review of Sociology* **18**, 209-232.
- Conrad P. (2007) *The Medicalisation of Society: On the Transformation of Human Conditions into Treatable Disorders*. John Hopkins Press: New York.
- Constantine R., Andel R., Petrila J., Becker M., Robst J., Teague G., Boaz T., Howe A. (2010) Characteristics and experiences of adults with a serious mental illness who were involved in the criminal justice system. *Psychiatric Services* **61**, 451-457

- Coptly M. & Whitford D. L. (2005) Mental health in general practice: assessment of current state and future need. *Irish Journal of Psychological Medicine* **22**(3): 83–86.
- Corbin J. & Strauss A. (2008) *Basics of qualitative research*. Thousand Oaks, CA: Sage.
- Corrigan P. W. & Calabrese J. D. (2005) Strategies for assessing and diminishing self-stigma. In *On the stigma of mental illness. Practical strategies for research and social change*. (Corrigan P. W. ed.), Washington, DC: American Psychological Association, pp. 239–256
- Corrigan P. W. (2004) Target-specific stigma change: a strategy for impacting mental illness stigma. *Journal of Psychiatric Rehabilitation* **28**, 113–121
- Corrigan P. W. (2005) *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*. Washington, DC: American Psychological Association.
- Corrigan P., Larson L., & Rusch N. (2009) Self-stigma and the "why try" effect: Impact on life goals and evidenced-based practices. *World Psychiatry* **8**(2), 75-81
- Corston J. (2007) *The Corston Report: a review of women with particular vulnerabilities in the criminal justice system*. Home Office, UK, London.
- Coton X., Poly S., Hoyois P., Sophal C. & Vincent, D. (2008) The healthcare-seeking behaviour of schizophrenic patients in Cambodia. *International Journal of Social Psychiatry*, **54**(4), 328–337.
- Cousins K. & McIntosh W. (2005) More than typewriters, more than adding machines: Integrating information technology into political research. *Quality & Quantity* **39**(5), pp 81-614.
- Coyle A. (1997), The International Context. *Criminal Justice Matters*, **30**, p32-34.
- Coyle A. (2005) *Understanding Prisons: Key Issues in Policy and Practice*. Maidenhead: Open University Press.
- Crabtree B. F. & Miller L (1999) *Doing Qualitative Research*. Sage Publications, CA.
- Cratsley K., Regan J., McAllister V., Simic M. & Aitchison K. J. (2008) Duration of untreated psychosis, referral route, and age of onset in an early intervention in psychosis service and a local CAMHS. *Child and Adolescent Mental Health* **13**, 130–133.
- Creswell J. & Plano-Clark V. (2007) *Designing and Conducting Mixed Methods Research*. Thousand Oaks: Sage publications, California.

- Creswell J. W. & Plano-Clark V. L. (2011) *Designing And Conducting Mixed Methods Research*. Thousand Oaks: Sage publications, California.
- Creswell, J, W & Plano Clark, V. L. (2006) *Designing and Conducting Mixed Methods Research*. Thousand Oaks: Sage publications, California.
- Creswell, J. W., Plano-Clark V. L., Guttman M. & Hanson W. (2003) Advanced mixed methods research designs. In *Handbook on Mixed Methods in the Behavioral and Social Sciences*. (Tashakkori A, & Teddlie C. eds), Thousand Oaks, California: Sage Publications; pp. 209–240.
- Crewe B. (2007) The Sociology of Imprisonment. In *Handbook on Prisons*, (Jewkes Y. ed), Cullompton, Willan Publishing, pp. 123-151.
- Crotty M. (1998) *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London. Thousand Oaks, New Delhi: Sage Publications Ltd.
- Crowley F. (2003) *Mental Illness: The Neglected Quarter*. Dublin: Amnesty International.
- Curry L. A., Nembhard I. M. & Bradley E. H. (2009) Key issues in outcomes research: qualitative and mixed methods provide unique contributions to outcomes. *Research Circulation* **119**, 1442-1452.
- Curtin K, Monks S., Wright B., Duffy D., Linehan S. & Kennedy H. G. (2009) Psychiatric morbidity in 615 male remanded and sentenced committals to Irish Prisons. *Irish Journal of Psychological Medicine* **26**, p169 – 173.
- Curtis T., Dellar D., Leslie E. & Watson B. (2000) *Mad Pride: A Celebration of Mad Culture*. Spare Change Books: London.
- Cusack M., Gavin J. & Kavanagh D. (2003) Dancing with Discrimination: Managing stigma and identity. *Culture and Organisation* Volume **9**(4) pp. 295 – 310
- Daly A., Walsh D., Moran R. & Kartalova O'Doherty Y. (2004) *Activities of Irish Psychiatric Services 2003*. Health Research Board: Dublin.
- Deane M., Steadman H., Deane M., Borum R., Veysey B., & Morrissey J. (1999) Emerging partnerships between mental health and law enforcement. *Psychiatric Services* **50**, pp 99-101.
- Declaration of Helsinki. World Medical Association. Retrieved at; www.wma.net/e/ethicsunit/helsinki.htm on the 1st March 2007.

Demyttenaere K Bruffaerts R, Posada V J. *et al.* (2004) Prevalence, severity, and unmet need for treatment of mental disorders. World Health Organisation Consortium, World Mental Health Surveys. *Journal of the American Medical Association*, **291**(21), 2581–2590.

Denzin N. K. & Lincoln Y. S. (1998) Entering the Field of Qualitative Research. In *Collecting and Interpreting Qualitative Materials*. (Denzin N. K. & Lincoln Y. S. eds) London: Sage.

Denzin N. K. (1970) *The research act: A theoretical introduction to sociological methods*. Chicago: Aldine.

Department of Environment, Community and Local Government (2011) *Housing Policy Statement*. Stationary Office, Dublin.

Department of Health & Children (2001) *Primary Care: A New Direction*. Stationary Office, Dublin

Department of Health & Children (2001) *Quality and Fairness – A Health System for You*. Dublin. Stationary Office, Dublin

Department of Health & Children (2006) ‘A Vision for Change’ *Report of the Expert Group on Mental Health Policy*. Stationery Office, Dublin.

Department of Health & Children (2006). *A Vision for Change: Report on the Expert Group on Mental Health Policy*. Stationary Office, Dublin

Department of Health & Home Office (1992) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services: Final Summary Report (Reed report)*. Cm 2088. London: HMSO.

Department of Health (1966) *The Tuarascail Report of the Commission of Inquiry on Mental Illness*. Dublin: The Stationary Office.

Department of Health (1984) *The Psychiatric Services-Planning For the Future*. Stationary Office, Dublin

Department of Health (2000) *The NHS Plan: a Plan for Investment, a Plan for Reform*. London: HMSO.

Department of Health (2001) *Changing the Outlook. A Strategy for developing and modernising mental health services in Prisons*, London.

Department of Health (2002) Commission of McClelland, Glenda Mock. *Irish Journal of Psychological Medicine* **19**(1), 21-26.

- Derrida J. (1976) *Of Grammatology*. Baltimore: Johns Hopkins University Press.
- Dewey J. (1920) *Reconstruction in Philosophy*. Cosimo Classics Publications, New York.
- Dickson-Swift V, James EL, Kippen S and Liamputtong P (2007): *Doing sensitive research: what challenges do qualitative researchers face? Qualitative Research*. Los Angeles: Sage Publications. Vol. 7(3) 327–353.
- Diefenbach D. & West M (2007) Television and attitudes toward mental health issues: Cultivation analysis and the third-person effect. *Journal of Community Psychology* 35(2), 181-195.
- Doyle L., Brady A-M., Byrne G. (2009) An overview of mixed methods research. *Journal of Research in Nursing*, 14(2), p175 – 185.
- Dressing H. & Salize H. J. (2009) Pathways to psychiatric care in European prison systems. *Behavioral Sciences & the Law* 27, 801–810.
- Duffy D., Linehan S. & Kennedy H (2003) Screening prisoners for mental disorders. *Psychiatric Bulletin*, 27, p241 – 242.
- Durcan G. (2008) *From the inside: experiences of prison mental health care*. London: Sainsbury Centre for Mental Health.
- Edwards K.A. (2000) Stigmatizing the stigmatized: a note on the mentally ill prison inmate. *International Journal of Offender Therapy and Comparative Criminology* 44(4), 480-489.
- Edwards, K. A. (1985) *Mental illness in prison: A study of inmates transferred to a mental hospital*. Unpublished manuscript. Oklahoma State Penitentiary. McAlester: Oklahoma.
- Elpers J. R. (1987) Are we legislating re-institutionalisation. *American Journal of Orthopsychiatry* 57, 441-446.
- Eriksson P. & Kovalainen A. (2008) *Qualitative Methods in Business Research*. Thousand Oaks, California: Sage.
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (2007). *Report to the Government of Ireland on the Visit to Ireland Carried out from 2nd to 10th October 2006*, Strasbourg: Council of Europe, Inf 40 [EN], par. 111–13.

- Eynan R, Langley J, Tolomiczenko G, et al: (2002) The association between homelessness and suicidal ideation and behaviours: results of a cross-sectional survey. *Suicide and Life-Threatening Behaviour* **32**, 418–427,
- Farrell M., Boys A., Singleton N., Meltzer H., Brugha T., Bebbington P., Jenkins R., Coid J., Lewis G. & Marsden J. (2006) Predictors of mental health service utilization in the 12 months before imprisonment: analysis of results from a national prisons' survey. *Australian and New Zealand Journal of Psychiatry* **40**(6–7), 548–553.
- Farrington D. (2008) The psychosocial milieu of the offender. In *Forensic Psychiatry: Clinical, Legal and Ethical Issues* (Gunn J. & Taylor P. eds), Butterworth Heinemann, pp. 252-285.
- Fazel S. & Danesh J. (2002) Serious mental disorder among 23,000 prisoners: a systematic review of 62 surveys. *Lancet* **359**, 545–550.
- Finnane M. (1981) *Insanity and the insane in post-famine Ireland*. London: Groom Helm.
- Fischer P. J. (1988) Criminal activity among the homeless: a study of arrests in Baltimore. *Hospital and Community Psychiatry* **39**, 46–51.
- Fischer P. J. (1992) The criminalization of homelessness. In *Homelessness: A National Perspective*. (Robertson M. J. & Greenbatt M. eds), New York, Plenum.
- Fossey E, Harvey C, McDermott F, Davidson L (2000) Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry* **36**(6), pp 717-732.
- Foucault M. (1967) *Madness and Civilization: A history of insanity in the age of reason*. London: Tavistock.
- Foucault M. (1972) *The Archeology of Knowledge*. London: Tavistock.
- Foucault M. (1973) *The Birth of the Clinic*. London: Tavistock.
- Foucault M. (1977) *Discipline and Punish: The Birth of the Prison*. London, Allen Lane.
- Foucault M. (1980) *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (ed. C. Gordon). Brighton: Harvester.
- Foucault M. (1985) *The History of Sexuality: Volume 2, The Use of Pleasure*. New York, Pantheon.
- Frazier M. (2011) The Prison's Cheap Health-Care Secret. *Daily Beast*. 23rd June, 2011

- Freidson E. (1970) *Profession of Medicine*. New York: Dodd, Mead.
- Friedli L. & Parsonage M. (2007) *Mental Health Promotion: Building an economic case*. Belfast: Northern Ireland Association for Mental Health.
- Funder M. (2005) Bias, Intimacy and Power in Qualitative Fieldwork Strategies. *Journal of Transdisciplinary environmental Studies* **4**(1).
- Furstenberg A. & Davis L. J. (1984) Lay consultation of older people. *Social Science and Medicine* **18**, 827-837.
- Gadd D. & Farrall S. (2004) Criminal careers, desistance and subjectivity: Interpreting mens narratives of change. *Theoretical Criminology* **8**, 123-56.
- Gately C., Bowen A., Kennedy A., MacDonald W. & Rogers A. (2006) Prisoner perspectives on managing long term conditions: a qualitative study. *International Journal of Prisoner Health* **2**(2), 91-99.
- Gater R, Goldberg D. (1991) Pathways to psychiatric care in South Manchester. *British Journal of Psychiatry* **159**, 90-96
- Gater R., de Almeida e Sousa., Barrientos G., Caraveo J., Chandrashekar C.R., Dhadphale M., et al (1991) The pathways to psychiatric care: a cross-cultural study. *Psychological Medicine* **21**, 761 -774
- Gater R., Jordanova V., Maric N., Alikaj V., Bajcs M., Cavic T., Dimitrov H., Iosub D., Mihai A., Szalontay A. S., Helmchen H. & Sartorius N. (2005) Pathways to psychiatric care in Eastern Europe. *British Journal of Psychiatry* **186**, 529-535
- Gelberg L., Linn L. S. & Leake B. D. (1988) Mental health, alcohol and drug use, and criminal history among homeless adults. *Hospital and Community Psychiatry* **145**, 191-6.
- Genders E. & Player E. (1995) *Grendon: a Study of a Therapeutic Prison*. Oxford: Oxford University Press.
- Gillis C. A. (2000) 'Offender Employment Programming'. In *Compendium on Effective Correctional Programming*. (Motiuk L. & Serin R. C. eds), Volume 1, Ottawa: Correctional Services of Canada, pp. 64-74.
- Goffman E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Harmondsworth: Penguin

- Goffman E. (1963) *Stigma: Notes on the management of a spoiled identity*. United Kingdom: Prentice-Hall.
- Golberstein E., Eisenberg D. & Gollust S. E. (2008) Perceived stigma and mental health care seeking. *Psychiatric Services* **59**, 392–399.
- Goldberg D. & Huxley P. (1980) *Mental Illness in the Community: The Pathway to Psychiatric Care*. London: Tavistock.
- Goldberg D. & Huxley P. (1992) *Common Mental Disorders. A Bio-social Model*. London: Tavistock.
- Goldberg D. (1995) Epidemiology of mental disorders in primary care settings. *Epidemiologic Reviews* **17** pp 182 -190.
- Gordon H., Lindquist P. (2007) Forensic Psychiatry in Europe. *Royal College of Psychiatrists, Psychiatric Bulletin* **31**, 421-424.
- Gordon, H., Lindquist, P. (2007) Forensic Psychiatry in Europe, *Psychiatric Bulletin* 31: 421-424, Royal College of Psychiatrists
- Gostin L . O., Vanchieri C. & Pope A. (2007) *Ethical considerations for research involving prisoners*. The National Academies Press: Washington.
- Government of Ireland (1772) *Irish Workhouses Act*. Dublin: Stationery Office.
- Government of Ireland (1787) *Prisons Act*. Dublin: Stationery Office.
- Government of Ireland (1821) *Lunacy (Ireland) Act*. Dublin: Stationery Office.
- Government of Ireland (1838) *Dangerous Lunatics (Ireland) Act*. Dublin: Stationery Office.
- Government of Ireland (1842) *Private Lunatic Asylums (Amendment) Act*. Dublin: Stationery Office.
- Government of Ireland (1845) *Central Criminal Lunatic Asylum (Ireland) Act*. Dublin: Stationery Office.
- Government of Ireland (1945) *Mental Treatment Act*. Dublin: Stationery Office.
- Government of Ireland (1978) *Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons: Treatment and Care of Persons Suffering from Mental Disorder Who Appear Before the Courts on Criminal Charges*. [Chair: Henchy J.] (Prl. 8275, J85/1, Stationery Office, Dublin, 1978).

