Responding to Female Inmates' Prior Histories of Violent Victimisation

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STATEMENT OF AUTHORSHIP

This thesis contains no material that has been extracted in whole or in part from a thesis that I have submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgment in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees.

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ABBREVIATIONS AND SYMBOLS

Abbreviation / Symbol	Description
AASW	Australian Association of Social Workers
AC	Approved Counsellor
ACS	Approved Counselling Service
AHPRA	Australian Health Practitioner Regulation Agency
CSNSW	Corrective Services NSW
CFA	Confirmatory factor analysis
DASS	Depression anxiety stress scale
d	Cohen's Effect Size
df	Degrees of freedom
CI	Confidence interval
χ^2	Chi square
ES	Standard deviation unit effect size
ITG	Immediate treatment group
M	Mean
OIMS	Offender integrated management system
PAP	Professional advisory panel
PTSD	Post-traumatic stress disorder
RANZCP	Royal Australian and New Zealand College of Psychiatry
SD	Standard deviation
SE	Standard Error
T0, T1, T2, T3, T4	Time 0, Time 1, Time 2, Time 3, Time 4.
TIC	Trauma-informed care
TICC	Trauma-informed correctional care
TRQ	Treatment readiness questionnaire
TSS	Trauma-specific services
TSTP	Trauma Specific Treatment Program
WCG	Waitlist control group
WCGD	Waitlist control group design
VS	Victims Services NSW

ABSTRACT

The central theme of this thesis is the analysis of female inmates' experiences following participation in a Trauma Specific Treatment Program (TSTP). Three separate but inter-related studies were undertaken to determine: if differences existed between an inmate sample (offending) and a matched community sample (non-offending): if a trauma-specific service would work in a prison: and finally, what the experiences of the participants and staff were of the trauma-specific service. Study 1 determined that there were marked differences between the community and custodial populations, with the custodial population reporting higher levels of polyvictimisation and more offenders, characterised by: more familial offenders, a marked difference in diagnoses, and experiencing victimisation across each point of the lifespan.

This study provided support for the literature which suggests that the community and custody samples significantly differed in regard to their trauma histories. Having determined that there were differences between the two populations, Study 2 then investigated the effects of a TSTP within both an inmate population, and matched community sample. Firstly, the study found that baseline Depression Anxiety and Stress Scale (DASS) scores were unaffected by the prison environment. Next, when participants completed the TSTP, their corresponding DASS scores across all three DASS subscales, had significantly reduced, indicating improved wellbeing and a reduction in emotional disturbance. The inmate cohort also demonstrated positive effects of the TSTP after the treatment period had ended. Finally, Study 3, based on the rich testimonies of the participants, provided support for implementing the study as a standard program, and recommended the implementation of a model of trauma-informed correctional care.

CHAPTER 1 INTRODUCTION

"*Tada gam iatrarchy" (Nothing is done without effort*)
Albert Frye

Introduction

From an international perspective, the male to female ratios of any given population averages out at 50%. Yet compared with their male counterpart's females make up only 5% of the prisoner population (Australian Bureau of Statistics, 2008; Berman, 2012; Stern, 1988). In Australia, those trends are similar with women making up approximately 51% of the population (Australia Institute of Health and Welfare, 2019) and accounting for only 7% of prisoners. However, in June 2018, the NSW female prison population grew by 6.6%, bringing the total of female prisoners to 1,067 doubling the increase of females in custody since 2011. This shows that despite the low prison population numbers for women, the actual incarceration rate of women (50%) is outstripping the male incarceration rate (35%) (Bureau of Crime Statistics and Research, 2019).

This increase in the numbers of incarcerated women is important, not only for society in general but for the women themselves. Research (e.g., Australian Bureau of Statistics, 2004; Blanchette & Brown, 2006; Kruttschnitt & Gartner, 2003; Morton, 1994) indicates that an overwhelming majority of women in prison have experienced more instances of domestic violence, more instances of childhood abuse, a higher likelihood of mental illness, a higher likelihood of having substance abuse problems, and are more likely to come from impoverished backgrounds than women in the general population. Hence, it is important to address the trauma issues that these women have experienced to minimise the cycle of violence and victimisation, and consider how this influences re-offending.

Traditional prison programs are deficit based and address a specific lack of offenders' skills through psychoeducation, vocational education, and preventative programming (Corrective Services NSW, 2016). The focus of the programs is of very limited value in that these programs overtly address only offence-based behaviours with little or no attention given to other significant factors associated with offending, such as a history prior victimisation. If the outcomes of rehabilitation or treatment programs are to reduce recidivism (Day, 2020; Kratcoski, 2017), then efforts "need to consider the whole person who always comes with human needs, emotions and attitudes" (Deaton, 2005, p. 46). This suggests that a specific program is required to address those prevalent histories of prior victimisation. The program at the centre of this research does adopt more of a holistic approach, as it considers inmates' histories of prior victimisation and acknowledges the presence of trauma.

For many women who have experienced trauma, when leaving prison, they are often in a very vulnerable state (e.g., limited social networks, no job, homelessness, feelings of shame). Women (and men), should not have to go to prison to receive trauma-informed care, however, if they are in prison, then they should have the same opportunities to access such services as do the community population. To address this identified gap in services to inmates in correctional centres, who are also victims of crime (in incidents often unrelated to their offence), in November 2011, Victims Services introduced victim-based counselling in a correctional centre in NSW. This process was instigated to allow inmates to access counselling-based services to address issues of prior victimisation and unaddressed trauma.

Counselling would address trauma symptoms related to female inmates' experiences as victims of violence. This includes developing strategies to assist inmates in effectively dealing with traumatic events and in attaining skills that may contribute to their rehabilitation from their own experiences with victimisation. The long-term impact benefits to inmates, by providing a specific intervention to overcome trauma, gain confidence, improve resilience, and

build capacity to overcome the conditions that contribute to the offending pathway, could potentially be associated with a reduction in recidivism (Yates,200) Given the high rates of inmates who will resume parenting responsibilities on their release, it is assumed that they would also benefit from addressing their own trauma histories, which, in turn, would likely to enhance their capacity to safely and effectively care for their children (Australian Institute of Health and Welfare, 2010; Stathopolous & Quadara, 2014; Ward, Collie, & Bourke, 2009).

Overall, accessing the services that deal with earlier victimisation, allows inmates the same right of access to services as the general population has. This contributes to inmates' all-round psychosocial well-being. Based on the available research on female offenders, an evaluation of this counselling service for female inmates would be highly beneficial, if not necessary, specifically to measure the effectiveness of providing therapeutic counselling services that address victimisation issues prior to the offending behaviour that led to imprisonment. The present investigation will undertake to contribute to knowledge in the area of "trauma-informed correctional services" where there is a clear paucity of programs both nationally and internationally that offer such a service. It will consider not only if the program works, but also how it works.

Purpose of the Research

The purpose of the proposed investigation is to examine the effectiveness of, a trauma-based counselling program for female inmates, who had self-reported a prior history of victimisation. The program, which will be evaluated in the proposed study, was delivered by Victims Services, Department of Communities and Justice. It was anticipated that the program would reduce the impact of psychological trauma sustained by individuals as a direct result of experiencing violent criminal victimisation. Counsellors' reports and the psychological interview were used to determine the likelihood that the trauma sustained could be attributed directly to the act of violence which occurred.