- Government of Ireland (1996) *Domestic Violence Act*. Dublin: Stationery Office.
- Government of Ireland (1998) (Amendment 2003) *Data Protection Act*. Dublin: Stationery Office.
- Government of Ireland (1998) *Child Abuse Act*. Dublin: Stationery Office.
- Government of Ireland (2001) *Mental Health Act*. Dublin: Stationery Office.
- Government of Ireland (2006) Amendment (2010) *Criminal Law (Insanity) Act*. Dublin: Stationery Office.
- Grant R. L. (2007) Blindness to Comprehensive psychiatric diagnosis in the correctional system. In *Public Health Behind Bars*. (Greifinger R., ed) Springer: New York, pp, 292-303.
- Green H., McGinnity A., Meltzer H., Ford, T. & Goodman R. (2005) *Mental Health Of Children And Young People In Great Britain, 2004*. Crown Copyright. Basingstoke, Hampshire: Palgrave Macmillan
- Green J. C., Caracelli V. J. & Graham W. F. (1989) Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis*, **11**(3), 255-274.
- Greenberg G. A. & Rosenheck R. A. (2008) Jail incarceration, homelessness, and mental Health: A National study. *Psychiatric Services* **59**, 170-177
- Greene J. C. & Caracelli V. J. (2003) Making paradigmatic sense of mixed methods practice. In *Handbook of mixed methods in social and behavioral research*. (Tashakkori A. & Teddlie C. eds.), Thousand Oaks, CA: Sage, pp. 91–110.
- Grisso T. & Appelbaum P.S. (1995) Comparison of standards for assessing patients' capacities to make treatment decisions. *The American Journal of Psychiatry*, **152** (7), 1033 - 1037.
- Groger L., Mayberry P. & Straker J. (1999) What we didn't learn because of who would not talk to us. *Qualitative Health Research* **9**(6), 829-835.
- Gunn J. (1977) Criminal behaviour and mental disorder. *British Journal of Psychiatry*. **130**, 317–329.
- Gurney J. N. (1991) Female Researchers in Male-Dominated Settings. In *Qualitative Approaches to Criminal Justice: Perspectives From the Field*. (Pogrebin, M. ed 2002). Sage, London.

- Habermas J. (1987) *The Theory of Communicative Action. Vol. 2: Lifeworld and System: A Critique of Functionalist Reason*. London: Polity Press.
- Hamlyn, D. (1995). Epistemology, history of. In T. Honderich (Ed.), *The Oxford companion to philosophy* (pp. 242-245). Oxford: Oxford University Press.
- Hanson W., Creswell J., Plano-Clark V., Petska K. & Creswell J. (2005) Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology* **52**, 224-235.
- Happell B. (2008) Determining the effectiveness of mental health services from a consumer perspective: Part 1: Enhancing recovery. *International Journal of Mental Health Nursing* **17**(2), 116-122.
- Harper D (1999) Tablet talk and depot discourse: discourse analysis and psychiatric medication. In *Applied Discourse Analysis* (Willig C., ed). Open University, Buckingham.
- Hartwell S. (2004) Triple Stigma: Persons with mental illness and substance abuse problems in the Criminal Justice System. *Criminal Justice Policy Review* **15**, 84-99.
- Harvey D. (1990) *"The Condition of Postmodernity"*, United Kingdom, Blackwell.
- Hayward M. & Moran P. (2007) Personality disorder and pathways to in-patient psychiatric care. *Social Psychiatry and Psychiatric Epidemiology* **42**(6), 502-506.
- Health Research Board (2004) *Mental Illness in Ireland 1750-2002 'reflections of the rise and fall of institutional care in Ireland'*. Published by Health Research Board: Dublin.
- Health Research Board (2006) *LINK The Newsletter of the Mental Health Research Division*. **3**, 1-4.
- Heflinger C A. & Hinshaw S. P. (2010) Stigma in child and adolescent mental health services research: understanding professional and institutional stigmatization of youth with mental health problems and their families. *Administration and Policy in Mental Health* **37**(1-2), 61-70
- Howe K. (1985) Two dogmas of educational research. *Educational Researcher* **14**(8), 10-18.
- Howe K. R. (1992) Getting over the quantitative-qualitative debate. *American Journal of Education*, **100**, 236–256.

- Howerton A., Byng R., Campbell J., Hess D., Owens C & Aitken P. (2007) Understanding help seeking behaviour among male offenders: qualitative interview study. *British Medical Journal* **334**(7588), pp. 303-306.
- Huntington T. (2008) What Is the Nature of Media Representation of Mentally Disordered Offenders? Unpublished MSc dissertation, University of Portsmouth.
- Hyde A., Lohan M. & McDonnell O. (2004) *Sociology for Health Professionals in Ireland*. Dublin: Institute of Public Administration.
- Ignatieff, M. (1978) *A Just Measure of Pain: The Penitentiary in the Industrial Revolution 1750-1850*. New York: Peregrine Books.
- Inspector of Prisons Annual Report (2011) Inspector of Prisons Standards for the Inspection of Prisons in Ireland - Women Prisoners' Supplement. Retrieved from www.inspectorofprisons.gov.ie on the 8 August 2011.
- Irish Penal Reform Trust (2001) 'Out of Sight, Out of Mind: Solitary Confinement of Mentally Ill Prisoners' Dublin: Irish Penal Reform Trust. Retrieved from www.iprt.ie on 06 September 2011.
- Irish Penal Reform Trust (2001) *Out of Mind, Out of Sight: Solitary Confinement of Mentally Ill Prisoners*. By Dr. Valerie Bresnihan on behalf of IPRT. Retrieved from <http://www.iprt.ie/iprt-publications/2> on the 20/01/06
- Irish Prison Service (2009) *Annual Report*. Retrieved from http://www.irishprisons.ie/documents/2009_Annual_Report.pdf on September 5 2009.
- Irish Prison Service (2010) *Annual Report*. Retrieved from http://www.irishprisons.ie/documents/2010_Annual_Report.pdf on September 5 2011.
- Jacob D.A., Holmes D. & Buus N. (2008) Humanism in forensic psychiatry: the use of the tidal nursing model. *Nursing Inquiry* **15**(3), 224–230.
- James D., Farnham F., Moorey H., Lloyd H., Blizard R. & Barnes T (2002) Outcomes of psychiatric admissions through the courts. London Home Office, RDS Occasional paper No 79.
- Johnson R. B. & Onwuegbuzie A. J. (2004) Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher* **33**(7), 14–26

- Johnson R. B. Onwuegbuzie A, J. & Turner L, A. (2007) Toward a definition of mixed methods research. *Journal of Mixed Methods Research* **1**(2), 112-133
- Johnstone P. L (2007) Weighing up triangulating and contradictory evidence in mixed methods organisational research. *International Journal of Multiple Research Approaches* **1**(10), 27
- Joint Committee on Health and Children (2007) *The Adverse Effects Of Pharmaceuticals*. Houses of the Oireachtas. Report available at: <http://www.oireachtas.ie/documents/committees29thdail/committeereports2007/side-effects.pdf>
- Jones M.L. (2007) Using Software to Analyse Qualitative Data. *Malaysian Journal of Qualitative Research* **1**(1), 64-76.
- Judge A. M., Estroff S. E., Perkins D. O. & Penn D. L. (2008) Recognizing and responding to early psychosis: a qualitative analysis of individual narratives. *Psychiatric Services* **59**(1), 96-9.
- Kadushin C. (1966) The Friends and Supporters of Psychotherapy: On Social Circles in Urban Life. *American Sociological Review* **31**, pp 786-802.
- Kaplan A. (1968) Positivism. In *International Encyclopedia of the social Sciences*. (Sills D. L. ed), Macmillan, Free Press: New York.
- Kelley K., Clark B., Brown V. & Sitzia J. (2003) Methodology Matters: Good practice in the conduct and reporting of survey research. *International Journal Quality Health Care*, **15**(3), 261-266
- Kelly B. D. (2007) Penrose's Law in Ireland: An ecological analysis of psychiatric inpatients and prisoners. *Irish Medical Journal* **100**(2):373-4
- Kelly BD (2008) 'Mental health law in Ireland, 1945 to 2001: reformation and renewal' *Medico-Legal Journal* **76** (2):65-72.
- Kelly B. D. (2007) The Irish Mental Health Act (2001). *Psychiatric Bulletin* **31**, 21-24
- Kennedy H. G. (2007) *The Annotated Mental Health Acts*. Blackhall Publishing Dublin: Ireland.
- Kennedy H, G., (2006) The future of forensic mental health services in Ireland, *Irish Journal of Psychiatric Medicine*, **23**(2), pp. 45-46.

- Keogh B & Daly L. (2009) The ethics of conducting research with mental health service users. *British Journal of Nursing* **18**(5), p277 – 281.
- Kilcommins S., O'Donnell I., O'Sullivan, E. & Vaughan B. (2004) *Crime and Punishment and the Search for Order in Ireland* Institute of Public Administration (IPA): Dublin, Ireland.
- Kincheloe J. L. & McLaren P. (2000) Rethinking critical theory and qualitative research. In *Handbook of Qualitative Research* (Denzin N.K. & Lincoln Y.S. eds), Thousand Oaks: Sage Publications, pp. 279-324.
- King R., Waghorn G., Lloyd C., McLeod P., McMahan T. & Leong C. (2006) "Enhancing employment services for people with severe mental illness: the challenge of the Australian service environment". *Australian and New Zealand Journal of Psychiatry* **40** (5), 471-7.
- Kirkpatrick T. & Percy C. A. (1931) *A note on the history of the Care of the Insane in Ireland: Up to the end of the Nineteenth Century*. Dublin: University Press by Ponsonby and Gibbs.
- Knight L. & Stephens M. (2009) Mentally Disordered Offenders in Prison: A Tale of Neglect? *Internet Journal of Criminology*, pp. 1-16. Retrieved from www.internetjournalofcriminology.com on the 2nd February 2011.
- Konrad N. (2002) Prisons as new asylums. *Current Opinion in Psychiatry* **15**, 583-587.
- Koos E.L. (1994) *The Health Regionville*. Columbia University Press New York.
- Kristeva J. (1984) *Revolution in Poetic Language*. New York: Columbia University Press.
- Kuhn, T.S. (1962) *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press,
- Kushel M.B., Hahn J.A., Evans J., Bangsberg D. R. & Moss A. R. (2005) Revolving doors: imprisonment amongst the homeless and marginally housed population. *American Journal of Public Health* **95**, 1747–1752,
- Kvale S. (1983) The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. *Journal of Phenomenological Psychology* **14**, 171-196.

- Lahariya C., Singhal S., Gupta S. & Mishra A. (2010) Pathway of care among psychiatric patients attending a mental health institution in central India. *Indian Journal of Psychiatry* **52**(4): 333–338.
- Lai Y. M., Hong C. P. H. & Chee C. Y. I. (2000) Stigma of Mental Illness. *Singapore Medical Journal*, **42**(3), 111-114
- Lamb R. H. & Weinberger L. E. (1998) Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services* **49**, 483-492.
- Lacro J. P., Dunn L. B., Dolder C. R., Leckband S. G. & Jeste D. V. (2002) Prevalence of and risk factors for medication non-adherence in patients with schizophrenia: a comprehensive review of recent literature. *Journal of Clinical Psychiatry*, **63**, 892–909.
- Law Reform Commission (2007) *Spent Convictions*. Law Reform Commission, Dublin.
- Lidz C.W. & Hoge S.K (1993). Introduction to coercion in mental health care. *Behavioral Sciences and the Law* **11** pp 237-238.
- Lincoln C. V. & McGorry P. (1995) Who cares? Pathways to psychiatric care for young people experiencing a first episode of psychosis. *Psychiatric Services* **46**(11), 1166-1171.
- Lincoln Y.S. & Guba E.G. (1985) *Naturalistic Inquiry*. Sage, Beverley Hills California.
- Linehan S., Duffy D., Wright B., Curtin K., Monks S. & Kennedy H. G. (2005) Psychiatric morbidity in a cross-sectional sample of male remanded prisoners. *Irish Journal of Psychological Medicine* **22** (4), 128–132.
- Lingam R. & Scott J. (2002) Treatment non-adherence in affective disorders. *Acta Psychiatrica Scandinavica* **105**, 164–172.
- LoBiondo-Wood G. & Haber J. (2002) *Nursing Research, Methods, Critical Appraisal and Utilization*. St Louis: Mosby.
- LoBiondo-Wood G. & Haber J. (2006) *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice*, 6th edn. St Louis: Mosby Elsevier.
- Lofland J. & Lofland L. H. (1984) *Analyzing social settings*. Belmont, CA: Wadsworth Publishing Company, Inc.
- Lofland J., Snow D., Anderson L., & Lofland L.H. (2006). *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis*. Canada: Thomson Wadsworth.

- Ludwig J, Marcotte D. & Norberg K. (2007) *Anti-Depressants and Suicide*. Working paper 12906. Cambridge, MA: National Bureau of Economic Research.
- Lyall I., Holland A. J. & Collins S. (1995) Offending by adults with learning disabilities and the attitudes of staff to offending behaviour: implications for service development. *Journal of Intellectual Disability Research* **39**, 501–508.
- Lynd R.S. & Lynd H.M. (1929) *Middletown, A study in American culture*. Harcourt Brace New York.
- MacGabhann L., Scheele A., Dunne T., Gallagher P., MacNeela P., Moore G. Philbin M. (2004) *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland*. National Advisory Committee on Drugs, Dublin, Government Public Sales Office.
- Maguire M., Morgan R., & Reiner R. (2007) *The Oxford Handbook of Criminology, 4th edn*. Oxford University Press Inc., New York
- Maki P, Veijola J, Jones P B, Murray G K, Koponen H, Tienari P, Miettunen J, Tanskanen
- Mason T. & Mercer D. (2000) The silent resistance. In *Forensic Mental Health Care: A Case Study Approach*. (Mercer D., Mason T., McKeown M. & McCann G. eds). Edinburgh: Churchill Livingstone.
- Maxcy S. (2003) 'Pragmatic threads in mixed methods research in the social sciences: The search for multiple modes of inquiry and the end of the philosophy of formalism'. In *Handbook of Mixed Methods in Social & Behavioral Research* (Tashakkori A. & Teddlie C. eds), Thousand Oaks CA: Sage.
- Maynard M (1994) Methods, practice and epistemology: The debate about feminism and research. In *Researching women's lives from a feminist perspective* (Maynard M., & Purvis J. Eds), pp. 10-26. London: Taylor & Francis.
- Mays N. & Pope C. (2000) Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, **320**, 50-52.
- Mays N. and Pope C. (1995) Qualitative Research: Rigour and Qualitative Research. *British Medical Journal* 311(6997), 109-112.
- McAuley F. & McCutcheon J. P. (2000). *Criminal liability: A grammar*. Dublin: Round Hall Sweet and Maxwell.

- McClelland R. J. (1988) The madhouses and mad doctors of Ulster. *The Ulster Medical Journal* **57**(2), 101–120.
- McGartland R., Berg-Weber M., Tebb S.S., Lee E.Z. & Rauch S. (2003) Objectifying Content Validity: Conducting a Content Validity Study in Social Work Research. *Social Work Research* **27**(2), 94-104.
- McKenzie K., Patel V. & Araya R. (2004) Learning from low income countries: mental health. *British Medical Journal* **329**, 1138-1140.
- McMillan J. & Schumacher S. (2006) *Research in Education: Evidence-Based Inquiry*, 6th edn. Boston: Pearson.
- Mechanic, D. (1968) *Medical Sociology*. New York: Free Press.
- Medalie J. H. & Zyzanski S. J. (1992) Problems and issues in family medicine psychological research. *Family Practice* **9**, 222–230.
- Menezes P. R., Johnson S. & Thornicroft G. (1996) Drug and alcohol problems among individuals with severe mental illness in South London. *British Journal of Psychiatry* **168**, 612-619
- Mental Health Commission (2005) *Quality in Mental Health– Your Views*. Mental Health Commission, Dublin
- Mental Health Commission (2006), *Discussion Paper – Forensic Mental Health Services for Adults in Ireland-Discussion paper*. Mental Health Commission, Dublin.
- Mental Health Commission (2011) *Forensic Mental Health Services Adults in Ireland – Position paper*. Mental Health Commission, Dublin
- Mental Health Declaration for Europe (2005) Facing the Challenges, Building Solutions. Copenhagen, World Health Organization Regional Office for Europe. Retrieved at www.euro.who.int/document/mnh/edoc06.pdf on November 2007.
- Mental Health Foundation (2010) Be Mindful. London, Mental Health Foundation.
- Mercer D., Mason T. & Richman J (2001) Professional convergence in forensic practice *Australian and New Zealand Journal of Mental Health Nursing* **10**(2)pp 105-115.
- Mertens D. (2007) Transformative Considerations: Inclusion and Social Justice. *American Journal of Evaluation* **28**(1), 86-90.

- Mertens D. M. (2005) *Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches*, 2nd ed. Thousand Oaks: Sage.
- Mezey G. (2007) Improving the mental health of offenders in primary care. *British Medical Journal*; **334**(7588), 267–268.
- Milburn K., Fraser E., Seeker J. & Pavis S. (1995) “Combining Methods in Health Promotion Research: some considerations about appropriate use.” *Health Education Journal*, **54**, 347-56
- Mill J S (1859) *Essays on Politics and Culture*. Edited by Gertrude Himmelfarb, 368-84. Gloucester, Peter Smith, 1973.
- Mills S. (2003) Criminal Law (Insanity) Bill 2002: Putting the sanity back into insanity? *Bar Review* **8**(3), 101.
- Mitchell W. E. (2003) *Self-Made Madness: Rethinking Illness and Criminal Responsibility*. Ashgate Publishing, United Kingdom.
- Moffic S. (2010) Better off in prison. *Behavioural Healthcare* **30**, 26-29.
- Monahan J. & Steadman H. (1983) Crime and mental illness: an epidemiological approach. In: *Crime and Justice*, Vol. 4 (ed. Morris N. & Tonry M.), pp. 145–189. University of Chicago Press, Chicago.
- Moore L.W. & Miller M. (1999) Initiating research with doubly vulnerable populations, *Journal of Advanced Nursing* **30**(5), pp 1034–1040.
- Morgan D. L. (2007) Paradigms lost and pragmatism regained: methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods* **1**(1), 48-76.
- Morgan M. & Kett M. (2003) *The Prison Adult Literacy Survey*. Department of Justice and Law Reform: Dublin.
- Morgan R. & Liebling A. (2007) Imprisonment: An Expanding Scene. In *The Oxford Handbook of Criminology (4th Ed)*. (Maguire, M. Morgan, R., and Reiner, R., Eds) Oxford: Oxford University Press: 1100-1139.
- Morgan R. D., Steffan J., Shaw L. B. & Wilson S. (2007) Needs for and barriers to correctional mental health services: Inmate perceptions. *Psychiatric Services* **58**(9), 1181 - 1186.

Morgan, C., Mallett, R., Hutchinson, G. & Leff J. (2004) Negative pathways to psychiatric care and ethnicity: the bridge between social science and psychiatry. *Social Science and Medicine* **58**, 739–752.

Morris T., Morris P. & Barer B. (1963) *Pentonville: A Sociological Study of an English Prison*. London: Routledge and Kegan Paul.

Morse J. M. & Field P. A. (1994) *Qualitative Research Methods for Health Professionals*, 2nd ed. Thousand Oaks, California: Sage.

Morse J., Wolfe R. & Niehaus L. (2006) Principles and procedures of maintaining validity for mixed-method design. In *Improving Aging and Public Health Research: Qualitative and Mixed Methods*. (Curry L., Shield R. & Wetle T. eds), Washington, DC: American Public Health Association and Gerontological Society of America.

Munk-Jorgensen P. (1999) Has deinstitutionalization gone too far? *European Archives of Psychiatry and Clinical Neuroscience* **249**, 136–143.

Munthe C., Radovic S. & Anckarsäter H. (2010) Ethical issues in forensic psychiatric research on mentally disordered offenders. *Bioethics* **24**(1), 35-44.

Murphy E. (1992) The effects of National Health Service reorganisation on forensic psychiatric services. *Journal of Forensic Psychiatry* **3**, 13-30.

National Association for the Care and Resettlement of Offenders (NACRO). (2005) *Findings of The 2004 Survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for Mentally Disordered Offenders in England and Wales*. London: NACRO.

National Association for the Care and Resettlement of Offenders (NACRO). (2007) *Mentally Disordered Offenders Standard 5 – In the Community*. London: Nacro.

National Disability Authority (2003) *Review of Access to Mental Health Services for People with Intellectual Disabilities*. National Disability Authority: Dublin.

National Economic and Social Forum (2006) *Creating a More Inclusive Labour Market*. Dublin: National Economic and Social Forum.

National Economic and Social Forum (2007) *Mental Health and Social Inclusion* retrieved from www.who.int/mental_health/policy/services/en/index.html on the 8th September 2011). Mental Health, Human rights and Legislation Information Sheet, (4). World Health Organisation Geneva,

- National Qualifications Authority of Ireland. *The National Framework of Qualifications (2003), overview of the awards recognised through the Framework as at 29 January 2010*. Retrieved on December 2011 <http://www.nqai.ie/awardsframework.html>
- Newnes C., Holmes G. & Dunn C. (Eds.) (2001) *This Is Madness Too: Critical Perspectives On Mental Health Services*. Ross-on-Wye: PCCS Books.
- Ni Raifeartaigh Ú. (2007) The European Convention on Human Rights and the Criminal Justice System. *Judicial Studies Institute Journal*. Retrieved from http://www.jsijournal.ie/html/Volume/207/20No./202/2007/5B2/5D_Ni/20Raifeartaigh_ECHR/20and/20the/20Criminal/20Justice/20System.pdf on the 10/05 2008
- Niven S. & Olagundoye J. (2002) *Jobs and Homes: A Survey of Prisoners Nearing Release*. Home Office Research Findings (no 173). London: Home Office
- Niven S. & Stewart D. (2005) *Resettlement Outcomes on Release from Prison in 2003*. Findings (no 248). London: Home Office.
- Nolan P. (1993) *A History of Mental Health Nursing*. London: Chapman & Hall.
- Nolan P., Bradley E. & Brimblecombe N. (2011) Disengaging from acute inpatient psychiatric care: a description of service users' experiences and views. *Journal of Psychiatric and Mental Health Nursing*, **18**, p.359–367.
- Nurse J., Woodcock P. & Ormsby J. (2003) Influence of environmental factors on mental health within prisons: focus group study. *British Medical Journal* **327**(7413), 480.
- O'Mahony, P. (1997) *Mountjoy Prisoners: A sociological and criminological profile*, Dublin, Stationary Office.
- O'Neill A. (2005) *Irish Mental Health Law*. First Law: Dublin.
- O'Neill C. (2006) Liaison between criminal justice and psychiatric systems: Diversion services. *Irish Journal of Psychological Medicine* **23**(3) 87.
- O'Shea, E & Kennelly B. (2008) *The Economics of Mental Health Care in Ireland*. Mental Health Commission: Ireland.
- Oggers C, Moffitt T., Broadbent J., Dickson N., Hancox R., Harrington H., Poulton R., Sears M., Thomson W. & Caspi A. (2008) Female and male antisocial trajectories: From childhood origins to adult outcomes. *Development and Psychopathology* **20**, 673-716

Office of National Statistics (2003) *Mental Health and Social Exclusion*. Office of the Deputy Prime Minister: London.

Office of the High Commissioner for Human Rights, "Fact Sheet No. 22- Discrimination against Women: The Convention and the Committee", Geneva, undated as accessed at <http://www.ohchr.org/Documents/Publications/FactSheet22en.pdf>

Ogloff J., Davis M., Rivers G. & Ross S. (2007)'The identification of mental disorders in the criminal justice system'. *Trends and Issues in Crime and Criminal Justice* **334**, 1-6.

Okello E. S. (2007) Explanatory Models and Help-Seeking Behavior: Pathways to psychiatric Care among Patients Admitted for Depression in Mulago Hospital, Kampala, Uganda. *Qualitative Health Research* **17**(1), 14-25.

Oliver M. I., Pearson N., Coe N. & Gunnell D. (2005) Help-seeking behaviour in men and women with common mental health problems: cross-sectional study. *The British Journal of Psychiatry* **186**, 297–301

Onwuegbuzie A. & Leech N. L. (2005) On becoming a pragmatic researcher: The importance of combining quantitative and qualitative methodologies. *International Journal of Social Research Methodology* **8**(5), 375-387.

Oppenheim A. N. (1992) *Questionnaire, Design, Interviewing and Attitude Measurement*. Pinter Publishers: London.

Osborne L. (1974) Beyond stigma theory: A literary approach. *Issues in Criminology* **9**(1), 71–90.

O'Sullivan T., Batra R., Nolan M. & Scott A. (2007) Goldberg and Huxley's model 27 years on. *Psychiatric Bulletin* **31**(8), 316.

Oxford Modern English Dictionary (1995) (Swannell J. ed). Oxford University Press

Özden M. (2006) The Right to Health. A fundamental human right affirmed by the United Nations and recognized in regional treaties and numerous national constitutions. Centre Europe - Tiers Monde (CETIM). (Part of a series of the Human Rights Programme of the Europe-Third World Centre (CETIM). Retrieved from

Pallant J. (2010) *SPSS Survival Manual: A Step By Step Guide to Data Analysis Using SPSS*, 4th edn. McGraw Hill, England.

- Panzer P., Broner N. & McQuiston H. (2001) Introduction. *Psychiatric Quarterly*, **72**(1), 41-3.
- Parahoo K. (2006) *Nursing Research – principles, process and issues*. (2nd ed). Palgrave, Houndsmill.
- Patenaude L. (2004) No promises but I'm willing to listen and tell what I hear: conduction qualitative interviews among inmates and staff. *The Prison Journal* **84**(4), 69s-91s.
- Patton M. (2001) *Qualitative Research and Evaluation Methods (2nd Ed)* Sage Publications, Thousand Oaks.
- Patton M. Q. (1990) *Qualitative Evaluation and Research Methods*, 2nd edn. Newbury Park, California: Sage.
- Patton M.Q. (2002) *Qualitative Research and Evaluation Methods 3rd Ed*. 3rd edn. Sage publications, Thousand Oaks: CA.
- Paykel E. S., Hart D. & Priest R. G. (1998) Changes in public attitudes to depression during the Defeat Depression Campaign. *British Journal of Psychiatry*, **173**, 519 –522.
- Payton A. R. & Thoits P.A (2011) Medicalisation, direct-to-consumer advertising, and mental illness stigma. *Society and Mental Health*, **1**, 55-70.
- Peay J. (2003) *Decisions and Dilemmas: Working with Mental Health Law*. Oxford Hart.
- Penal Reform International, (2008). "Women in prison: incarcerated in a man's world", (1). Retrieved from www.penalreform.org/files/brf-03-2008-women-in-prison-en.pdf on January 2010.
- Penhale B & Parker J. (2007) *Working with Vulnerable Adults*. London: Routledge.
- Penrose L. S. (1939) Mental disease and crime: outline of a comparative study of European statistics. *British Journal of Medical Psychology* **18**, 1 -15.
- Perron A., Fluet C. & Holmes D. (2005) Agents of care and agents of the state: Bio-power and nursing practice. *Journal of Advanced Nursing* **50**, 536–44.
- Pescosolido B. A. (1992) Beyond rational choice: The social dynamics of how people seek help. *American Journal of Sociology*.**97**, pp 1096–1138.
- Pescosolido B. A., Brooks-Gardner C. & Lubell. K.M. (1998) How people get into mental health services: stories of choice, coercion and 'muddling through' from first-timers. *Social Science and Medicine* **46**(2), 275-286.

- Phelan J, C. (2005) Geneticization of deviant behavior and consequences for stigma: The case of mental illness. *Journal of Health & Social Behavior* **46**(4), 307-22.
- Phelan J. C., Lawrence H. Y. & Rosangely C-R. (2006) Effects of attributing serious mental illnesses to genetic causes on orientations to treatment. *Psychiatric Services* **57**(3), 382-87.
- Pilgrim D., Rogers A. & Pescosolido B. (2011) *The Sage Handbook of Mental Health and Illness*. Sage Publications Limited.
- Polit D. and Beck C. (2004) *Nursing Research: Principles and Methods* (7th ed). Lippincott Williams & Wilkins, Philadelphia.
- Porter R. (2002) *Madness – A Brief History*. Oxford University Press, Oxford.
- Porter S. (1993) Nursing research conventions: objectivity or obfuscation? *Journal of Advanced Nursing* **18**, 137-143.
- Porter S. (1993) Critical Realist Ethnography: the case of racism and professionalism in a medical setting. *Sociology*, **27**, 591-609.
- Priebe S, Badesconyi A, Fioritti A, Hansson L., Torres-Gonzales F. Turner T. & Wiersma D, (2005) Re-institutionalisation in mental health care: comparison of data on service provision from six European countries. *British Medical Journal* **330**, 123–126.
- Priebe S., Frottier P., Gaddini A., Kilian R., Lauber C., Martinez-Leal R., Munk-Jorgensen P., Walsh D., Wiersma D. & Wright D. (2008) Mental health care institutions in nine European countries, 2002 to 2006. *Psychiatric Services* **59**, 570-573.
- Prince P. N. (2003) A historical context for modern psychiatric Stigma. In *Mental Health and Patients' Rights in Ontario: Yesterday, Today and Tomorrow*. Psychiatric Patient Advocate Office, Ontario, Canada, pp. 58-60.
- Prins H. (1990) Mental abnormality and criminality – an uncertain relationship. *Medicine, Science and the Law* **30**, 247–257.
- Prins H. A. (2005) *Offenders, Deviants or Patients?* (3rd ed). London: Routledge.
- Prior P. M (2003) Dangerous lunacy: The misuse of mental health law in nineteenth-century Ireland. *Journal of Forensic Psychiatry and Psychology* **14**, 525–541.

- Quina K., Varna Garis A., Stevenson J., Garrido M., Brown J., Richman R., et al. (2007). Through the bullet-proof glass: Conducting research in prison settings. *Journal of Trauma & Dissociation* **8**, pp 123-139.
- Rabin R., Rosser R. M. & Butler C. (1993) Impact of diagnosis on utilities assigned to states of illness. *Journal Royal Society Medicine* **86**(8), 444–448.
- Ramazanoglu C. & Holland J.(2002) *Feminist Methodology: Challenges and Choices*. Thousand Oaks: Sage.
- Rauscher L. & Greenfield B. H. (2009) Advancements in contemporary physical therapy research: use of mixed methods designs. *Journal Physical Therapy* **89**(1), 91-100
- Rautanen M. & Lauerma H. (2011) Imprisonment and diagnostic delay among male offenders with schizophrenia. *Criminal Behaviour and Mental Health* **21**(4), 259–264.
- Redfern S. J. & Norman I. J. (1997) Validity through triangulation. *Nurse Researcher* **2**(2), 41-56.
- Reed J. L. & Lyne M. (2000) Inpatient care of mentally ill people in prison: results of a year's programme of semi-structured inspection. *British Medical Journal* **320**, (7241), 1031-1034.
- Reeves C. L. (2010) A difficult negotiation: fieldwork relations with gatekeepers. *Qualitative Research* **10**(3), 315- 331.
- Rescher N. (2000) *Realistic Pragmatism: An Introduction to Pragmatic Philosophy*. State University of New York Press, Albany.
- Rhodes J. (2008) Ex-offenders, Social Ties and the Routes into Employment. The Internet Journal of Criminology. Retrieved from <http://www.internetjournalofcriminology.com> on August 2011.
- Richards M. & Abbott R. (2009) Childhood mental health and life chances in post-war Britain. Retrieved from www.scmh.org.uk/publications on March 2008.
- Roberts L., W, Warner T., Brody J., Roberts B., Lauriello J. & Lyketsos C. (2002) Patient and psychiatrist ratings of hypothetical schizophrenia research protocols: assessment of harm potential and factors influencing participation decisions. *The American Journal of Psychiatry* **159**(4), 573-584.