Proposed Studies

In undertaking this investigation, the studies' aims and objectives had to be grounded in current research, knowledges and methodological approaches. This ensured that appropriate academic rigour would be applied and address the need to expand on the current body of research in the area. With that in mind, Chapter 2 commences with a review related to the understanding of how trauma is understood, before introducing current research into the impacts of effects of violent victimisation. This material provides a basis for introducing the links between trauma, victimisation and the criminal justice system, on which the proposed studies are based. Guiding theories for the investigation are also considered within this chapter, and are drawn from psychological trauma, clinical recovery and criminology perspectives. The chapter concludes with a summary of the research and confirms the rationale for the research approach taken.

After presenting the supporting literature and building the research case, Chapter 3 (Aims and Hypothesis), will outline the specific research question, "Can trauma be effectively treated in a correctional facility?". It will set out the proposed hypothesis and present a series of research aims and questions for each of the three studies as they are introduced. Study 1 (quantitative) will consider differences between the reported trauma histories of two exact matched cohort groups (inmate and non-inmate). It will be evaluated against aspects of the literature review in Chapter 2 and contribute to existing research into this area. It will then introduce Study 2, a quantitative study, which utilises an experimental group and wait list control group to consider if the Trauma Specific Treatment Program (TSTP) had an impact on psychological wellbeing for each of the two groups. The third study adopts a qualitative approach and will draw on the experiences of participants, as well as those professionals who work with the participants, to evaluate the TSTP.

The methodology for each of the studies are presented in Chapter 4 and outlines the rationale for adopting a mixed-methods approach to the investigation. It specifies each of the populations being investigated and provides details of each of the participant groups, the psychometric tools used, data sources and proposed data analysis procedures.

As the results from each of the studies are necessarily voluminous, the results for each of the studies are presented in Chapters 5, 6, 7, and 8. The findings from the results of the three studies are then discussed in Chapter 9 and will consider the implications of those results will be considered, while recommendations for future research and practice will be provided.

In summary, this thesis provides much needed hard evidence by empirically evaluating the effects of TSTP's in a custodial setting and exploring participants' opinions and understanding for the effects of these programs. The thesis provides a strong contribution to the literature on a trauma-informed model of corrections and provides insights for future research to improve outcomes and promote recovery options for female inmates who have experienced significant levels of trauma.

Anticipated Research Outcomes and Significance

Current Australian approaches to offender rehabilitation, namely, risk-need-responsivity (Blanchette & Brown, 2006), are predominantly based on cognitive social learning theory, rather than being considered within the context of inmates' social relationships (Heseltine, Day, & Sarre, 2011). However, if the final goal is to reduce recidivism and the reintegration of the inmate into the community, then a range of emotionally significant issues and practical difficulties must be considered beyond any cognitive behavioural model (UNODC, 2019). This includes the opportunity for addressing their history of victimisation whilst in a correctional environment.

The notion of the therapeutic environments in models of treatment remains influential, particularly in regard to rehabilitation. Most offender-based rehabilitation program providers

would support the adoption of some aspects of the trauma-informed therapeutic model in the correctional environment, specifically, the idea that an expansion of a trauma-informed environment can itself act as a therapeutic tool. It is this concept that will then not only provide opportunities for inmates to reflect on their past choices but also reinforce the positive attitudes and behaviours that are required to address recidivism.

It was anticipated that the research would make three important contributions to the area of addressing victimisation histories of women in prison. In the first instance, the study contributed to the expanding body of research on the use of trauma-based therapy in prisons. It determined the effectiveness of providing a therapeutic response to address inmates' prior victimisation, and, as such, improved recovery from trauma.

Secondly, this research was the first attempt, certainly in NSW, to implement a trauma-specific service approach with a sample of women prisoners, acknowledging them as victims of prior traumatic events. So often, this subgroup is overlooked in terms of service provision. The research contributes towards a more comprehensive understanding of this subgroup and the role, which prior victimisation plays in contributing to offending behaviour and provide a framework in which to operate.

The ultimate issue underpinning the research, was addressing a prior history of victimisation and its resulting impacts, which is the right of any Australian citizen, whether they are inmates or not. It was anticipated that the third contribution which would be made through this research, was that the analysis would assist in providing options by which the victim-based counselling service can contribute to the improved functioning and wellbeing of people within the prison population. While this is a significant change to current rehabilitation paradigms, the findings from the current investigation will provide a clear direction in which operational programs can progress.

The subject of women as victims of violent crime has been clearly documented and remains a prevalent component of modern society (Bennett & Holloway, 2009; Carlson & Shafer, 2010; Dierkhising, et al., 2013; Salisbury & Van Voorhis, 2009). The sequela to the crimes and the associated trauma responses resulting from this victimisation have been well researched and are demonstrated to have an influence on all aspects of the victim's life, including impaired social functioning and impaired physical and mental health (Anumba, Dematteo, & Heilbrun, 2012; Guay, Beaulieu-Prevost, Sader, & Marchand, 2019; Ponic, Varcoe, & Smutylo, 2018)

For those female victims of violent crime, there are indicators that the history of victimisation correlates directly with offending behaviour (Gonzalez & Connell, 2014; Moe, 2004; Richie, 2003). This is not to say that all female victims of violent crime will become offenders; rather, that a significant proportion of female offenders will present with history/histories) of violent victimisation (Harden & Hill, 1998). However, there remains a deficit of research into the areas of treating trauma for female inmates who have experienced violent victimisation.

Forensic-based research across multiple disciplines (e.g., McGlue, 2016; Reichert & Bostwick, 2010) indicates that inmates are likely to have been victims as well as offenders of violent crime, prior to their incarceration. Data profiles on the health, mental health, social and demographic profiles of inmates from state (e.g., Indig, et al., 2010), national (e.g., Australian Bureau of Statistics, 2017); and international (e.g., Leigey & Reed, 2010) perspectives, all indicate the presence of trauma as well as trauma-related conditions and significant prior history of victimisation (Salisbury & Van Voorhis, 2009).

Female inmates report episodes of past violent victimisation, such as sexual assault or physical assault (Salisbury & Van Voorhis, 2009). Females report that assaults by strangers are lower than familial assaults. However, in cases of sexual assault, females report higher rates of

sexual assault by intimate partners and family members (Moloney, Van den Bergh, & Moller, 2009). This history of victimisation for both genders cuts across the entire lifespan occurring in early childhood as well as their adult life (Kaufman, Tsnag, Sabri, Budhathoki, & Campbell, 2019; Knefel, Lueger-Schuster, Karatzias, Shevlin, & Hyland, 2019). This history is considered likely to be a significant contributing factor to many inmates' offending behaviours (Warren, et al., 2002) such as sexual misconduct (Smith, Leve, & Chamberlain, 2006), drug and alcohol abuse (Johnson, 2006) violent behaviour or psychological symptoms that manifest in other offending behaviours such as gambling, theft or fraud (Belknap & Holsinger, 2008).

Research (e.g., Andrews, Bonta, & Hoge, 1990; Anumba, Dematteo, & Heilbrun, 2012; Blanchette & Brown, 2006; Covington & Bloom, 2006) has informed the development of therapeutic interventions as well as a broader incident recovery model for victims of crime. These interventions are freely available within the community and are used extensively by victims of crime. However, these interventions are not necessarily available to those prisoners who hold dual roles as both victim and offender (Bartels & Easteal, 2016; Mulford, et al., 2018; Pollack & Brezina, 2006). This research investigates that gap.