- Robins J. (1986) *Fools and Mad: A History of the Insane in Ireland*. Dublin: Institute of Public Administration.
- Robson C. (2002) *Real World Research: A Resource for Social Scientists and Practitioner-Researchers 2nd Ed*. Blackwell publishing, Oxford.
- Rocco T. S., Bliss L. A., Gallagher S. Perez-Prado A., Alacaci C, Dwyer E.S., Fine J.C. & Pappamihiel N. E. (2003) In *Handbook of Mixed Methods in Social and Behavioural Research*. (Tashakkori A. & Teddlie C. eds), pp. 595-615. Thousand Oaks: Sage Publications.
- Rogers A. (2002) Analysing demand and use of primary care in the general population. The Research Finding Registrar. Retrieved from <http://www.refer.nsh.uk/veiwrecord.asap?ID=977> on the 19th March 2007
- Rolfe G (2001) Postmodernism for healthcare workers in 13 easy steps. *Nurse Education Today* **21**, 38–47.
- Rolfe G. (2006) Validity, Trustworthiness and Rigour: Quality and the Idea of Qualitative Research. *Journal of Advanced Nursing* **53**(3), 304-310.
- Rorty R. (1979) *Philosophy and the Mirror of Nature*. Princeton: Princeton University Press.
- Rueve M. E. & Welton R. S. (2008) Violence and mental illness. *Psychiatry* **5**(5), 35-48.
- Russell, C., Touchard, D. and Porter, M. (2002) 'What's Rapport Got to do with it? The Practical Accomplishments of Fieldwork Relations between Young Female Researchers' *Qualitative Research* **10**(3).
- Ryan G. W. & Bernard H. R. (2003) Techniques to Identify Themes. *Field Methods* **15** (1), 85–109.
- Ryan, M. (2009) Making visible the coding process: Using qualitative data software in a post-structural study. *Issues In Educational Research* **19**(2), pp 142-161.
- Sainsbury Centre (2009) *Briefing 38: The Bradley Report and the Government's Response: The implications for mental health services for offenders*. London: Sainsbury Centre for Mental Health.

- Salize H.J., Schanda H. & Dressing H. (2008). From the hospital into the community and back again - a trend towards re-institutionalisation in mental health care? *International Review of Psychiatry* **20**(6), 527-34.
- Sandelowski M. (1986) The Problem of Rigor in Qualitative Research. *Advances in Nursing Science* **8**(3), 27-37.
- Sandelowski M. (2001) Real Qualitative Researchers Do Not Count: The Use of Numbers in Qualitative Research. *Research in Nursing and Health* **24**, 230-240.
- Saunders M., Lewis P. & Thornhill A. (2007) *Research Methods for Business Students*, 4th ed. London: Prentice Hall.
- Sayal K, Tischler V., Coope C., Robotham S., Ashworth M., Day C., Tylee A. & Simonoff E. (2010) Parental help-seeking in primary care for child and adolescent mental health concerns: qualitative study. *British Journal of Psychiatry* **197**(6), 476-81.
- Sayal K. (2006) Annotation: Pathways to care for children with mental health problems. *Journal of Child Psychology and Psychiatry* **47**(7), 649–659.
- Sayal K., Goodman R. & Ford T. (2006) Barriers to the identification of children with attention deficit/hyperactivity disorder. *Journal of Child Psychology and Psychiatry*, **47**(7), 744-50.
- Schlosser J. A. (2008) Issues in Interviewing Inmates: Navigating the methodological landmines of prison research. *Qualitative Inquiry*. Retrieved from <http://qix.sagepub.com/content/14/8/1500.abstract> on December 2008
- Schulze B. (2007) Stigma and mental health professionals: a review of the evidence on an intricate relationship. *International Review of Psychiatry* **19**(2), pp 137-55.
- Schutz A. (1973) Concept and theory formation in the social sciences. In Alfred Schutz collected papers I: The problem of social reality, (Natanson M. Ed.), pp 48-66. The Hague: Martinus Nijhoff.
- Secker J. & Membrey H. (2003) Promoting mental health through employment and developing healthy workplaces: the potential of natural supports at work. *Health and Education Research* **25**(3), 312-24.
- Seddon T. (2007) *Punishment and Madness: Governing Prisoners with Mental Health Problems*. Abingdon: Routledge-Cavendish.

- Seymour M. & Costello L. (2005) A study of the Number, Profile and Progression Routes of Homeless Persons before the Courts and in Custody, Probation and Welfare Service. Department of Justice, Equality and Law Reform, Government Publications, Dublin.
- Shaw J. (2007) *Pathways to care in adolescent offenders with mental health problems*. Retrieved from www.portal.nihr.ac.uk/profiles/NPP on the 06/02/2008
- Shepherd G. & Murray A. (2001). Residential care. In *Textbook of Community Psychiatric Care*. (Thorncroft G. & Szukler G., eds) Oxford: Oxford University Press, pp 309-320.
- Singh S. P. & Grange T (2006) Measuring pathways to care in first-episode psychosis: a systematic review. *Schizophrenia Research* **81**, 75–82.
- Singleton N., Meltzer H., Gatward R., Coid J. & Deasy D. (1998) *Psychiatric morbidity among prisoners*. London: Stationery Office.
- Sirotych F. (2008) Correlates of crime and violence among persons with mental disorder: *An Evidence-Based Review* **8**(2), 171-194.
- Social Exclusion Unit (2002) *Reducing Re-offending by Ex-Prisoners*, London: HMG Cabinet Office. Retrieved from www.thelearningjourney.co.uk on May 2008.
- Social Exclusion Unit (2004) *Mental health and social exclusion: Social exclusion unit report*. London: Office of the Deputy Prime Minister.
- Somekh B. & Lewin C. (2005) *Research methods in social sciences*. Thousand Oaks: Sage.
- Soothill K., Rogers P. & Dolan M. (2008) *Handbook of Forensic Mental Health*. Willan Publishing Ltd, Devon England.
- Soyka M. (2000) Substance misuse, psychiatric disorder and violent and disturbed behaviour. *The British Journal of Psychiatry* **176**, 345-350.
- Steel Z., McDonald R., Silove D., Bauman A., Sandford P., Herron J. & Minas I. H. (2006) Pathways to the first contact with specialist mental health care. *Australian and New Zealand Journal of Psychiatry* **40**, 347–354.
- Stein L. I. & Santos A. B., (1998) *Assertive Community Treatment of Persons with Severe Mental Illness*. New York and London: W. W. Norton.
- Stevenson J. (2009) The methodological and ethical implications of 'story telling' in educational research, ESREA Wisdom and knowledge in researching and learning lives: diversity, difference and commonalities *Conference Paper*, Milan, March 2009.

- Strauss A. & Corbin J, (1990) *Basics of Qualitative Research*. Newbury Park, California: Sage.
- Stuart H (2006) Mental Illness and Employment Discrimination. *Current Opinion in Psychiatry* **19**(5), 522-526.
- Suppe E. (1977) *The Structure of Scientific Theories*, 2nd ed. Urbana: University of Illinois Press.
- Swartz J. & Lurigio A. (2007) Serious Mental Illness and Arrest. *Crime and Delinquency* **53**(4), 581-604.
- Szasz T. (1997) *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*. Syracuse, New York: Syracuse University Press.
- Szasz T. (2003) Psychiatry and the control of dangerousness: on the apotropaic function of the term "mental illness" *Journal of Medical Ethics* **29**, 227-230.
- Szasz, T. (2011). The myth of mental illness: 50 years later. *The Psychiatrist* **35**, 179-182.
- Tabachnick B. G. & Fidell L. S. (2007) *Using Multivariate Statistics*, 5th ed. Boston: Allyn and Bacon.
- Tashakkori A. & Creswell D. (2007) Exploring the Nature of Research Questions in Mixed Methods Research. *Journal of Mixed Methods*, **1**: 207-211.
- Tashakkori A. & Teddlie C. (1998) *Mixed Methodology: Combing Qualitative and Quantitative Approaches*. Thousand Oaks, CA: Sage.
- Tashakkori A. & Teddlie C. (2003b) Major issues and controversies in the use of mixed methods in the social and behavioral sciences. In *Handbook of Mixed Methods in Social and Behavioural Research*. (Tashakkori A. & Teddlie C. eds), pp. 3–53. Thousand Oaks: Sage Publications.
- Tashakkori A. & Teddlie C. (2003c) The past and future of mixed methods research: From data triangulation to mixed model design In *Handbook of Mixed Methods in Social and Behavioural research*. (Tashakkori A. & Teddlie C. eds), pp. 671–702. Thousand Oaks: Sage Publications.
- Tashakkori A. & Teddlie C. (2009) *Foundations of Mixed Methods Research; Integrating Quantitative and Qualitative Approaches in the Social and Behavioural Sciences*. Thousand Oaks, CA: Sage.

- Taylor P. (2004) *Mental Illness and Serious Harm to Others*. NHS National Programme on Forensic Mental Health Research and Development.
- Tedstone Doherty D. & Kartalova-O'Doherty Y. (2010) Gender and self-reported mental health problems: predictors of help-seeking from a general practitioner. *British Journal of Health Psychology* **15**(Pt 1), 213–228.
- Tedstone Doherty D. & Moran R. (2009) *Mental Health and Associated Health Service Use on the Island Of Ireland*. HRB Research Series 7. Dublin: Health Research Board.
- Tedstone Doherty D., Moran R. & Kartalova O' Doherty Y. (2006) Psychological Distress, Mental Health Problems Use Of Health Services In Ireland. Dublin: Health Research Board.
- Tedstone Doherty D., Moran R. & Kartalova-O'Doherty Y. (2008) *Psychological Distress, Mental Health Problems and Use of Health Services In Ireland*. HRB Research Series 5. Dublin: Health Research Board.
- Tedstone Doherty D., Moran R., Kartalova-O'Doherty Y. & Walsh D. (2007) HRB National Psychological Wellbeing And Distress Survey: Baseline Results. HRB Research Series 2. Dublin: Health Research Board.
- Tee S. & Lathlean J. (2004) The ethics of conducting a cooperative inquiry with vulnerable people. *Journal of Advanced Nursing* **47**(5), 536–43.
- Teplin L. (1984) Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist* **39**, 794-803.
- Teplin L. (1985) The criminality of the mentally ill: A dangerous misconception. *American Journal of Psychiatry* **142**, 593-599.
- Teplin L. A. (1990) The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiologic Catchment Area program. *American Journal of Public Health*, **80**, 663 -669.
- Teplin L. A., Abram K. & McClelland G. M. (1996) Prevalence of psychiatric disorders among incarcerated women: Pretrial jail detainees. *Archives of General Psychiatry* **53**, 505 -512.
- Thornicroft G. & Tansella M. (1999) *The Mental Health Matrix. A Manual to Improve Services*. Cambridge: Cambridge University Press.

- Tobin G. A. & Begley C. M. (2004) Methodological rigour within a qualitative framework. *Journal of Advanced Nursing* **48**(4), 388-96.
- Todorov T. (1977) *The Poetics of Prose*. Ithaca, New York: Cornell University Press.
- Tsakanikos E., McCarthy J., Kravariti E., Fearon P. & Bouras N. (2010) The role of ethnicity in clinical psychopathology and care pathways of adults with intellectual disabilities. *Research in Developmental Disabilities*, **31**(2), 410-415.
- Turner R. H. (1969) Madness in society. *The American Journal of Sociology* **74**(5), 541-542.
- U.S. Department of Justice (2006) *Mental Health Problems of Prison and Jail Inmates* Office of Justice Programs Bureau of Justice Statistics September, NCJ 213600. Retrieved from www.bjs.gov/content/pub/pdf/mhppji.pdf on October 2008.
- Uggen C. (2000) Work as a turning point in the life course of criminals: a duration model of age, employment, and recidivism. *American Sociological Review* **65**(4), 529-546.
- Ulmer J. T. & Spencer W. J. (1999) The Contributions of an interactionist approach to research and theory on criminal careers. *Theoretical Criminology* **3**(1), pp 95-124.
- United Nations General Assembly (2011) *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)* <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/526/28/PDF/N1052628.pdf?OpenElement>
- United Nations (2002) *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Ireland*. Office of the United Nations High Commissioner for Human Rights Geneva: Switzerland.
- United Nations General Assembly (1991) *The protection of persons with mental illness and the improvement of mental health care*. A/RES/46/119, 75th plenary meeting. Retrieved from <http://www.un.org/documents/ga/res/46/a46r119.htm> on the 20th November 2007.
- Vitelli R. (1993) The homeless inmate in a maximum-security prison. *Canadian Journal of Criminology* **35**, 323-31.
- Vogel L. & Wade G. (2009) Stigma and help-seeking. *The Psychologist* Part 1, **22**, 20-23.
- Vogel, D.L., Wade, N.G. & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counselling Psychology*, **53**, 325-337.

- Waghorn G. & Lloyd C. (2005) The employment of people with mental illness, *Australian e-Journal for the Advancement of Mental Health* **4**(2) (Supplement), 1-43.
- Wahlberg K-E, Koskinen J, Lauronen E & Isohanni M. (2005) Predictors of schizophrenia: a review. *British Medical Bulletin* **73-74**(1), 1-15
- Waldram J. (2009) Challenges of prison ethnography. *Anthropology News* **50** (1), pp: 4-5.
- Walker M. T. (2006) The social construction of mental illness and its implications for the recovery model. *International Journal of Psychosocial Rehabilitation* **10**(1), 71-87.
- Wallcraft J., Steffenb S. & Amering M. (2011) conceptual bases of psychiatry for the person, service user and family perspectives on psychiatry for the person. *The International Journal of Person Centered Medicine* **1**(1), 152-154.
- Walsh D. (1988) Delivery of Psychiatric Care to Those Mentally Ill in Ireland Proposals for Change. *Journal of the Statistical and Social Inquiry Society of Ireland* **XXV** (Part V), 147-161.
- Weaver K. & Olson, J. M. (2006) Understanding Paradigms Used for Nursing Research. *Journal of Advance Nursing* **53**(4), 459-469.
- Webb D. & Harris R (1999) *Managing People Nobody owns*. London Routledge.
- Webb M., McClelland R. & Mock G. (2002) Psychiatric services in Ireland: north and south. *Irish Journal of Psychiatric Medicine* Volume **19**(1), 21-26
- Wessely S. & Taylor P (1991) Madness and crime, criminology versus psychiatry. *Criminal Behaviour and Mental Health* **1** pp 193- 228.
- Whelan C. T., Hannan E .F. & Creighton S. (1991) *Unemployment, Poverty and Psychological distress. General Research, Series No. 150*. Economic and Social Research Institute. Dublin.
- Whelan D. (2007) Fitness for trial in the district court: the legal perspective. *Judicial Studies Institute Journal* **2**, 124.
- Whitaker R. (2010) *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. Crown Publishers New York.
- Wing J. K., Babor T., Brugha T, et al. (1994) Perceived barriers to care in St Louis and Christchurch: reasons for not seeking professional help for psychological distress. *Social Psychiatry and Psychiatric Epidemiology* **29**, 155–164.

Woods Byrne M (2005) Conducting Research as a Visiting Scientist in a Women's Prison
Journal of Professional Nursing **21**(4), Pp 223-230.

World Health Organisation (1978) *International Conference on Primary Health Care Alma-Ata USSR*. Geneva: World Health Organisation

World Health Organisation (1995) *Health in Prisons Programme (HIPPP)*. Retrieved from <http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp> on February 10th 2009.

World Health Organisation (1995) Health in Prisons Project (HIPPP). Retrieved from www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health on August 2007

World Health Organisation (2001) *Mental Health: New Understanding New Hope*. Geneva: World Health Organisation

World Health Organisation (2009) Women's health in prison, correcting gender inequity in prison health. Retrieved from www.unodc.org/documents/commissions on the September 2011

World Health Organisation (2011) Prisons and Health – facts and figures. Accessed on 27th September 2011, <http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health/facts-and-figures>

World Health Organisation (2011) WHO urges more investments, services for mental health. Retrieved from www.who.int/mental_health/who_urges_investment/en/index.html on July 30, 2011.

World Health Organization (2005), Balancing institutional and community-based mental health care. One of a series on health care issues by the European Observatory on Health Systems and Policies. Available online at: www.observatory.dk

World Health Organization, (2003) *"Historical Perspective"*, Section 3, in The Mental Health Context, Mental Health Policy and Service Guidance Package, Geneva: World Health Organisation

World Health Organization. (2003) *Mental health policy and services guidance package: Organization of services for mental health*. Geneva: World Health Organisation.

World Health Organization. (2007) *Mental health in prisons*. Retrieved from www.who.int/mental_health/policy/services/en/index.html on 14th May 2007. WHO Geneva.

World Health Organization. (2007) *WHO Health in Prisons Project in collaboration with its Collaborating Centre, UK Department of Health and the Sainsbury Centre for Mental Health*. Trenčín, Slovakia. Geneva: World Health Organisation.

Wren M-A. (2003) *Unhealthy State – Anatomy of a Sick Society*. Dublin: New Island.

Wright B. & Russell V. (2007) Integrating mental health and primary care services: a challenge for psychiatric training in Ireland. *Irish Journal of Psychological Medicine* **24**(2), 71-74

Wrigley S., Jackson H., Judd F. & Komiti A. (2005) Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australia and New Zealand Journal of Psychiatry* **39**:514–521.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health* **15**, pp 215-228.

Yin R. K. (2006) Mixed methods research: Are the methods genuinely integrated or merely parallel? *Research in the Schools*, **13**(1), 41-47.

Yourstone J., Lindholm T., Grann M. & Fazel S. (2009) Gender differences in diagnoses of mentally disordered offenders. *International Journal of Forensic Mental Health* **8**(3), 172-177

Zaph P., Roesch R. & Hart S. (1996) An Examination of the Relationship of Homelessness to Mental Disorder, Criminal Behaviour, and Health Care in a Pre-trial Jail Population. *Canadian Journal of Psychiatry* **41**, 435–440

Zwaanswijk M. (2005) Pathways to Care. Doctoral dissertation. Utrecht, University of Utrecht, Netherlands.

APPENDIX 1

School of Nursing & Midwifery
Trinity College Dublin
24, D'Olier Street
Dublin 2

Director of Healthcare
Irish Prison Service,
IDA Business Park,
Ballinalee Road, Longford,
Co. Longford

Dear Sir,

I would like to begin by introducing myself; my name is Michael Brennan, I am currently working as a lecturer in Trinity College. I am also doing my doctoral studies in Trinity College. I am writing to you seeking permission to carry out part of a PhD study into the 'Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System'. I will be supervised throughout this study by Dr Damien Brennan Lecturer in Sociology Trinity College Dublin and Prof Harry Kennedy Clinical Director of the National Forensic Mental Health Service and Senior Lecturer in Trinity College Dublin. I understand that access for the conduct of this study needs to be provided through your department and I would ask you to take this request forward for approval. If approval to access your service is granted, I then propose to approach forensic community mental health nurse's working in the inreach clinics to act as gatekeepers. This role will involve distributing an information leaflet to those who meet the inclusion criteria.

Prior to taking up my current position as a lecturer I worked as a nurse/addiction counsellor in the National Forensic Mental Health service, Central Mental Hospital. I have been attached to this service for the past twenty three years. I have a great interest in the mental health care needs of prisoners. The aim of this research is to conduct a pathways analysis of the process through which people with mental illness end up in the criminal justice system. It is also concerned with understanding the experiences of this group of people in trying to access/maintain a link with mainstream mental health services prior to incarceration.

Ethical approval for this study is currently being sought from the Faculty of Health Sciences Ethics Committee, Trinity College Dublin. The maximum care and attention has been given to protect potential participants for this study confidentiality, anonymity and privacy. At no stage will the identity of any prison participating in this study be revealed in the final report or any publications relating to this study.

I enclose an information leaflet on this study for your perusal. I would be obliged if I could arrange to meet you to discuss this project further or answer any queries which you may have.

Yours sincerely,

Michael Brennan RPN, RNT, MEd, Dip in Addiction Studies, PhD student
Lecturer, Trinity College/National Forensic Mental Health Service

Mr Michael Brennan
Lecturer, Trinity College Dublin
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APPENDIX 2

Study Information Leaflet (Director of Healthcare, Prison Governors & Gatekeepers)

Title of study:

Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System

Introduction:

Primary care is generally regarded as the first point of contact people have with the health and personal social services (DoH&C 2001, WHO 2001, DoH&C 2006). However, despite policy directives to ensure equitable mental health services, evidence exists to indicate that for many this is not the case (Lincoln & McCorry 1995, Boydell & Pong 2004, Bhugra et al 2004, Shaw 2007, Hayward & Moran 2007). Wright (2007) commented that the links between primary and secondary care within the Irish health system have been markedly underdeveloped. Penrose's law (1939), showed an inverse relationship between the number of mental hospital beds and the number of prisoners in any given society, suggesting that a reduction in psychiatric hospital beds leads to an increase of mentally ill people in the criminal justice system.

Studies have shown that the prevalence of mental illness in prisons is higher than in the general population (Singleton et al 1998, Duffy *et al.* 2003). A recent study of the extent of mental illness in prisoners revealed an incidence of psychosis among men on remand of 7.6% and among those on a sentence 2.6%. The rate of psychosis in remand prisoners is much higher than in comparable samples from abroad. This is most likely due to the fact the Republic of Ireland has had no system of court diversion until 2005. The findings also revealed 70% of prisoners were addicted to drugs or alcohol (Linehan et al 2005). WHO Health in Prisons Project (2007) draws the attention of all countries in Europe to the essential need for greater focus on mental health problems among people in custodial settings. The WHO (2007) highlighted in its 'Trencin Statement' that unless immediate action is taken, that prisons will become twenty-first Century asylums for the mentally ill, full of those who most

require treatment and care but who are held in unsuitable places with limited help and treatment available

The aim of this research is to conduct a pathways analysis of the process through which people with mental illness end up in the criminal justice system CJS. It is also concerned with understanding the experiences of this group of people in trying to access/maintain a link with mainstream mental health services prior to incarceration. It is intended to use a transformative sequential mixed methods approach to explore different aspects of the issue of pathways to care from the service users' perspective. The study is concerned with understanding the welfare of a sub-set of the population and with improving the responsiveness, efficacy and effectiveness of mental health services interventions with that population.

Research Objectives

- To explore the process through which people with mental health problems encounter the Criminal Justice System
- Identify current strengths and weaknesses in policy, protocols and service delivery for people with mental health problems within the criminal justice system.

Procedures

As a nurse/researcher who has extensive experience in mental health care I will meet with participants for approximately one hour to talk about their experiences with mental health services prior to current involvement with the criminal justice system. During the (interview/questionnaire) participants will be asked to provide some general background information. Experiences in relation to access, care and treatment provided by mental health services will also be gathered.

With the participants permission the interview (phase 1) will be audio-taped. After the interview the recording will be transcribed and analysed. Participants are entitled to see or have read to them a copy of the interview after it has been transcribed if they so wish. Phase 2 will involve completion of a questionnaire which should take approx 15-20mins. A report on this study will be submitted for publication. Findings from this study may be presented at conferences and may be the basis for the development of interventions to encourage a better understanding of mental health issues for people within the criminal justice system.

The identity of any participants or any prisons involved in this study will not be revealed in the final report or any publications relating to this study.

Who can participate in the study?

Participants are invited to participate in this study if they fulfil the following sets of criteria:

Inclusion criteria:

- Is attending the prison inreach mental health clinic
- Has been diagnosed (DSM IV TR) with a mental disorder
- Is at least 18 years old
- Is willing to voluntarily participate in the study
- Understands the purpose and process of the research and able to give informed consent

Benefits:

There are no direct benefits for the participants of this research; however there is the potential for indirect benefits which may result from the findings of this study. These may be;

- A greater understanding of the factors leading to recognition of mental health problems in this population.
- To identify individual, social and service characteristics that influence the service pathways at the time of the index allegation or offence, thus providing information for future policy and service developments.
- By mapping the care pathways for this population will establish the strengths and weaknesses of present service provision.
- A greater understanding of how and what services are provided for this population.
- The provision of more appropriate services for this population resulting in fewer people ending up in the criminal justice system.
- Reduction in the stigma of having a criminal record.

Risks:

There are no foreseeable risks to participants, however, it may address some distressing and traumatic issues for participants. It will involve reflection and possibly evoke strong emotional responses to their personal experiences with health and allied services. Throughout this study the researcher will consider carefully the possibility that the research

experience may be a disturbing one, particularly for those who are vulnerable by virtue of factors such as social status, mental illness or powerlessness and will seek to minimise such disturbances.

I am an experienced nurse/addiction counsellor having worked in the National Forensic Mental Health service, for the past twenty three years. I have extensive experience of working with people who experience mental health problems and who have offended.

In the event of a participant becoming distressed during the interview, the interviewer will acknowledge the participant's distress, stop the interview and give the participant time to consider if they wish to continue. If the participant chooses to continue, the interviewer will respect their wish and proceed sensitively. If the participant chooses not to continue, the interviewer will also respect this decision. In the event of the researcher considering that to continue with the interview would have a negative impact on the person, he will in consultation with the participant stop the interview. Should the person wish the researcher to contact and inform the person in charge of their care, he will do so. Contact details will be provided for supportive services available within the prison service e.g. AWARE, GROW, Shine, Irish Advocacy Network, Mental Health Association and other appropriate services.

Exclusion from participation:

The following criteria will exclude participation in this study:

Exclusion criteria:

- Has not been diagnosed (DSM 1V TR) with a mental illness
- Is not willing to participate in the study
- Those experiencing illness who in consultation with medical and nursing personnel are considered as too ill to give consent
- Does not understand the purpose and process of the research
- Is not able to participate or respond in the interview
- Is not under the age of 18

Confidentiality:

All information collected in this study will be treated as confidential. Participant's identity will remain confidential. A code will be assigned to interview/questionnaire data. Names will not be published and will not be disclosed to anyone. However, there are some exceptions to the

duty of confidentiality first; the welfare of the subject warrants disclosure. Second, the welfare of another person warrants disclosure. Third, the welfare of society in general is at stake. And fourth, the researcher is obliged to disclose information on foot of a court order or under legislation, for example, the Protection for Persons Reporting Child Abuse Act, 1998 (IPA Guidelines).

Voluntary Participation:

Participation in this study is voluntary. Participants may withdraw at any time. If a person decides not to participate, or if they withdraw, there will be no penalty and will not give up any benefits which they may have had before entering the study.

Compensation:

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails individuals' rights.

Funding

Fees for this study are being paid for by Trinity College, Dublin any other costs incurred will be at the expense of the researcher.

Further information:

You can get more information or answers to your questions about the study, from Michael Brennan at 01-8963950\086 0247433 or email at brennami@tcd.ie.

APPENDIX 3

LETTER TO GATEKEEPER

School of Nursing & Midwifery
Trinity College Dublin
24.D'Olier Street
Dublin 2

Date

Dear XXXXX,

Your name was provided to me by the Director of Healthcare, in the Irish Prison Service. I would like to begin by introducing myself; my name is Michael Brennan, I am currently working as a lecturer in Trinity College. I am also doing my doctoral studies in Trinity College. I am writing to you seeking permission to carry out part of a PhD study into the 'Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System'. I will be supervised throughout this study by Dr Damien Brennan lecturer in Sociology Trinity College Dublin and Prof Harry Kennedy Clinical Director of the National Forensic Mental Health Service and senior lecturer in Trinity College Dublin.

I have been granted approval to access your service for phase (X) of the study. I am contacting you for assistance in gathering potential participants for the study. This would involve you acting as a gatekeeper. This role will entails distributing an information leaflet to those who meet the inclusion criteria. The information leaflet will provide an overview of the research explaining the purpose of the study, how to participate, potential benefits and harm, data collection procedures, time commitment, voluntary participation, the right to withdraw without prejudice to care, assurance of confidentiality, and an offer from the researcher to discuss and answer any questions. An expression of interest form and a sealable envelope for potential participants to return (to the gatekeeper), indicating interest in the study, will be enclosed.

Ethical approval for this study has been granted from the Faculty of Health Sciences Ethics Committee, Trinity College Dublin. The maximum care and attention has been given to protect potential participants for this study confidentiality, anonymity and privacy. At no stage will the identity of this prison be revealed in the final report or any publications relating to this study.

I enclose a copy of the letter of ethical approval from the Faculty of Health Sciences Ethics Committee, Trinity College, Dublin and an information leaflet for your perusal. If you have any queries regarding this study or need further clarification please do not hesitate to contact me.

Yours sincerely

Michael Brennan RPN, RNT, MEd, Dip in Addiction Studies, PhD student
Lecturer, Trinity College/National Forensic Mental Health Service

Mr Michael Brennan
Lecturer, Trinity College Dublin
Course Coordinator MSc in Mental Health
brannami@tcd.ie or +353 18963950

APPENDIX 4

LETTER OF INVITATION TO POTENTIAL PARTICIPANTS

STUDY TITLE:

Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System

Dear Sir

You are invited to take part in this study because of your experiences of mental illness and mental health services available to you.

Please read the information sheet for this study and what taking part would mean.

If you wish to discuss taking part in this study, please fill in the 'Expression of Interest' form and return it as soon as possible to the forensic community mental health nurse in the self addressed envelope provided? You will then be contacted by me to discuss the study and answer any questions you may have. If you decide not to take part in this study, you will not be contacted any more regarding this matter.

Yours sincerely,

Michael Brennan,
Researcher.

APPENDIX 5

Study Information Sheet - Participants

Study Title:

Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System

Introduction

You are invited to take part in this study because of your experiences of mental illness and mental health services available to you. The aim of this study is to explore the process through which people with mental illness end up in the criminal justice system. It is also concerned with understanding your experiences in trying to access or maintain a link with mental health services before this period in prison.

Plan

A nurse with vast experience in mental health care will meet with you for about one hour to talk about your experiences with mental health services prior to your current period of imprisonment. During the interview you will be asked for some general background information. You will then be asked to describe your experiences in relation to access, care and treatment provided by mental health services.

Taking part in this study is completely of your own free will and you may withdraw at any time. If you decide not to take part, or withdraw there will be no draw backs and it will not affect any benefits you had before entering the study. The interview will be tape recorded with your say so and then written out word for word. This copy of the interview will have no information that could identify you or anybody or place you may mention. You are entitled to access the recordings or to see or have read to you a copy of the interview after it has been written out if you wish. All of this information will be stored in a locked press in the researcher's office. A report of this study may be submitted for publication and/or presentation at conferences. The identity of any participants or any

individual prison taking part in this study will NOT be revealed in the final report or any publications relating to this study. The findings of the interviews will be used to develop a questionnaire. This questionnaire will be given to people with mental illnesses attending inreach mental health clinics in prisons around Ireland.

Who can take part in this study?

You are invited to take part in this study if you meet the following set of terms:

- Has been diagnosed with a mental disorder (DSM IV TR) and has been informed of that diagnosis
- Is willing to take part of your own free will in the study
- Understands the aim and process of the study and is able to give informed consent
- Is attending the prison inreach mental health clinic
- Is over the age of 18 years

Benefits:

There are no direct benefits for people taking part in this study; however there is the possibility for indirect benefits. These may be;

- A greater understanding of the factors leading to recognition of mental health problems in this group.
- To identify trends that may influence service pathways before being involved with the criminal justice system, thus providing information for future policy and mental health service developments.
- By mapping the care pathways for this group will establish the strengths and weaknesses of present service provision.
- A greater understanding of how and what services are provided for this group.
- The provision of more suitable mental health services for this group resulting in fewer people ending up in the criminal justice system.
- Reduce the stigma of having a criminal record.