Despite the research findings that prior victimisation is associated with subsequent offending, correctional facilities in New South Wales (NSW) do not provide a specific therapeutic service to inmates to address any psychological, emotional or social impacts relating to their experiences as victims of violent crime. Whilst they do provide some psychological services, these are limited to addressing the more immediate issues and factors leading to their criminal behaviour. Examples of these types of programs include: "The impact of dependence" – drug and alcohol, "The best bet is the one you don't have" – gambling; criminal conduct and substance abuse treatment; Domestic Abuse Program-perpetrators (DAP); and "Controlling Anger and Learning to Manage It (CALM). The need for a trauma

recovery model to address existing trauma associated with prior incidences of victimisation is then a missing, but necessary, component to address unresolved trauma.

CHAPTER 2

Literature Review

"It is not the prisoners who need reformation, it is the prisons"
Oscar Wilde

Introduction

This chapter is presented as a logical flow of key concepts and information which provide background to the proposed research. In order to articulate the rationale behind the current research, it is necessary to review what exactly trauma and victimisation are; the impacts they have on the population as a whole and women in particular; the significance that intervention of this trauma-based history has for female offenders; and the implications that recovery has for recidivism. It should be pointed out that separating victimisation and trauma is a difficult task as they often go hand in hand and the terms frequently are used interchangeably in everyday practice. Neither is meant to be seen as more important than the other nor is one seen as developing in isolation of the other. Briefly, trauma is considered to be "a subset of the full range of psychological trauma that has as its unique trademark a compromise of the individual's self-development" (Kezelman & Stavropoulos, 2012, p. 46). Victimisation, or specifically violent victimisation is defined as, suffering "direct or threatened physical, emotional or financial harm as a result of an act by someone else, which is a crime" (Dubber, 2002, p. 284).

Research on the violent victimisation of women, forms the basis of multidisciplinary studies and has been presented across varying sectors (Daly, 1998; Kruttschnitt & Gartner, 2003, Morton 1994: Osofsky, 1999; Sinclair & Bourne, 1998); Salisbury & Van Voorhis, 2009). The extraordinary range of subtopics alone (e.g., domestic and family violence, sexual

assault, date rape, etc.) makes it difficult for mental health practitioners, health service professionals and researchers to form a complete understanding of what is actually happening.

However, this range of categories and subcategories of violent victimisation against women is important, as research (e.g., Acoca & Austin, 1996) suggests that a prior history of victimisation impacts on women's pathways to prison. To fully understand this association between prior victimisation and offending, it is necessary to consider what is meant by psychological trauma, what victimisation actually is and what the prevalence for victimisation is for women.

Understanding Trauma

Research indicates that most people will experience, or know someone close to them who will experience, some form of trauma during their life course (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). While some people may report slight or even no adverse reactions to a traumatic event, others report severe and debilitating reactions that can last for significant periods of time (Breslau, Davis, Andreski, & Peterson, 1996). Potentially, traumatic events are seen in daily media reports and viewed as natural disasters, criminal victimisation, motor vehicle accidents, or the death of a celebrity. When considering trauma, it must be noted that people are individuals, and as a result will present with individual responses even when exposed to the same traumatic event. Some individuals may experience a particular event as traumatic yet another may perceive it very differently. By the same token some individuals will recover faster from incidents of trauma whilst others realise a longer recovery process, or indeed, no recovery at all. As the stimulus-organism-response model suggests, people's individual behavioural responses are affected differently, and by different environment stimuli (Jacoby, 2002). With this in mind, it should be noted that just because an individual experiences some form of trauma, it does not necessarily follow that they will experience traumatisation.

Clear definitions are required in order to ensure the correct label is assigned to the appropriate term.

Defining Trauma

The term trauma is used across many different environments and within varying contexts. Trauma can be either psychological or physical and the term is used to refer to a negative event that produces distress (Norris, 1992). It usually involves a "single experience, or an enduring or repeating event or events that negatively impact a person's ability to cope with that experience" (SAMHSA, 2015, p.2). The Macquarie Dictionary (Delbridge, et al., 2002, p.1997) defines the experience of trauma as: "profound emotional shock following a stressful event". The *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition, (*DSM-5;* American Psychiatric Association [APA], 2013) is more restrictive in its definition and defines a trauma, within the PTSD diagnosis, as: "directly experiencing the traumatic event(s); witnessing in person, the event(s) as it occurred to others; learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death, the event(s) must have been violent or accidental; and experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (p. 271).

For the purposes of this paper, a broader definition of trauma will be used as experiences need not be life threatening as proposed in the DSM-5 (2013) to be considered as traumatic. The definition proposed by Cozolino (2002, p. 45) "a state of high arousal that impairs integration across many domains of learning and memory" is then preferred and used within the context of this paper. Next, the different types of trauma are outlined to provide further context to a definition of trauma.

Types of Trauma

Different types of trauma can be defined by the timeframes in which they occur, rather than by the nature of the trauma sustained. The first of these types is referred to as acute trauma

and is a term used to describe that form of trauma which is associated with sudden or rapid onset, such as those experienced following a car accident, a fall, or an injury on the sporting field (Breslau, Davis, Andreski, & Peterson, 1996). A person with untreated acute trauma, can progress to Post Traumatic Stress Disorder (PTSD) in the long-term, or even present with other mental illnesses/conditions including depression and anxiety disorders (Zlotnick, 1997). By comparison, chronic trauma occurs when multiple traumatic instances or events are experienced or as a result of the culmination of multiple traumatic experiences (Smith, Leve, & Chamberlain, 2006). The consequences of chronic trauma tend to be more severe than acute trauma as one traumatic experience can often resurrect feelings and issues associated with another. The more straightforward types of trauma that appear throughout the research in the field are usually characterised as single one-off events, such as car accidents or the loss of a family member, and are referred to as simple trauma (Helzer, Robins, & McEvoy, 1987; Kessle, Avenevoli, & Merikangas, 2001; Resick, 1987). Despite the "simple" term used, these forms of trauma are single events that people who have experienced them, can still have clinically significant signs and symptoms relating to the event. They are referred to as simple for the reason that they have a single antecedent and do not result from multiple forms of trauma (Breslau, Davis, Andreski, & Peterson, 1996).

Conversely, complex trauma is seen as significantly more pervasive and is seen as "a sub set of the full range of psychological trauma that has as its unique trademark, a compromise of the individual's self-development" (Courtois & Ford, 2009, p. 16). Complex trauma is frequently referred to when an individual experiences cumulative and repetitive episodes of intentional and pre-meditated episodes of trauma, such as domestic and family violence (Kezelman, 2011). This form of trauma can also be a consequence of poly-victimisation and is associated with the development of severe forms of psychological disorder such as PTSD. If complex trauma occurs within specific developmental stages, it can compromise psycho-

biological, social and emotional development (Courtois & Ford, 2009). Further, recognised correlates of complex trauma during certain developmental stages include certain behavioural issues, such as offending behaviour (Weeks & Widom, 1988). However, it is also important to recognise how trauma is diagnosed and why it is often misdiagnosed.

Diagnosing Trauma

There are a range of symptoms associated with experiencing any form of psychological trauma, which can have cognitive, behavioural, physical, and emotional effects (Briere & Scott, 2006; Williams, 1995). Often clients presenting to health and mental health providers oversimplify their symptoms and report as having depression or anxiety, even though the underlying condition may warrant a more serious diagnosis (Sayer, Murdoch, & Carlson, 2007). The similarity in symptoms, particularly between depression and PTSD, are frequently confused for one another and can even coexist simultaneously. The diagnoses are closely linked with research indicating that there is a probability that PTSD sufferers will have depression; whilst a diagnosis of depression is likely to result in sufferers having higher levels of anxiety and stress (Breslau, Peterson, & Schultlz, 2000; DeKloet, et al., 2008; Neria & Bromet, 2000; Pinna & Johnson, 2014). The diagnosis frequently depends on the amount of information provided by the individual and often that does not occur immediately.