Risks:

There are no known risks to you if you choose to take part in this study. Sometimes however talking about your own experiences of mental illness, effects on family and trying to access care may be upsetting. At all times your welfare will be the main concern over the study. You may decide to stop the interview at any time. The interview can start again at another time if that suits you. Information about support services available within the prison will be provided

if you require them e.g. AWARE, GROW, Shine, Mental Health Association and/or other services within the prison.

Who cannot take part?

You cannot be in this study if any of the following are true:

- Has not been diagnosed with a mental illness (DSM IV TR)
- Is not willing to take part in the study
- Does not understand the aim and process of the study
- Is not able to take part or respond in the interview
- Is under the age of 18 years

Confidentiality:

All information collected in this study will be treated as confidential. Your identity will remain confidential. A code will be assigned to your interview notes. If you wish to do so, you may have access to a copy of your interview. Your name will not be published and will not be disclosed to anyone. However, there are some exceptions to the duty of confidentiality first; the welfare of the person taking part demands informing a suitable carer. Second, the welfare of another person demands disclosure of information given. Third, the welfare of society in general is at stake. And fourth, the researcher is obliged to disclose information on foot of a court order or under legislation, for example, the Protection for Persons Reporting Child Abuse Act, 1998 (IPA Guidelines).

Interviews will be conducted in a private office within that prison. However, due to the nature of the environment the interview must be held in view of a prison officer at all times to ensure a safe environment. Thus, a prison officer will be outside the office but will be unable to hear the content of the interview.

Voluntary Participation:

Your involvement in this study is totally of your own free will. If you decide not to take part, or withdraw there will be no drawbacks and it will not affect any benefits you had before entering the study.

Compensation:

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Funding

Fees for this study are being paid for by Trinity College, Dublin any other costs incurred will be at the expense of the researcher.

Further information:

I will be in contact with you in at least seven days time. If you would like more information or answers to your questions about the study, what it means to take part in this study, and your rights I will do so then. Before I make contact I will need to have received an 'Expression of Interest' form which is enclosed.

APPENDIX 6

EXPRESSION OF INTEREST (POTENTIAL PARTICIPANTS PHASE 1)

STUDY TITLE:

Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System

Name (Block Capitals) _____

I wish to be contacted to discuss taking part in this study.

I can be contacted. I am aware that by agreeing to discuss this study with the researcher, I am not consenting to take part in it.

Signature: _____

APPENDIX 7

INFORMED CONSENT FORM

STUDY TITLE:

Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System

RESEARCHER: Michael Brennan

BACKGROUND

You are invited to take part in this study because of your experiences of mental illness and mental health services available to you. The aim of this study is to explore the process through which people with mental illness end up in the criminal justice system. It is also concerned with understanding your experiences in trying to access or maintain a link with mental health services before this period in prison.

Taking part in this study is completely of your own free will and you may withdraw at any time. If you decide not to take part, or withdraw there will be no drawbacks and it will not affect any benefits you had before entering the study. The interview will be tape recorded with your say so and then written out word for word. This copy of the interview will have no information that could identify you or anybody or place you may mention. You are entitled to access the recordings or to see or have read to you a copy of the interview after it has been written out if you wish. All of this information will be stored in a locked press in the researcher's office.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME

CONTACT DETAIL

PARTICIPANT'S SIGNATURE:

Date

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE: **Date**.....

ENCOUNTER FORM: PATHWAYS TO CARE (Contd..)

D: THE SECOND CARER

- i. Who was seen? ii. How long ago? weeks
 (a.g. native/religious healer, general practitioner, community/specialist nurse, osteopath, acupuncturist, alternative medicine, health visitor, social worker, police, solicitor or legal representative, court of law, priest, hospital doctor, psychiatric services) (first occasion)
- iii. who made the referral to the second carer?
 (this may be the patient)
- iv. What was the main problem presented?
- v. What was the main treatment offered?
 (if any, state; if none, say so)
- vi. Duration of patient's first journey to carer? hours mins

FOR CODER'S USE ONLY

| | | | |
|---|--|--|---------|
| D | | | (34-35) |
| | | | (36-38) |

| | | | |
|--|--|--|---------|
| | | | (39) |
| | | | (40-41) |
| | | | (42-43) |
| | | | (44-46) |

E: THE THIRD CARER

- i. Who was seen? ii. How long ago? weeks
- iii. who made the referral to the third carer?
 (this may be the patient)
- iv. What was the main problem presented?
- v. What was the main treatment offered?
 (if any, state; if none, say so)
- vi. Duration of patient's first journey to carer? hours mins

| | | | |
|---|--|--|---------|
| E | | | (47-48) |
| | | | (49-51) |
| | | | (52) |
| | | | (53-54) |
| | | | (55-56) |
| | | | (57-59) |

F: THE THIRD CARER

- i. Who was seen? ii. How long ago? weeks
- iii. who made the referral to the fourth carer?
 (this may be the patient)
- iv. What was the main problem presented?
- v. What was the main treatment offered?
 (if any, state; if none, say so)
- vi. Duration of patient's first journey to carer? hours mins

| | | | |
|---|--|--|---------|
| F | | | (60-61) |
| | | | (62-64) |
| | | | (65) |
| | | | (66-67) |
| | | | (68-69) |
| | | | (70-72) |

G: MENTAL HEALTH PROFESSIONAL'S ICD-10 DIAGNOSIS

- i. First diagnosis:
- ii. Second diagnosis (if any):
 (this is addition, NOT alternative!)

| | | | | | |
|---|--|--|--|--|---------|
| G | | | | | (73-76) |
| | | | | | (77-80) |

Filled in by(initials) on (date) Coded by(initials) on (date)

Permission to use Pathways to Encounter Form

From: Richard Gater [richard.gater@btinternet.com]
Sent: 07 May 2009 20:56
To: brennami@tcd.ie
Subject: Pathways to Care Encounter Form
Attachments: ENCOUNTER FORMS.doc; PATHWAYS PACK MAR 04.doc

Dear Michael,

As soon as I returned from leave, Wendy Gregson passed on your messages asking about using the Pathways Encounter form. There is no problem, and you can use the form. I've attached a couple of Word files that you may find useful. The form was developed for the WHO study of Pathways to Care (Psych Med, 1991, 21, 761-774) and was intended as a quick study to generate useful information at relatively little expense. It was piloted but not formally tested, and I'm not aware of any validity or reliability studies.

Best wishes

Richard Gater

APPENDIX 9

Pathways to Encounter Form – Professor Agnes Higgins

SECTION A

Name of the Study:

"Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System"

This study is about how people with mental health problems made contact with mental health services before being in prison.

I would like to hear your story of what services you were in touch with about your mental health problems and what that experience was like.

This form will take 10-15 minutes to fill in.

Thank you for your time.

I want to fill in this form

Yes

No

Witness's Signature

SECTION B

Demographic Information

B1. GENDER: (Circle one)

- 1 - Male
- 2 - Female

B2. MARITAL STATUS: (Circle one number)

- 1 - Married /living with someone as married
- 2 - Divorced or annulled
- 3 - Separated
- 4 - Widowed
- 5 - Never married

Comment [u1]: Very heterosexual focused what about if I have been in a ~~same sex~~ relationship, or was married as a same sex partner overseas and was living with the person in ~~question~~

Do you want to ask about what country they are from or were in before

B3. AGE RANGE (Circle one number)

- 1. 18-25
- 2. 26-35
- 3. 36-45
- 4. 46-55
- 5. 56+

B4. LIVING CIRCUMSTANCES

At the time you developed psychiatric symptoms (this episode) what were your living circumstances? (Circle one number)

- 1 - Living with family of origin
- 2 - Living with others (not spouse/partner)
- 3 - Living in sheltered care
- 4 - Homeless
- 5 - Living with spouse/partner
- 6 - Living on own in apartment, home, etc.
- 7 - In Prison
- 8 - Other _____

Comment [u2]: There seems to be 2 questions here one who they were living with and where in terms of types of accommodation I would separate what about living in rented accommodation, or living in housing provided by state

Do you want to know anything about their income or source of income before age; alarv. disability etc

B5. EDUCATION

4. Highest level of education (select from codes below):

- 1. Primary School
- 2. Secondary school successfully completed leaving certificate
- 3. Secondary school Unsuccessfully completed leaving certificate
- 4. Secondary school didn't take leaving certificate
- 5. Apprenticeship successfully completed
- 6. Apprenticeship course Unsuccessful didn't complete
- 7. Attended University Graduated with Diploma
- 8. Attended University Graduated with a primary Degree
- 9. Attended University Graduated with a masters Degree
- 10. Attended university, didn't graduate
- 11. Other: _____

Were you still enrolled in education programme as of the onset of mental health problem?
(Circle yes or no)

NO - Finished level of education (see question 4) prior to onset of mental illness.

Indicate approximate date of completion ____/____/____

YES --was still enrolled in school at time of onset of psychosis (Circle 1 or 2):

1 - STOPPED attending education programme, last date of attendance ____/____/____

Year when quit* _____

2 - CONTINUED attending education programme after onset of mental illness *refers to number of years in school

B6. OCCUPATION

Did you hold a salaried job before coming into prison? (Circle YES or NO)

YES (Circle 1 or 2) 1 - FULL TIME

2 - PART TIME, average hours per week: _____

a) Current occupation _____

NO If not you EVER held a salaried job? (Circle 1, 2, or 3)

1 - FULL TIME Date last worked full time: ____/____/____

2 - PART TIME Date last worked part time: ____/____/____

3 - NONE Never held salaried employment.

B7. PRISON CIRCUMSTANCES

7. Are you currently on remand? Yes No

8. Are you currently serving a sentence? Yes No
(If so for how long) _____

9. Are you currently receiving help for your mental illness Yes.....No

9 (A) if yes list types of help you are receiving _____

6. Is this prison close to your place of abode Yes No

SECTION C

QUESTIONS ABOUT PATHWAYS TO CARE

I'd like to ask you some questions about your contact with mental health services prior to current committal:

C1. How long ago did you first come into contact with psychiatric services?

weeks / months / years

___ / ___ / ___

C2. Were you regularly seeing someone from the mental health services before committal to prison?

1. Yes
2. No

C3. What were the main problems that that caused you make contact with mental health services?

Record verbatim:

C3 i) C3 ii) C3 iii)

**C4. IF MORE THAN ONE PROBLEM: Which of these is most important?
(This is now the main problem)**

C2

C5. How long ago did this main problem begin?

weeks / months / years

__ / __ / __

C3

| | | |
|--|--|--|
| | | |
|--|--|--|

C6. How long ago is it since you first saw someone about this (main problem)?

weeks / months / years

__ / __ / __

C4

| | | |
|--|--|--|
| | | |
|--|--|--|

FIRST CARER

C7. What kind of person did you first see about _____ (MAIN PROBLEM)

Circle ONE only

- | | | |
|---|---------------------------|------------------------------------|
| 1 | GP | 6. Hospital doctor (not A&E) |
| 2 | Social worker | 7. <u>Alternative Practitioner</u> |
| 3 | Psychiatric services | 8. Prison Doctor |
| 4 | Casualty Department (A&E) | 9. Counsellor |
| 5 | Psychologist | 10. Priest/minister |
| | | 11. Psychiatric services (Prison) |
| | | 12. Other _____ |

C7

| |
|--|
| |
|--|

Comment [u3]: What does this mean

C8. Who suggested that you get help from _____ (CARER NAMED IN C7)

Circle ONE only

1. Self
2. Family
3. Friend
4. Employer/work colleague
5. Teacher
6. Prison Staff

7. Solicitor
8. Gardai
9. Other _____

C8

C9. What was the main treatment offered by _____ (CARER NAMED IN C7)

Circle UP TO THREE only

- | | | |
|------------------------------------|-------------------------------|---------------------------------|
| 1. Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2. Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine |
| 3. Practical aid | 8. Antidepressant drug | 13. Referral |
| 4. Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Other _____ |
| 5. Prayer/spiritual support | 10. Mood stabilizer (lithium) | 15. Don't know |

16. **ADMISSION (END OF PATHWAY)**

C9 i)

C9 ii)

C9 iii)

SECOND CARER

C10. What kind of person did you see next about _____ (MAIN PROBLEM)

Circle ONE only

- | | |
|------------------------------|-----------------------------------|
| 1. GP | 6. Hospital doctor (not A&E) |
| 2. Social worker | 7. Alternative Practitioner |
| 3. Psychiatric services | 8. Prison Doctor |
| 4. Casualty Department (A&E) | 9. Counsellor |
| 5. Psychologist | 10. Priest/minister |
| | 11. Psychiatric services (Prison) |
| | 12. Other _____ |

C10

C11. Who referred you to see _____ (CARER NAMED IN C10)

Comment [u4]: What about peer support group eg grow aware

Comment [u5]: Do you want to know if people are in receipt of disability benefit

Comment [u6]: Not sure what you mean, is it just drugs

Circle ONE only

1. First carer (C7)
2. Self
3. Family
4. Friend
5. Employer/work colleague
6. Teacher
7. Prison Staff
8. Solicitor
9. Gardai
10. Other _____

C11

C12. How long ago did you first see__ (CARER NAMED IN C10)?

weeks / months / years

____ / ____ / ____

C12

C13. What was the main treatment offered by _____ (CARER NAMED IN C10)

Circle UP TO THREE only

- | | | |
|------------------------------------|-------------------------------|--------------------------|
| 1. Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2. Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine |
| 3. Practical aid | 8. Antidepressant drug | 13. Referral |
| 4. Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Other _____ |
| 5. Prayer/spiritual support | 10. Mood stabilizer (lithium) | 15. Don't know |

1. ADMISSION (END OF PATHWAY)

C13 i)

C13 ii)

C13 iii)

THIRD CARER

C11. What kind of person did you see next about _____ (MAIN PROBLEM)

Circle ONE only

- | | |
|-------|------------------------------|
| 1. GP | 6. Hospital doctor (not A&E) |
|-------|------------------------------|

Comment [u7]: What does this mean

- | | |
|-----------------------------|-----------------------------------|
| 2 Social worker | 7. Alternative Practitioner |
| 3 Psychiatric services | 8. Prison Doctor |
| 4 Casualty Department (A&E) | 9. Counsellor |
| 5 Psychologist | 10. Priest/minister |
| | 11. Psychiatric services (Prison) |
| | 12. Other _____ |

C11

C12. Who referred you to see ____ (CARER NAMED IN C7)

Circle ONE only

1. First carer (C7)
2. Second carer
3. Self
4. Family
5. Friend
6. Employer/work colleague
7. Teacher
8. Prison Staff
9. Solicitor
10. Gardai
11. Other _____

C12

C13. How long ago did you first see __ (CARER NAMED IN C11)?

weeks / months / years

__ / __ / __

C13

C14. What was the main treatment offered by _____ (CARER NAMED IN C11)

Circle UP TO THREE only

- | | | |
|------------------------------------|-------------------------------|--------------------------|
| 1. Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2. Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine |
| 3. Practical aid | 8. Antidepressant drug | 13. Referral |
| 4. Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Other _____ |
| 5. Prayer/spiritual support | 10. Mood stabilizer (lithium) | 15. Don't know |

C14 i)

C14 ii)

C14 iii)

FOURTH CARER

C11. What kind of person did you see next about _____ (MAIN PROBLEM)

Circle ONE only

- | | |
|-----------------------------|-----------------------------------|
| 1 GP | 6. Hospital doctor (not A&E) |
| 2 Social worker | 7. Alternative Practitioner |
| 3 Psychiatric services | 8. Prison Doctor |
| 6 Casualty Department (A&E) | 9. Counsellor |
| 5 Psychologist | 10. Priest/minister |
| | 11. Psychiatric services (Prison) |
| | 12. Other _____ |

C11

C12. Who referred you to see _____ (CARER NAMED IN C7)

Circle ONE only

1. First carer (C7)
2. Second carer
3. Third Carer
4. Self
5. Family
6. Friend
7. Employer/work colleague
8. Teacher
9. Prison Staff
10. Solicitor
11. Gardai
12. Other _____

C12

C13. How long ago did you first see__ (CAREER NAMED IN C11)?

weeks / months / years

__ / __ / __

C13

| | | |
|--|--|--|
| | | |
|--|--|--|

C14. What was the main treatment offered by ____ (CAREER NAMED IN C11)

Circle UP TO THREE only

- | | | |
|------------------------------------|-------------------------------|--------------------------|
| 1. Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2. Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine |
| 3. Practical aid | 8. Antidepressant drug | 13. Referral |
| 4. Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Other _____ |
| 5. Prayer/spiritual support | 10. Mood stabilizer (lithium) | 15. Don't know |

C14 i)

C14 ii)

C14 iii)

APPENDIX 10

Pathways Questionnaire – Liz Brosnan

From: Liz.Brosnan [Liz.Brosnan@ul.ie]
Sent: 09 August 2010 12:17
To: Michael Brennan
Subject: RE: Pathways questionnaire

Hi Micheal

I was trying to call you, as it took longer that I wanted to find this email again, I don't seem to have an mobile that works for you. (mine again 0877779551

Anyway now I'm here I'll make some comments or observations I had, especailly on section c. I'm interested to see your use of the term carer. Have you defined it on the questionnaire, so that there is no confusion when you begin to analyse the results?