By comparison to a diagnosis of anxiety or depression, a diagnosis of PTSD (*DSM-5;* American Psychiatric Association [APA], 2013, p. 271) is given when:

> an individual presents with a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of five symptom clusters: intrusion, persistent avoidance, negative alterations in cognitions and mood associated with the traumatic event; and marked alterations in arousal and reactivity. A sixth criterion specifies that the duration of the previous symptoms exceeds one month and the seventh criterion specifies that the event has to have caused significant clinical distress or impairment in

functioning. Finally, to obtain the PTSD diagnosis, the disturbance must not be attributable to the physiological effects of a substance or medication.

The DSM 5 (2013, p. 2) diagnostic criterion identifies the trigger to PTSD as "exposure to actual or threatened death, serious injury, or sexual violation". It further specifies "that the exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event;
- witnesses the traumatic event in person;
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
- experiences repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related)".

The Australian Bureau of Statistics (ABS: 1998) conducted a national survey which provided some indication of the prevalence of PTSD in Australian Communities. Whilst the study considered PTSD, it also indicated that men (64.5%) were more likely to report a traumatic incident than women (49.5%) and that the most common triggers for trauma were: witnessing a life threatening incident (such as a murder or assault); being subjected to a life-threatening accident; and being caught up in an occurrence considered to be a natural disaster. Further research suggests that it is likely that females will develop PTSD symptoms than males under similar circumstances (Creamer, Burgess, & McFarlane, 2001). Studies in America found similar indicators, with the exception that the rate of PTSD was three times higher among the American population than the Australian study (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

While PTSD is usually diagnosed after more than a month of presenting symptoms, acute stress disorder (ASD) typically presents within two days and one month. The major difference between PTSD and ASD is the presence of dissociation in PTSD. Individuals that

present with dissociation immediately following a traumatic incident often present at a higher risk of developing PTSD. They are characterised as individuals who, in "addition to experiencing one or more of the symptoms from each of the PTSD symptom clusters, also experience reduced emotional responsiveness and a lack of pleasure in previously enjoyable activities and concentration difficulties. They may also report: dissociative amnesia, depersonalisation, and derealisation" (American Psychiatric Association, 2013, p. 13).

Providing an accurate definition of any phenomena is essential to research. The rationale for this is because it will assist in excluding behaviours, such as accidents and self-defence, as well as including those behaviours associated with the research, including child abuse, sexual assault, domestic and family violence … etc. The next section will then provide relevant details of definitions used and in turn allow a more accurate identification of causes and consequences of violence.

Violent Victimisation

The United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, General Assembly Resolution 40/34, 29 November 1985, refers to victims as:

> persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that do not yet constitute violations of national criminal laws but of internationally recognized norms relating to human rights (p. 45).

This definition is expansive enough to accommodate the different international standards under which an individual may be considered a victim; however, whilst it does provide a high-level platform on which to discuss victims' rights and the application of justice, there is no clear definition for the present investigation. Defining a "victim" remains a complex process and is not easily defined despite seemingly being straightforward (Sumner, 1999).

There are a number of reasons for this. The first is that there is often a distinction made between primary and secondary victims (Langan & Farrington, 1998; Laub, 1997; Lurigio, 1987; Office of Crime Statistics [OCS], 1988). Additionally, this is complicated by the time period in which the victimisation occurred. For survivors of child sexual assault, particularly those giving evidence at the Royal Commission into Institutional Responses to Child Sexual Abuse, they still consider themselves as victims/survivors (Commonwealth of Australia, 2014). However, many victims of physical assault no longer view themselves as victims as they have "recovered" to the point where the label is no longer appropriate.

Primary victims are normally those people who experience direct injury as a consequence of victimisation, whilst secondary victims are that group who may have been witnesses to a crime; the family of a primary victim; or in other cases the broader community in general (friends, neighbours, etc.) who may be considered to have experienced trauma as a result of victimisation. In NSW, the *Victims' Rights and Support Act 2013* (VRSA 2013) also makes this distinction. It is important to note that, based on this act and in accordance with Principle 2 in the UN Declaration, "a person may be considered a victim of a crime regardless of whether the offender is identified, located, apprehended, prosecuted, or convicted" (p. 2). The Act provides the following definitions:

- A primary victim of an act of violence is a person who is injured, or dies, as a direct result of that act;
- A secondary victim of an act of violence is a person who is injured as a direct result of witnessing the act of violence that resulted in the injury to, or death of, the primary victim of that act;
- A family victim of an act of violence is a person who is, at the time that act is committed, a member of the immediate family of a primary victim of that act who has died as a direct result of that act.

The second reason that poses difficulties in defining a victim is that to become a victim or, at least, attain victim status, individuals have to go through a particular process (Jousten, 1987; Lake, 1993; Resick, 1987). Often, it is usually the criminal act or the act of violence which is defined rather than the victim. Official agencies define victims for the purposes of responding to a need, rather than a person. The definition of the victim will then only be referred to within the context of which they are part. If a victim reports a crime within the criminal justice system, they are a victim only for the purposes of acknowledging that a breach of the *Crimes Act 1900* has occurred (Reiche, 2002). If the matter proceeds to court, they are considered a witness rather than a victim (DeHart, 2008). If they are seeking financial assistance or compensation, they are considered a victim of a particular act of violence under the *Victims' Rights and Support Act 2013* for the purposes of meeting specific requirements under the administrating scheme. If attempting to access services, the status of victim is often dependant on certain reporting obligations, to the police, health practitioners or government departments. This means that the definition applied will vary in each instance and will consider the context in which the victim finds themselves (Whitrod, 1986).

Additionally, whilst the actual act of being physically, psychologically, or economically harmed is, in some way, necessary in defining who a victim is, it does not appear to be the only factor in determining victim status. Other contributing factors such as: social norms, cultural influences, socio-economic status, etc., all influence how we decide victim status is to be given (Cook, David, & Grant, 1999). A person's perception of being victimised is important, as if they do not consider themselves a victim, how can anyone else? If we consider the circumstances of someone in a non-violent domestic violence situation, such as financial abuse or psychological abuse the definition of victimisation will depend upon their perception of what is occurring, whether they are aware of this victimisation; whether it is a culturally or socially acceptable practice which is occurring; and whether they consider themselves to be a victim,

or importantly, whether or not government agencies (the police, NSW Health, etc.) or even the public consider them to be a victim (Whitrod, 1986).

For the purposes of this paper, a victim will be taken to be "a person, who suffers harm as a direct result of an act committed, or apparently committed, by another person in the course of a criminal offence" (Victim Services, 2015). It will include physical and psychological injuries or a combination of the two. However, there are specific categories of victimisation that will be required for this research study. For that reason, a brief exploration of those categories is presented below. They include:

- the impact of victimisation
- psychological impacts
- physical impacts
- the prevalence of victimisation

As with trauma, violent victimisation has a range of impacts associated with it. Whilst there is a degree of overlap with the impacts of trauma, many are specific to the nature of the violence experienced. These are presented in the following section.

The Impact of Victimisation

Research (e.g., Grabosky, 1989; Sumner, 1999; Victims Services, 2013; Whitrod, 1986) suggests that the culmination of individual impacts of violent victimisation may be enduring, diverse, and importantly, can have far reaching effects across the entire life course (Newburn, 1993). The consequences of victimisation as a result of violent crime can include: death, physical injury, psychological injury, and financial loss and property damage (Jousten, 1987; Kezelman, 2011; Resick, 1987; Schaaf & McCanne, 1998). However, it is also just as important to consider that often victims may experience none, some, or many of the possible impacts of victimisation at different points in time (Boyd, 2011). There is no standard way that individuals respond to victimisation; everyone is different and there are a range of factors

which influence that response. These can include "the extent and severity of the injury sustained, the severity of the act of violence, the length of time that the act of violence occurred over, their personal history, prior life events, and prior instance of victimisation" (VRSA, 2013 p. 4).

Reactions to victimisation are similar if not the same as those of other traumatic events, such as a parent dying. The differentiation between a traumatic event and an act of violence is important, especially when considering the sequelae of symptom development. The reactions commonly manifest in victims as symptoms, which include, depression, and shame (Newburn, 1993). However, in many cases, these symptoms carry over from internal symptoms to external ones, such as hyper-arousal, physical maladies, etc., which can affect the victim's day to day life (Kezelman, 2011). For more serious cases of violent victimisation, many of the symptoms are durable enough to last a significant period of time following the actual incident and can be specific to the act of victimisation itself (Schaaf & McCanne, 1998).

Short-term impacts of victimisation are often referred to as "shock" in which the victim often goes through a sense of disbelief that something bad has happened to them (Kilpatrick, Saunders, Veronen, Best, & Von, 1987). It is not unusual for victims to suffer from emotional mood swings of depression, anger, denial, and disbelief and demonstrate feelings of fear, distress, and anxiety. These are considered normal reactions to the victimisation, however it is worth noting that every victim will experience their own victimisation and react in their own unique way (Schaaf & McCanne, 1998).

The Royal Commission into Institutional Responses to Child Sexual Abuse was an inquiry, into institutional responses to child sexual abuse and related matters, which highlighted the implications that child sexual assault had for the Australian community. It did more that demonstrate the extent of the problems associated with child sexual assault in the community, it provided an overview of the experiences of survivors and the long-term impacts it had on

their lives and the lives of their families. Of note was the fact that the Royal Commission itself, asked prisons what services were in place to manage the long-term effects of child sexual assault were in place, and how they could be improved. Again, this provided support for the current research and further highlighted the inadequacies of institutions to manage the issues and provided recommendations for organisations which conformed with the implementation of trauma-informed care in organisations and institutions across Australia.

Psychological Impacts of Violent Victimisation.

The actual experience (of the traumatic event) of the victim as well as the victim's personality, age, gender, financial attributes, psycho-social wellbeing, and social supports will all contribute to the psychological impact that the victimisation has on them (SAMHSA, 2015). This is important as it plays a part in defining the duration and extent of the recovery that may occur (Kilpatrick et al., 1987). Key factors which contribute to the extent of the trauma suffered, duration, and the associated recovery can be seen as resilience, interpersonal support, extent of the injuries sustained, pre-victimisation adjustment, and the type of the victimisation that has occurred (Grabosky, 1989).

Some types of victimisation have very specific psychological impacts. For example, sexual assault victims may experience debilitating fear of future assaults, leading to restricted social activities, not attending work, and the development of inappropriate relationships (Crone & McCabe, 1995). Other psychological impacts may be the avoidance of areas associated with the victimisation (Boyd, 2011), or certain aspects of the victimisation, such as men if the offender was male (Crone & McCabe, 1995). Suicidal ideation or feelings of despair and depression are also common following victimisation. These impacts can often lead to the manifestation of mood disorders (for example depression) or in more serious cases, PTSD, as discussed previously (Kilpatrick, et al., 1987).

Physical Impacts of Victimisation

There are often physical injuries associated with victimisation, some of which are obvious and some not. In the cases of physical assault, there may be cuts, bruises, lacerations or broken bones which are evident (Newburn, 1993). In cases of sexual assault, there may be pelvic pain, pain syndromes, and gynaecological problems (Ashbury, 2006). However, in some instances, the damage may not be so clear, particularly if the incident goes unreported or the victim decides not to seek help. Aside from the injuries sustained, there is the risk of pregnancy, contracting a sexually transmitted disease etc., all of which can then impact on the psychological or emotional state of the victim (Schaaf & McCanne, 1998).

Other physical reactions are also common following victimisation and can manifest physically such as, a disruption in sleeping patterns, change in appetite, fatigue, hyper vigilance, and vomiting. These reactions, however, are not always apparent at first and often misunderstood by victims when they occur (Bard & Sangrey, 1986). Eating disorders, are related physical impacts which can slowly escalate if the victimisation/trauma is unresolved. Finally, there is the risk that victims can self-medicate with alcohol or other drugs (Boyd, 2011). These physical impacts may be acute or chronic in nature and, if unresolved can have long-term health implications as well as impacts on interpersonal relationships. Given that victimisation and violence threaten the lives and physical and mental health of millions of people, overburdens health systems, undermines human capital formation, and slows economic and social development, it is important to understand how common it is in society.

Prevalence of Victimisation

Whilst crimes, in general, are decreasing across Australia there is an upward trend of certain categories, specifically violent crimes, and, as a result, victimisation (ABS, 2012). Similar trends exist in NSW in the recorded rates of assault and sexual assault (Moffat & Goh,

2012). It should be noted that these figures include domestic and family violence. Compared with previous rates almost two decades previously (1990), the rate of:

- assault – has increased by 74 %;
- sexual assault – has increased by 130 %; and
- lesser sexual offences – have increased by 77 %.

These trends are long-term over a significant reporting period and may seem high; however, even compared with previous reports within the last decade, there has been a significant increase in victimisation since 2000 (Moffat & Goh, 2012). Whilst there in no definitive evidence to suggest that it is the rate of reporting of crimes that is increasing rather than the rate of reporting, the estimated rates of unreported crime remain stable at approximately 33% (ABS, 2006). The prevalence of these types of victimisation (i.e., sexual and assault) is important for the proposed study as it demonstrates a clear and ongoing need to provide a response for victims of crime to address the associated victimisation and trauma issues. What follows is a breakdown of the state and national trends and how these trends compare with international research in the same areas.

Socio-economic Factors and Costs

As highlighted throughout this chapter, there are significant socio-economic costs and implications for children and adults who experience trauma as a result of violent victimisation (Nemeroff, 2004). Trauma associated with abuse includes sexual, physical, and emotional abuse. Whilst the physical and psychological effects of trauma are prominent and gain significant attention, the impact and costs of trauma on socio-economic factors are less prominent (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2013).

Research shows that for children who experience adverse childhood trauma, they are negatively impacted across their lifespan and more at risk of attaining a lower socio-economic status in adulthood (Centers for Disease Control and Prevention, 2016). That status is

characterised by risky health behaviours, chronic health conditions, low life potential, and early death (Fang, Brown, Florence, & Mercy, 2012). Children from lower socio-economic status classes are also more than twice as likely as peers from higher status to have multiple adverse experiences, highlighting that lower socio-economic status can be both a cause and an outcome of trauma (Child Trends, 2013). Children who experience trauma also have an economic cost to the community in general, specifically on welfare, education, and health (physical and mental) (Fang, Brown, Florence, & Mercy, 2012).

Adolescents who experience trauma also have socio-economic impacts, such as seeing a reduction in options of marriage, lower educational attainment, reduced employment options, and lower income levels (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2013; Covey, Menard, & Franzese, 2013; Crowne, et al., 2011). Experiencing trauma during this period within the lifespan is also reflected in the mental health of adolescents, who experience increased depressive symptoms, see an increase in anhedonia and reduced academic performance, when compared to peers who have not experienced trauma (Borofsky, Kellerman, Baucom, Oliver, & Margolin, 2013; Eisman, Stodadard, Heinze, Caldwell, & Zimmerman, 2015; Strom, Thoresen, Wentzel-Larsen, & Dyb, 2013).