There was some mixing up of question numbers in that section, but apart from that it seems like a comprehensive information gathering question and worth repeating as you do.

Also I thought question B5 re education is a bit confusing. Maybe seperating out yes /no answers more clearly, eg if yes then was it a or b, and if no, when? (and next question perhaps the same.) Also you slip in the term psychosis there in middle of that questionB5 ,whereas along you'd used the term mental illness.

My main observation and thought provoking point is your use of the term carer.

I don't think it's inappropriate at all, but can see it being something that family members might bridle at, as they sometimes present as more benign than controlling, and it has the association of being a voluntary role, whereas the professional is not termed a carer usually, even though they are, some would claim healer too. The fact that they can prescribe and give out medications within their role makes the 'carer' aspect more transparent.

No more than the term service user, it is a highly contested term carer. which is why I suggest you define it as you intend to use it.

Hope my comments are helpful, sorry about the delay, I've been taking time off, before I start my own data collection process in September.

Good luck with it all

Best Regards

Liz

Liz Brosnan

ISSP Government of Ireland Scholar

F114

Department of Sociology

University of Limerick

Republic of Ireland

Phone 35361 2347778

APPENDIX 11

Pathways to Mental Healthcare Encounter Form Used

SECTION A

Name of the Study:

"Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System"

This study is about how people with mental health problems made contact with mental health services before being in prison.

I would like to hear your story of what services you were in touch with about your mental health problems and what that experience was like.

This form will take 10-15 minutes to fill in.

Thank you for your time.

I want to fill in this form

Yes

No

Witness's Signature

PATHWAY TO CARE ENCOUNTER FORM

SECTION B
Demographic Information

B1. GENDER: *(Circle one)*

- 1 - Male
- 2 - Female

B2. MARITAL STATUS : *(Circle one number)*

- 1 - Married /living with someone as married
- 2 - Single
- 3 - Same sex relationship
- 4 - Separated
- 5 - Divorced or annulled
- 6 - Widowed
- 7 - Never married

B3. AGE RANGE *(Circle one number)*

- 1. 18-25
- 2. 26-35
- 3. 36-45
- 4. 46-55
- 5. 56+

B4. LIVING CIRCUMSTANCES

B4. (a) At the time you developed psychiatric symptoms (this episode) what were your living circumstances? *(Circle one number)*

- 1 - Living with family of origin
- 2 - Living with others (not spouse/partner)
- 3 - Living in sheltered care
- 4 - Homeless
- 5 - Living with spouse/partner
- 6 - Living on own in apartment, home, etc.
- 7 - In Prison
- 8 - Other _____

B4. (b) Did your living conditions change at this time? *(Circle one)* Yes No

B4. (c) Have you ever been the subject of a barring/protection order Yes No

B5. (a) EDUCATION

Highest level of education *(select from codes below):*

- 1. Primary School
- 2. Secondary school successfully completed junior certificate
- 3. Secondary school successfully completed Leaving certificate
- 4. Secondary school Unsuccessfully completed junior certificate.
- 5. Secondary school Unsuccessfully completed leaving certificate Leaving certificate
- 6. Secondary school didn't take leaving certificate
- 7. Apprenticeship successfully completed
- 8. Apprenticeship course Unsuccessful/didn't complete
- 9. Attended University Graduated with Diploma
- 10. Attended University Graduated with a primary Degree
- 11. Attended University Graduated with a masters Degree
- 12. Attended university, didn't graduate
- 13. Other: _____

B5. (b) Were you still enrolled in education programme as of the onset of mental health problem? *(Circle yes or no)*

PATHWAY TO CARE ENCOUNTER FORM

NO - Finished level of education prior to onset of mental illness.

Indicate approximate date of completion ____/____/____

YES - was still enrolled in education programme at time of onset of illness (Circle 1 or 2):

1 - STOPPED attending education programme, last date of attendance ____/____/____

2 - CONTINUED attending education programme after onset of mental illness

B5. (c) Were you ever expelled from school (Circle YES or NO) Yes No

B6. OCCUPATION

Did you hold a paid job before coming into prison? (Circle YES or NO)

YES (Circle 1 or 2) 1 - FULL TIME

2 - PART TIME

a) Current occupation _____

b) Can you go back to your job when you leave prison Yes No

NO If not have you EVER held a paid job? (Circle 1, 2, or 3)

1 - FULL TIME

2 - PART TIME

3 - NONE (Never held paid employment)

B6 (b) did you ever loose a job due to your mental health problem Yes No

B6. (c) If answer No to B6 (3) above were you in receipt of disability benefit Yes No

B7. PRISON CIRCUMSTANCES

7. Are you currently on remand? Yes No

8. Are you currently serving a sentence? Yes No
(If so for how long) _____

9. Are you currently receiving help for your mental illness Yes.....No?

9 (A) if yes list types of help you are receiving _____

6. Is this prison close to your place of abode Yes No

PATHWAY TO CARE ENCOUNTER FORM

SECTION C

QUESTIONS ABOUT PATHWAYS TO CARE

I'd like to ask you some questions about your contact with mental health services prior to current committal:

C1. How long ago did you first come into contact with psychiatric services?

Weeks / months / years

____ / ____ / ____

C1

C2. Were you regularly seeing someone from the mental health services before committal to prison?

1. Yes

2. No

C2

C3. What were the main problems that caused you make contact with mental health services?

Record verbatim:

C3 i)

C3 ii)

C3 iii)

PATHWAY TO CARE ENCOUNTER FORM

**C4. IF MORE THAN ONE PROBLEM: Which of these is most important?
(This is now the main problem)**

C4

C5. How long ago did this main problem begin?

Weeks / months / years

_____ / ____ / ____

C5

C6. How long ago is it since you first saw someone about this (main problem)?

Weeks / months / years

_____ / ____ / ____

C6

FIRST CONTACT

C7. What kind of person did you first see about _____ (MAIN PROBLEM)

Circle ONE only

- | | | |
|---|---------------------------|-----------------------------------|
| 1 | GP | 7. Hospital doctor (not A&E) |
| 2 | Social worker | 8. Alternative Practitioner** |
| 3 | Psychiatric services | 9. Prison Doctor |
| 4 | Casualty Department (A&E) | 10. Counsellor |
| 5 | Psychologist | 11. Priest/minister |
| 6 | Self help group | 12. Psychiatric services (Prison) |
| | | 13. Other _____ |

C7

** (Relaxation, faith healer, massage therapy etc)

PATHWAY TO CARE ENCOUNTER FORM

C8. Who suggested that you get help from ____ (CONTACT NAMED IN C7)

Circle ONE only

1. Self
2. Family
3. Friend
4. Employer/work colleague
5. Teacher
6. Prison Staff
7. Solicitor
8. Gardai
9. Other _____

C8

C9. What was the main treatment offered by _____ (CONTACT NAMED IN C7)

Circle UP TO THREE only

- | | | |
|------------------------------------|-------------------------------|------------------------------|
| 1. Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2. Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine *** |
| 3. Support group | 8. Antidepressant drug | 13. Referral |
| 4. Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Psycho education |
| 5. Prayer/spiritual support | 10. Mood stabilizer (lithium) | 15. Don't Know |

Other _____

*** Herbal etc

C9 i)

C9 ii)

C9 iii)

SECOND CONTACT

C10. What kind of person did you see next about _____ (MAIN PROBLEM)

Circle ONE only

- | | | |
|------------------------------|--------------------------------|---------------------------------|
| 1. GP | 6. Hospital doctor (not A&E) | 11. Prison Psychiatric Services |
| 2. Social worker | 7. Alternative Practitioner ** | 12 Other _____ |
| 3. Psychiatric services | 8. Prison Doctor | |
| 4. Casualty Department (A&E) | 9. Counsellor | |
| 5. Psychologist | 10 Priest/minister | |

** (Relaxation, faith healer, massage therapy etc)

C10

PATHWAY TO CARE ENCOUNTER FORM

C11. Who referred you to see _____ (CONTACT NAMED IN C10)

Circle ONE only

1. First Contact (C7)
2. Self
3. Family
4. Friend
5. Employer/work colleague
6. Teacher
7. Prison Staff
8. Solicitor
9. Gardai
10. Other _____

C11

C12. What was the main treatment offered by _____ (CONTACT NAMED IN C10)

Circle UP TO THREE only

- | | | |
|------------------------------------|-------------------------------|------------------------------|
| 1. Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2. Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine *** |
| 3. Support group | 8. Antidepressant drug | 13. Referral |
| 4. Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Psycho education |
| 5. Prayer/spiritual support | 10. Mood stabilizer (lithium) | 15. Don't Know |

Other _____

*** Herbal etc

C12 i)

C12 ii)

C12 iii)

THIRD CONTACT

C13. What kind of person did you see next about _____ (MAIN PROBLEM)

Circle ONE only

- | | |
|------------------------------|----------------------------------|
| 1. GP | 6. Hospital doctor (not A&E) |
| 2. Social worker | 7. Alternative Practitioner** |
| 3. Psychiatric services | 8. Prison Doctor |
| 6. Casualty Department (A&E) | 9. Counsellor |
| 5. Psychologist | 10. Priest/minister |
| | 11. Psychiatric services(Prison) |

PATHWAY TO CARE ENCOUNTER FORM

12 Other _____

C13

** (Relaxation, faith healer, massage therapy etc)

C14. Who referred you to see ____ (CONTACT NAMED IN C13)

Circle ONE only

1. First Contact (C7)
2. Second Contact (10)
3. Self
4. Family
5. Friend
6. Employer/work colleague
7. Teacher
8. Prison Staff
9. Solicitor
10. Gardai
11. Other _____

C14

C15. What was the main treatment offered by ____ (CONTACT NAMED IN C13)

Circle UP TO THREE only

- | | | |
|------------------------------------|-------------------------------|------------------------------|
| 1. Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2. Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine *** |
| 3. Support group | 8. Antidepressant drug | 13. Referral |
| 4. Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Psycho education |
| 5. Prayer/spiritual support | 10. Mood stabilizer (lithium) | 15. Don't Know |

Other _____

*** Herbal etc

C15 i)

C15 ii)

C15 iii)

PATHWAY TO CARE ENCOUNTER FORM

FOURTH CONTACT

C16. What kind of person did you see next about _____ (MAIN PROBLEM)

Circle ONE only

- | | |
|-----------------------------|-----------------------------------|
| 1 GP | 6. Hospital doctor (not A&E) |
| 2 Social worker | 7. Alternative Practitioner ** |
| 3 Psychiatric services | 8. Prison Doctor |
| 7 Casualty Department (A&E) | 9. Counsellor |
| 5 Psychologist | 10. Priest/minister |
| | 11. Psychiatric services (Prison) |
| | 12. Other _____ |

C16

** (Relaxation, faith healer, massage therapy etc)

C17. Who referred you to see _____ (CONTACT NAMED IN C16)

Circle ONE only

1. First Contact (C7)
2. Second Contact (10)
3. Third Contact (14)
4. Self
5. Family
6. Friend
7. Employer/work colleague
8. Teacher
9. Prison Staff
10. Solicitor
11. Gardai
12. Other _____

C17

C18. What was the main treatment offered by _____ (CONTACT NAMED IN C16)

Circle UP TO THREE only

- | | | |
|-----------------------------------|-------------------------------|------------------------------|
| 1 Treatment of physical illness | 6. Nerve tablets unknown | 11. Anticonvulsant |
| 2 Counselling/discussion | 7. Sedatives/sleeping tablets | 12. Alternative medicine *** |
| 3 Support group | 8. Antidepressant drug | 13. Referral |
| 4 Cognitive/behavioural treatment | 9. Antipsychotic drug | 14. Psycho education |

PATHWAY TO CARE ENCOUNTER FORM

5. Prayer/spiritual support

10. Mood stabilizer (lithium)

15. Don't Know

Other _____

*** Herbal etc

C18 i)

C18 ii)

C18 iii)

Thank you for your time.

APPENDIX 12

Ethical Approval from TCD



THE UNIVERSITY OF DUBLIN
TRINITY COLLEGE

SCHOOL OF MEDICINE
FACULTY OF HEALTH SCIENCES

Professor Dermot Kelleher, MD, FRCPI, FRCP, F Med Sci
Head of School of Medicine
Vice Provost for Medical Affairs
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Mr Michael Brennan,
School of Nursing and Midwifery,
24 D'Olier St.,
Dublin 2

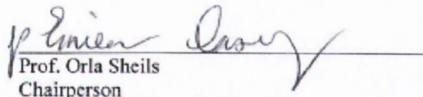
Wednesday, 21 October 2009

Study: Pathways to care of people with mental health problems within the Irish Criminal Justice System

Dear Applicant (s),

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in June 2009, we are pleased to inform you that the above project has been approved without further audit.

Yours sincerely


Prof. Orla Sheils
Chairperson
Faculty of Health Sciences Ethics Committee

Cc
Dr Damien Brennan
School of Nursing and Midwifery,
24 D'Olier St.,
Dublin 2

Prof Harry Kennedy
National Forensic Psychiatric Service
Central Mental Hospital,
Dundrum Road,
Dublin 14

Schools of the Faculty: Medicine, Dental Science, Nursing and Midwifery, Pharmacy and Pharmaceutical Sciences

APPENDIX 13

Ethical Approval from Irish Prison Service

Seirbhís Phríosúin na hÉireann
Ceanncheathrú
Lárionad Gnó an IDA
Bóthar Bhéal Átha na Lao
An Longfort
Co. an Longfoirt



Irish Prison Service HQ
IDA Business Park
Ballinalee Road
Longford
Co. Longford

Láithreán gréasáin/Website: www.irishprisons.ie
Ríomhphoist/Email: info@irishprisons.ie

Teilifón/Telephone: (043) 333 5100
Facs/Fax: (043) 333 5101

Mr Michael Brennan
4 The Priory
Trim
Co Meath

Dear Mr Brennan

Re: Research - "Pathways to Care of People with Mental Health Problems within the Irish Criminal Justice System"

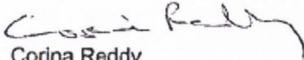
Your application to carry out the above research project was considered by the Prisoner Based Research Ethics Committee and by the Director General of the Irish Prison Service.

I am pleased to advise you that the research application has been approved. **A condition of approval is that IPS requires a copy of the research when it is completed and certainly prior to any publication.**

Please provide a copy of this letter to the Governor of the institution/s that you wish to visit as entry to the prison/institution for the purpose of the study is contingent on the agreement of individual governors and appropriate security clearance.