Research focusing on socio-economic impacts of trauma on adults indicate that employment instability or an inability to obtain employment are significant characteristics of adults experiencing trauma, highlighting women as being at higher risk than men (Crowne, et al., 2011; Miller, Cohen, & Wiersema, 1996). Children and adults who have experienced domestic and family violence, is cited as the leading cause of homelessness, showing the links between trauma and reduced socio-economic status (Kezelman, Hossack, Stavropoulos, & Burley, 2015). Research also shows that socio-economic status encompasses quality of life attributes, such as happiness and wellbeing and not just factors like mortality, poverty, and homelessness (e.g., Diette, Goldsmith, Hamilton, & Darity, 2016; Hanson, Sawyer, Begle, &

Hubel, 2010). As well as being a consistent and reliable predictor of outcomes across the lifespan, trauma also has an actual economic cost to society.

Whilst it is acknowledged that no methodological approach exists to determine the full extent of the cost of trauma, estimates can be provided for the cost of violent victimisation and the resulting trauma (Kezelman, Hossack, Stavropoulos, & Burley, 2015). Those estimated costs can be seen as a direct cost to the act of violence itself, such as health care, or indirect costs, such as loss of economic or financial advantage (Taylor, Moore, Pezzullio, Goodard, & DeBortoli, 2008). In 2016, KPMG undertook an analysis of violence against women and children. They determined that the overall cost of violent victimisation was an estimated $22 billion dollars a year in Australia, with the potential for that figure to increase should that violence not be reduced (KPMG, 2016). It should also be noted that this figure was an increase of approximately $8 billion from 2008 (KPMG, 2008). It should also be noted that the figures were derived from the Personal Safety Survey (ABS, 2013). It is also noteworthy that Aboriginal and Torres Strait Islander women, pregnant women, women with disability, and women experiencing homelessness were significantly underrepresented in this survey, despite being overrepresented in each of those categories (KPMG, 2016). The 2016 report by KPMG provides seven cost categories for the estimated cost of violent victimisation. These include:

- Pain, suffering, and premature mortality costs associated with the victims'/survivors' experience of violence.
- Health costs include public and private health system costs associated with treating the effects of violence against women.
- Production-related costs, including the cost of being absent from work, and employer administrative costs (for example, employee replacement).
- Consumption-related costs, including replacing damaged property, defaulting on bad debts, and the costs of moving.

- Second generation costs are the costs of children witnessing and living with violence, including child protection services and increased juvenile and adult crime.
- Administrative and other costs, including police, incarceration, court system costs, counselling, and violence prevention programs.
- Transfer costs, which are the inefficiencies associated with government benefits such as victim/survivor compensation and lost taxes.

The economic and non-economic impact of violence are evident in not only the pain and suffering of the victims, but also the impacts on the health system, education system, job market, production and consumption, and the criminal justice system. The report identifies that early and preventative intervention, support, and trauma-specific services are necessary to improve overall socio-economic functioning, prevent costs associated with trauma, and improve the socio-economic status of those who have experienced trauma (Kezelman, Hossack, Stavropoulos, & Burley, 2015).

Links Between Victimisation, Trauma, and the Criminal Justice System

There is an abundance of research which indicates that victimisation, be it domestic and family violence, sexual assault, or physical assault, features prominently in the lives of female prisoners (Johnson, 2004; Lake, 1995; Morash, Bynum, & Koons, 1998; Salisbury & Van Voorhis, 2009; Worrall, 1990). The 2009 NSW Inmate Census (Indig et al., 2009), undertaken for Corrective Services NSW, provided the following insights into women prisoners:

- 54% of women prisoners had been assessed for mental health issues, with depression, anxiety, and drug dependence as the main factors;
- 20% of women reported being admitted to a psychiatric unit;
- 38% of women had suicidal ideations and 27% of women had attempted suicide;
- 17% had reported incidents of self-harm;
- 78% used illicit drugs;

- 35% reported a previous head injury resulting in unconsciousness;
- 54% reported a disability or illness that impacted on their health for six months or more;
- 67% were unemployed; and
- 45% did not finish Year 10.

The National Prisoner Health Census (AIHW, 2010) provides findings consistent with the NSW Inmate Census and highlights that, as a population, women prisoners are likely to possess a range of complex health needs and have poor mental and physical health. Despite prisons implementing numerous screening process as well as specific assessment tools, by which to identify "prisoners with mental illness and any associated problems" (CSNSW, 2012, p.12), the problem arises that many women prisoners are unaware of these problems and as a result, do not seek help, thereby exacerbating the problem.

A review of the interpersonal histories of women prisoners shows that there is a distinct blurring of the role of offender and victim. This was highlighted by the "*Speak Out, Speak Strong*" report (Lawrie, 2003) from the Aboriginal Justice Advisory Council, which found that over 90% of female offenders surveyed had been the victim of sexual assault. This figure has continuously been supported through various Justice Health Inmates surveys which consistently show that offenders are previous victims of domestic and family violence and sexual assault. A recent review conducted by the Australian Centre for the Study of Sexual Assault (Stathopoulos, Quadara, Fileborn, & Clark, 2012) reported similar results.

Inmate Health and Trauma

Numerous bodies of research (e.g., DeHart, 2008; Gilfus, 1992; Lake, 1995) indicate that an early history of victimisation often directly correlates with female offending. In addition, early victimisation can influence health and wellbeing, psycho-social functioning, or institutionalisation which contribute to risks of offending (Coll, Miller, Fields, & Mathews,

1998). Other studies (e.g., Arnold, 1995; Chesney-Lind, 1997; DeHart, 2008) have found that a correlation between incarcerated women and women with a history of victimisation, specifically childhood victimisation, significantly increased the possibility of engaging in future offending behaviours (Acoca & Austin, 1996). Hence, a history of victimisation may be a significant factor in many inmates' offending behaviour, such as drug and alcohol abuse, violent behaviour, or psychological symptoms that manifest in other offending behaviour such as gambling, theft, or fraud.

Such statistics may lead to the broad assumption that prior victimisation can directly lead to offending; however, it is important to understand that such assumptions are misleading. There are actually a number of conditions that may contribute to such offending behaviours, which may include complex psychological and social processes and experiences (Pawagi & Lang, 1999). Specific examples of these factors include:

- parenting styles;
- parental supervision;
- parental responsiveness or un-responsiveness to the needs of the child;
- socio-economic stress;
- transience;
- school attendance and performance;
- peer influence and risk-taking behaviours; and
- alcohol and other drug use.