** Please note that the Governor must be contacted in advance of your proposed attendance at the prison/institution.*

Yours sincerely


Corina Reddy
Secretary
Prisoner Based Research Ethics Committee

06 October 2009

APPENDIX 14

IPS-Exceptions to Confidentiality

The **Research Ethics Committee of the Irish Prison Service** recommend that, because of the complexity of ethical issues that can be encountered, **researchers should consult their supervisors or colleagues about ethical issues**. This should occur in the planning stage, throughout the project, and in particular when ethical problems present themselves. The following principles should apply when a specific problem presents itself in the course of a project: **Supervisees** should consult with supervisor and/or appropriate groups and committees if faced with a difficult situation or apparent conflict. They should seek consensus on the most ethical course of action and the most responsible, knowledgeable and effective, and respectful way to carry it out. It is expected that a **Supervisor** assumes overall ethical responsibility for the scientific and professional activities of those (students, trainees, assistants, supervisees) whose research work they supervise. The responsibility includes monitoring of researchers' activity, and making them aware of the ethical principles involved.

Exceptions to Confidentiality

I. Whenever possible information should only be shared with the agreement of the subject. The consent must be a fully informed consent and must have been given voluntarily.

II. Where the subject lacks the capacity to consent to information being shared any sharing should be on the following basis:

The level of need and dependency

The nature and degree of assessed risk

The relevance of the information to ensuring that the subject receives the appropriate level of care, treatment and support

III. Where the subject has capacity but disagrees, information sharing will take place only on the following basis:

There is a serious risk of harm to the subject. Only the most compelling circumstances could justify a researcher acting contrary to the subject's perceived interests in the absence of consent. It remains the researcher's duty to make every responsible effort to persuade the subject to allow the information to be given. It is ethical to break confidentiality without a subject's consent when it is in his/her own interests to do so, for example in the case of suicidal intent. In such a case relevant authorities, for example, the governor and medical personnel should be informed.

There is serious risk of harm to others: The researcher may be confronted with allegations of child abuse by a subject. The researcher must have formed an opinion that a child is or has been assaulted, ill treated, neglected or sexually abused, or that the child's health, development or welfare is or has been avoidably impaired or neglected. A clinical decision regarding such allegations should be made in consultation with responsible authorities.

And if the disclosure is necessary to prevent or detect serious crimes against the person and the need to disclose is so serious as to warrant a breach of personal confidentiality. This dilemma may be posed by the possibility of violent crime. The researcher who decides to communicate should discriminate and ensure that the recipient is a responsible appropriate authority. In the prison setting this implies a designated responsible authority, for example, governor, psychologist, or psychiatrist. The risk of harm must be proved to be real before information can be disclosed, the threat must be serious and the potential victim must be readily identifiable. Where significant risk to others is indicated, information relevant to managing such risk will be shared on a 'need to know' basis.

The subject should be informed of this decision to disclose unless this places the researcher at risk.

The following exceptions to the duty of confidentiality are considered important in the prison context. First, the welfare of the subject warrants disclosure. Second, the welfare of another person warrants disclosure. Third, the welfare of society in general is at stake. And fourth, the researcher is obliged to disclose information on foot of a court order or under legislation, for example, the Protection for Persons Reporting Child Abuse Act, 1998.

APPENDIX 15

SEMI-STRUCTURED INTERVIEW GUIDE (PHASE 1)

Icebreaker/Background information

- Tell me about yourself?
- Tell me about growing up?
- Can you tell me about how you came to be in prison
- I'm aware that you are attending the prison in reach clinic about your mental health problem(s) can you tell me about this?

Experiences of contact with mental health services prior to entering prison

- Did you make contact with mental health services before you went into prison
- If yes can you tell me about ...?
 - Who helped you make contact with services
 - Who did you see about your mental health problem(s)?
 - What sort of treatment(s) you were offered
 - Can you tell me about the treatment(s) provided for your mental health problem(s)
- If no, can you tell me...?
 - If you think you should have made contact with mental health services
 - What do you think are the reasons why you didn't make contact?
 - What in your opinion may be the barriers to making contact with services to deal with mental health problem(s)?

Experiences in relation to mental health problems while in prison

- Tell me about your experiences in relation to your mental health problems while in prison
- Tell me about the kind of treatment you have been offered while here?
 - Tell me a little about how you are finding the treatment(s) you are receiving for your mental health problem(s) while here?

Future expectations and needs

- Can you tell me about what services/supports that you think would be useful to help you manage your mental health problem(s) after you leave prison?
- Can you tell me about how you would like to manage your mental health problem(s)?
- What are your hopes for the future?

Conclusion to the interview

- Is there anything else you would like to say at this stage?
- How are you feeling now after this interview?
- I would like to thank you for volunteering to take part in this study.

APPENDIX 16

Sample Transcript

Background

Icebreaker/Background information

How it all started I had depression for year but I was wrongly diagnosed I have bipolar depression they just said it was depression (doctors I always new ...well I didn't if you know what mean. A lot of things happened to me a lot of things...Major incidents happened to me.... like I boxed for Ireland and coached but eh as I said major things happened to me before I started coaching.... I eh was in a serious car accident my best friend was killed and I broke my neck.

So that lead to the depression getting worse like I had it before but it was really bad then. I was just taken anti depressants but they weren't really working and eh they just keep trying me on different ones.... Then eh I was with me girl and I got married to her and all but it didn't last very long... she just couldn't hack it any more... probably my fault because of me illness. I ended up getting barred from the house. Then eh with that everything just came down on me... I had no house... she had the house everything was gone... I have two sons I thought I would lose them too I thought I was loosing everything. So I had a car repayment... I got into taking drugs and eh I could see no other way of getting up (feeling normal) I was low.... Low low low all the time. So eh some bright spark said try cocaine that will get you up... it got me up alright...but jayus the down afterwards was unreal.... don't get me wrong... I loved it But then I got into depth. They I was approached and I was told that I had to do a delivery to pay off the depths. Which I thought were friends but they weren't friends... they weren't friends obviously they were very manipulative. But with the state I was in it just didn't matter to me you know what I mean.

I' m not happy I'm in prison now.... But to be honest with you I am glad because I was a way getting away from everything. I actually feel a lot better in here.

How long are you in prison?

I'm only in 4 months now... but I do feel better.

Is this your first time to be in prison?

Ah yeah I was never in trouble before you know... this is my first time.

- Tell me about yourself?
- Tell me about growing up?
- Can you tell me about how you came to be in prison
- I'm aware that you are attending the prison inreach clinic about your mental health problem(s) can you tell me about this?
- Is this your first time to be in prison?
 - If no, can you tell me if your mental health problem(s) were identified/treated while in prison before?

History of contact

Experiences of contact with mental health services prior to entering prison

In about 2000\01 was when I first when to see anybody about me depression. I just went the normal doctor (GP) you know eh... depression runs in the family

No I went of my own accord... nobody told me to go and see him. I'll never forget the day...one day I was just out in the garden fixing the lawnmower and then I don't know what happened...I just went bonkers....i don't know what it was so I said I m going to go see somebody... myself I said.

I knew me sister was very bad... cause she tried to kill herself load of times. So I went to the doctor. The first thing he prescribed me was lexatol so of course it was good for a few months but then I was on this for a year or maybe two maybe could a been a bit more... but it wasn't doing me any good. So somebody said to me if there not agreeing with you... so then in me madness I went to another doctor... me sister came with me this time. Then he gave me exaphor??? It didn't work either. But me sister came with me as I said and she said to the doctor that I think it is more than just depression... but the doctor no no... he just has depression. So I was on that for a long time but that didn't work either. So eh when I got into trouble with the police my solicitor got me assessed by a psychologist...so that's when I got diagnosed with bipolar

Do you think you should have sough help earlier?

Yeah

And what do you think are the reasons why you didn't make contact?

Well to be honest with you I think it was the male pride... I didn't want to be taken any tablets you know. I didn't want to be diagnosed with any thing

What sort of treatment(s) you were offered

He never offer me anything other than medication... he never offered me a psychologist or anything. And he knew about me sister and me father and the history of depression in the family and all that...

Can you tell me about the treatment(s) provided for your mental health problem(s)

Well just medication... but I did go for counselling you know of me own accord and that. That was after I went to the GP about the depression. Well after the crash... for a long time... but that's 12 years ago now you know...

But em I didn't really like it but em about 4 years ago I was going consistently every week I was going paying 60 quid a week I didn't get much out of it but like I'll never forget I leave and I'd have a fight with me wife every time you know... and don't think that was meant to be happening.

But then I got brilliant fella he was actually an addiction counsellor for the last two years...yeah he was brilliant

It was just after I got caught me brother in law put me on to him so I actually had stopped taking drugs then. He never told me to go and get assessed or that but the books he told me to read were brilliant you know all these self help books and that. Because I never read a book before in me life. But these were brilliant.

Where you still on medication at this time also?

I have actually stopped taking medication I had stopped for a long time but eh I was up and down for a long time

Last year I started taking it again I started taking the lexaphor again. But then the psychologist seen me last may ... but this I just took the lilies... I think they make you sleep.

How did you maintain the contact with your GP?

Well eh he didn't see you... I just went back for another prescription you know. He never asked to see you like. Just a repeat prescription. But they just weren't working I was more down all the time you know what I mean than up.

- If no, can you tell me...?
 - If you think you should have made contact with mental health services
 - What in your opinion may be the barriers to making contact with services to deal with mental health problem(s)?

Contact while in Prison

Experiences in relation to mental health problems while in prison

To be honest with you when I came into the prison I went to the governor. You go to the governor straight away. Then I went to the doctor I told him what I was prescribed so then em they gave me them so within a week I seen the psychologist and then fair play the first couple of months I seen them twice a month and then the last month or two once a month so they have been very good. They have kept an eye on me you know. They re asking me all the questions you know.

So you are seeing many professionals while in prison... psychologist, nurse and psychiatrist...

Sorry no if the nurse not the psychologist. Sorry about that.

I went to see the welfare only last week to ask to see an addiction counsellor so she said she would do her best so we'll see what happens....

So it good overall I have to say it is the nurse who comes out in the evening gives you your meds so yes they look after you very well you know.

- Tell me about your experiences in relation to your mental health problems while in prison
 - Can you tell me about how long you were in prison for before your mental health problem(s) were addressed?
 - Can you tell me about who suggested that you should get help for your mental health problem(s) while in prison?

- Tell me about the kind of treatment you have been offered while here?
 - Tell me a little about how you are finding the treatment(s) you are receiving for your mental health problem(s) while here?

Expectations

Future expectations and needs

- Can you tell me about what services/supports that you think would be useful to help you manage your mental health problem(s) after you leave prison?

Well they (GPO) say you have depression or that I think they should have checked me after a month or two months you know. Well medication doesn't seem to be working so eh lets refer you to a psychologist ... I think that would have been the best thing you know. If that happened they would have found out that I have bipolar and not just ordinary depression. That would have made a big difference I think. Definitely

Can you tell me about how you would like to manage your mental health problem(s)?

Well when I leave here I know I will have to go to my nearest mental health clinic they will assess me there and I think that would be good. I would like to be asked if the treatment is working. They need to keep checking up on you and see how you are doing you know.

For instance I need to keep active I got an injury recently and I have been very very very low because I need to be active. I got back to the gym today and there is an improvement already. From reading the book (Self help) I have to keep in control... I know I have to keep busy as is working and going to the gym.

Medication is just one thing it doesn't solve the problem it's a mix of things like as I say the activity.

Life events affect your illness it can change very quickly you know. If I was advising any that had a mental illness... I know what really helps me I go to NA every Wednesday and I really needed it recently because I was so down because I could train and that. NA is about keeping it in the day it helps me to control my illness.

What are your hopes for the future?

Well I know there is no cure for the ill but I am going to be very honest with you I'm only on the antidepressant now I'm not on the one at night time now because I have no stress in here... I've no bills nothing

But when I get out will I be able to keep it that way I hope I will be able to work I've worked since I was eight so I know when I get out I will need to work.

In terms of my illness at least I know if have it now ... where I didn't before and me wife never knew... she knew there was something wrong but I would go weeks without talking to her

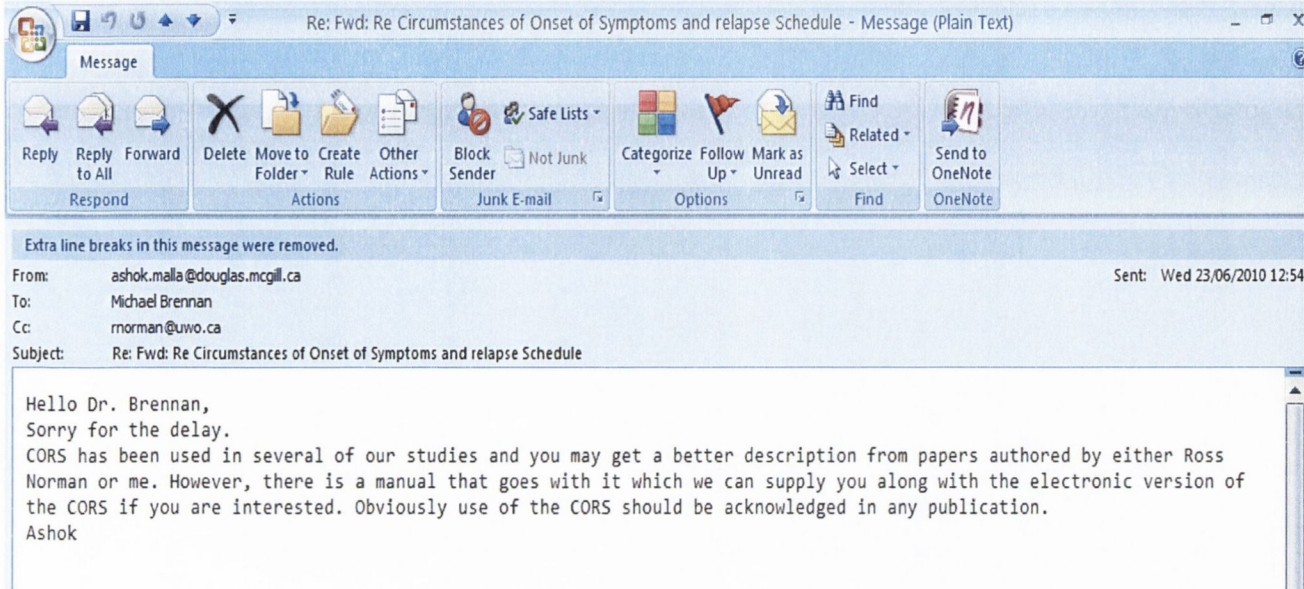
Conclusions

Conclusion to the interview

- Is there anything else you would like to say at this stage?
- How are you feeling now after this interview?
- I would like to thank you for volunteering to take part in this study.

APPENDIX 17

Permission to circumstances of onset of symptoms and relapse schedule (CORS)



Message

Reply Reply Forward Delete Move to Create Other Block Safe Lists Categorize Follow Mark as Find Related Select Send to
to All Forward Folder Rule Actions Sender Lists Up Unread Select OneNote
Respond Actions Junk E-mail Options Find

Extra line breaks in this message were removed.

From: ashok.malla@douglas.mcgill.ca Sent: Wed 23/06/2010 12:54
To: Michael Brennan
Cc: rnorman@uwo.ca
Subject: Re: Fwd: Re Circumstances of Onset of Symptoms and relapse Schedule

Hello Dr. Brennan,
Sorry for the delay.
CORS has been used in several of our studies and you may get a better description from papers authored by either Ross Norman or me. However, there is a manual that goes with it which we can supply you along with the electronic version of the CORS if you are interested. Obviously use of the CORS should be acknowledged in any publication.
Ashok