In context, the presence of these risk factors does not equate to children who experience abuse become offenders, but rather that many offenders have abuse in their backgrounds (Browne & Finkelhor, 1986). Violent victimisation, which occurs in early or late childhood, may have a number of deleterious and enduring effects on how children function socially and interpersonally (Fagan, Piper, & Ceng, 1987). Research indicates that this victimisation can

affect the child's behaviour, their problem-solving skills, and their ability to self-regulate emotions (Finkelhor & Dziuba-Leatherman, 1994). Unsurprisingly, these experiences often then lead to patterns of conflict, aggression, and eventually offending behaviours (Ford, 2002)

Research into reasons behind female offending indicates that the pathways to prison are different for males and females (Carlen, 1983; Chesney-Lind, 1997; Holmes, 2010; Kruttschnitt & Gartner, 2003; Reisig, Holtfreter, & Morash, 2006; Worrall, 1990) and that their types of offences also differ greatly. Two themes clearly emerge in relation to women's offending, namely psychological and social influence on the development of offending behaviours and recidivism. There is also a clear emphasis on how these behaviours contribute to women's entry points into custody. These characteristics include amongst others, homelessness, unemployment, and mental health issues (Andrews, Bonta, & Hoge, 1990; Bartels & Gaffney, 2011; Blagg, 2008; Butler & Allnutt, 2003; Cunningham, 2001; Moloney, Van den Bergh, & Moller, 2009). The Northern Ireland Department of Justice's (2010) report highlighted these factors in its review into engendered vulnerabilities or specific needs within the criminal justice system. It identified significant gendered-based differences in offenders which have been borne out in the UK as well as internationally (Morton, 1994; Salisbury & Van Voorhis, 2009) and included that:

- women should be seen as both offenders and victims;
- the biological differences between the genders create specific consequences for each;
- dysfunctional relationships contribute to women's pathways to crime;
- male coercion is a significant contributor to female offending;
- female inmates are generally primary carers in the home; and
- gaol is considered to be disproportionately severe for female inmates due to the fact that they were originally designed for male inmates, by male administrators.

The types of offending differ between genders also differ, with shop lifting, common assault, prostitution, drug use, drug possession, and low range fraud (Holmes, 2010) being more common for women. The circumstances of female offending pathways also differ between men and women when they enter prison, as women are often reported as being more disadvantaged than their male counterparts, in areas such as mental and physical health (AIHW, 2010), having carer responsibilities (DeHart, 2008), as well as low levels of education (DCS, 2008; NSWCS, 2008).

Indigenous Women and Trauma

As highlighted in the previous sections, Indigenous women as victims, are an under-represented population when gathering statistical data, but remain over represented as victims in NSW (KPMG, 2016). However, the number of Indigenous women in custody has been called by Aboriginal and Torres Strait Islander Social Justice Commissioner, June Oscar, "one of the most challenging human rights issues facing Australia" (McDonald, 2020). This is because even though Indigenous women make up only 3% of the overall population, they account for over 33% of the overall female inmate population (Phelan, Sotiri, & Scott, 2019). Indigenous women experience much lower levels of physical and mental health, and are seen as having much lower socio-economic status, than non-indigenous women. Unsurprisingly, as a population, Indigenous women are also seen as having significantly higher trauma histories, and Indigenous women in custody have higher trauma rates even when compared to non-indigenous inmates (Baranyi, Cassidy, Fazel, Priebe, & Mundt, 2018). In the current investigation, whilst not specifically identified for the purposes of the studies, it was anticipated that there would be a high proportion of Indigenous women participating in the study (Baroness Cortson, 2006; McFarlane, 2017).

International research presents little contention about the disadvantages faced by inmates exiting custody and returning to the community, and highlights the ineffectiveness of

prison in reducing recidivism and discusses a distinct lack of community-based services and interventions. While those female inmates with trauma share much in common, they should not be seen solely as a homogenous group. Of course, skilled counsellors know this, and will tailor their practices to meet the needs of the individual. However, there are subgroups within the prison system that share unique experiences that may not be considered when providing services to deal with trauma, specifically, Indigenous women. When discussing this group, care needs to be taken so as not to politicise their plight any more than it has been. However, the TSTP is a program to deal with trauma, and Indigenous women in prison are not only overrepresented, but the trauma they experience often varies from that of non-Indigenous women. Craven et al. (2016) have advocated for a strengths-based approach that combines Western understandings of mental health with Indigenous conceptualisations of health and wellbeing. Given the overrepresentation of Indigenous women in the prison system, who are disproportionately affected by trauma, there is potential in working with Indigenous researchers and mental health practitioners to use the TSTP in a way that better meets the needs of Indigenous women. Equally as important, the incorporation of Indigenous perspectives of wellbeing are likely beneficial to non-Indigenous women (Craven et al., 2016). Overall, the TSTP should offer a culturally safe and relevant, trauma-specific service, which works in conjunction with other services within the Corrective Services NSW system, to provide a reduction in trauma-specific symptoms. Trauma-specific programs are essential for those Indigenous inmates who are unable, or still working, to heal trauma.

Self Harm and Suicidality

There is a dearth of research (e.g., Andover & Morris, 2014; Dear, Thomson, & Hills, 2000; Gordon, et al., 2015; Sousa, Goncalves, Cruz, & de Castro Rodrigues, 2019; Wawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014; Vollm & Dolan, 2009) which highlights the risk and prevalence amongst female inmates in regard to self injurious (self-harm) behavour and

suicidality. This type of behaviour is defined as "any injury or act that an individual may cause to [themselves], regardless of the motive of lethal intent" (Sousa, Goncalves, Cruz, & de Castro Rodrigues, 2019, p. 2). Self-injurious behaviour is a major concern for inmate populations across the world, including in Australia, which has a reported 21% of female inmates reporting engaging in self harm (AIHW, 2019; Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014; Kenning, et al., 2006). As mentioned earlier, female inmates are a vulnerable group that have a range of complex issues which contribute to this problem, specifically their history of trauma. This history of trauma is often exacerbated by the impact of being in prison, which may in turn make them more vulnerable to mental health issues (Royal College of Psychiatrists, 2010). That history, specifically a history associated with chilhood trauma, has been consistently linked with self harm, which presents a major issue for the inmate poplation, given the high reports of childhood sexual assault.

Damage to the inmate's emotional processing abilities and any resulting dysregulation when they were young, may result in the use of self harm as a coping strategy when they reach adulthood (Yates, 2009). The inmates may also use self-harm as a method of punishing themselves due to misplaced blame, guilt or shame (Facer-Irwin, et al., 2019). However, the research (e.g., Howard, Karatzias, Power, & Mahoney, 2016) suggests that providing an intervention to ameliorate trauma histories, improve emotional regulation and address hyperarousal, could reduce self harm. As well as intervention, a significant factor in the mediation of self harm is the capability and capacity of correctional staff to respond appropriately. However, research indicates that there is frequently a lack of understanding by correctional staff to understand self harm and its consequences and that if it is to be managed appropriatley, specific training should be provided (Sousa, Goncalves, Cruz, & de Castro Rodrigues, 2019). This lends support to the need for not only a trauma-specifc service for female inmates, but also a trauma-informed model of care in which to administer it.

Treatment, Healing and Recovery

Underpinned by cognitive behavioural theory, the most common and universal treatment approach adopted for treating victimisation related trauma is the application of trauma-focussed cognitive behavioural therapy (TF-BCT: APA, 2004; Taylor, 2006). This type of therapy is part of a trauma-focussed treatment which belongs to the larger cognitive behavioural therapeutic (CBT) approach (Australian Centre for Post Traumatic Mental Health, 2013). This approach is a short to medium-term psychological intervention which sets out to address the sequelae of exposure to the reported victimisation and associated trauma.

Regardless of the type of modality used to treat the trauma there a number of factors which influence the outcomes of the treatment, referred to as moderating or mediating variables. These include, the nature of the trauma, therapist characteristics, the successful development of a therapeutic alliance, cultural context, social norms, active participation of the participant etc., The development of a strong therapeutic alliance with the counsellor, was considered to provide the strongest factor of success in regard to the outcome of counselling (Smith, Thomas, & Jackson, 2004).

Guiding Theories

The theories relating to gender, pathways to crime, and recovery from trauma, considered in this research are presented in this section. They provide a combination of criminological and psychological perspectives, which accounts for offending, its causes, the impact of trauma on offending, as well as recovery from trauma and desistence from crime.

Pathways Theory

When considering women's pathways to offending, Pathways Theory claims that gender plays a key role (Gehring, 2016). As Ney and Martin (2005) suggest, there are specific factors which contribute to women's offending behaviour are different than men's offending. For example, women are more susceptible to violent victimisation (e.g., sexual assault or

domestic and family violence) than men. These trauma histories are often intrinsically linked with lower socio-economic statuses, alcohol and other drug use, and are often at the root of women's pathways into prison (Chesney-Lind & Pasko, 2012).

Victim/Offender Impairment

Impairment theory puts forward the proposition that people with significant physical or psychological impairments are more likely to engage in offending types of behaviour than those without those impairments (Winter, Spengler, Bermpohl, Singer, & Kanske, 2017). Not only are those impairments more likely to influence their engagement in offending behaviours, they are also likely to put them at a higher risk of being victimised themselves (Raman, 2018). The female inmate population presents with a higher prevalence of mental health issues which provides support for this theory as they are often viewed as being psychologically impaired in some way.

Relational Theory

This theory, although not well presented in current literature, presents another gender-specific theory to account for women's development. Although it is a theory normally reserved for explaining women's development, it does apply in the context of women's offending as it suggests that at the core of a healthy sense of connection and interpersonal relationships (Mastrorilli, 2008). The sense of self is developed through women's interactions in establishing and maintaining relationships with others. However, once that connection has been severed as it often is when women experience the trauma of violent victimisation, the resulting experiences may lead them into engaging in offending behaviours. Additionally, this theory suggests that women's trauma histories account for alcohol and drug use as a way of self-medicating, which in turn is connected to poor mental health outcomes (Chesney-Lind & Pasko, 2012).

Trauma and Addiction Theories

When considering the trauma histories of women in custody, there is an intrinsic link between their experiences of trauma and addictions to drugs and alcohol. Despite the high correlation between the two issues, when it comes to being treated in custody, addictions are often treated separately and trauma not at all (Covington, 1998). This section considers trauma from, firstly, a trauma theory perspective, acknowledging the impact that the trauma has on the individual. This is followed by trauma-informed practice and trauma-specific services, which although connected, address organisational culture and practice when responding to trauma, and clinical interventions for the trauma itself.

Trauma Theory

Whilst there is a generally accepted consensus about what trauma is, there is less agreement on different aspects of trauma, as each type of trauma can provoke a different response in the individual experience the traumatic event (Beck, et al., 2015). For example, trauma resulting from the death of a parent to a long-term illness, would not elicit the same trauma response as a child victim of sexual assault, and which would be different again for an adult surviving an earthquake. As each type of traumatic event is different, so too are individual differences in women experiencing violent victimisation (Baldick, 2015). As some women may have an immediate reaction, others have a delayed response, trauma theory then suggests that the relationship between trauma and violence is a complex one (Evans, Watkins, & DiLillo, 2014). Regardless of the source of the trauma, trauma theory suggests that it is not the actual traumatic event which causes harm in an individual; rather, it is the physical and psychological reaction from the body and mind that causes the harm. The trauma then manifests itself by affecting memory, regulation, thoughts, attachments and physical health (Goodman, 2017). As this theory has gained acceptance, two main approaches have been suggested for working with

that trauma, specifically a model of trauma-informed care and within that model trauma-specific service.

Trauma-Informed Practice

As the name suggests, trauma-informed care/practice is a strengths-based approach to working with individuals which, according to SAMSHA (2015):

> realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients and their families; and responds by fully integrating knowledge about trauma into policies, procedures and practices, and seeks to actively resist re-traumatisation (p. 9).

Trauma-informed care is underpinned by a series of principles which include: establishing safety, building trust, providing support, working collaboratively with the traumatised client, and fostering the empowerment of the client by providing them control over their choices (Kezelman & Stavropoulos, 2012). These trauma-informed principles are important for working with coerced clients in the criminal justice system, where a high percentage of clients have experienced trauma and may be re-victimised through standard practices. The implications for establishing trauma-informed principles are significant and can be linked to a reduction in trauma driven behaviours and provide a basis on which to address criminogenic needs (Bloom & Covington, 2005). Once these principles are embedded in the service, the logical next step to working with clients is through engaging them in a trauma-specific service, which aims to assist them to resolve their experiences and symptoms of trauma (Harris & Fallot, 2001).

Trauma-Specific Services

Where trauma-formed services acknowledge the presence of trauma, trauma-specific services are clinical interventions designed to assist the client in their recovery (DeCandla, Guarina, & Clervil, 2014). These services are evidence-based and are specifically designed to

address trauma as well as co-occurring disorders that may have arisen during or after the trauma (Briere & Scott, 2006). The therapeutic approaches provide an understanding of how trauma is assessed and diagnosed as well as formulate a plan for treatment (Kezelman & Stavropoulos, 2012). There are a range of treatment approaches to treating trauma, such as trauma focussed, cognitive behavioural therapy, exposure therapy and eye-movement desensitisation therapy; however, it has been acknowledged that many of these interventions would require some form of adaptation for use in specific environments, such as prisons. Additional research in this area is vital in order to progress the theory, practice and treatment of trauma, particularly in the criminal justice sector. Providing a basis for understanding, working with and resolving trauma in a population that has been identified as presenting with high levels of complex trauma, is critical in understanding their recovery.

Desistence Theory

Desistence Theory, is a "criminological phenomenon which describes how criminal offenders stop their offending behaviour" (Harper, 2013, p. 1). Within the field of criminology, desistence is seen as "the long-term abstinence from criminal behaviour among those for whom offending had become a pattern of behaviour" (McNeill, Farrall, Lightowler, & Maruna, 2012, p. 2). Desistance theories take account of how the social positionality of an individual and opportunities to which they are exposed interact with agentic factors to bring about the termination of offending and offending-related behaviours (Farrall, Bottoms, & Shapland, 2010; Maruna, 2007; Massoglia & Uggen, 2007).

In developing any desistence theory based framework, consideration would have to be given as to how and why the process of desistance commences. Normally this is considered in the context of prisoners following their release from custody, however the current investigation focussed on inmate populations, not post-release offenders, so there would be no offending behaviours from which to desist. Additionally, it is argued that desistence theories, like many

other theories (Leverentz, 2014; Osterman, 2018) are generally "male centric, individualistic and ignore[s] the interlocking structural contexts of race, class and gender" (Carlton & Baldry, 2013, p. 65). Carlen (2002) suggests that this is a problem of scale, or more to the point, is "due to women not being delinquent enough" (p. 4). However, the findings from this thesis may contribute to the understanding of the factors that are seen as common to the desistence experiences and are central to understanding the applicability of this theoretical approach.

According to Maruna et al. (2015), the range of desistence theories can be organised into two groups, one characterised by 'internal' factors and the other is focussed on 'social' factors. The first group, relate to the maturation process, whilst the second group, is concerned with identity and cognitive transformation (Blakemore, 2013; Giordano, Cernkoovitch, & Rudolph, 2002; Hughes & Bayin, 2012). Relationships are significant to desistance theories in general, as the establishment of significant and meaningful relationships can be seen as a 'turning point' for many offenders (Bersani & Doherty, 2013; Laub & Sampson, 1993). It is acknowledged that for female offenders, their intimate relationships are characterised by abuse, violence, and drug use and often significant partners are regularly implicated in their offending behaviour (Barlow, 2016; Blanchette & Brown, 2006; Chesney-Lind & Pasko, 2103). Therefore, establishing safety and trust with another person, the core principles of trauma recovery models, is challenging (Broidy, Payne, & Piquero, 2018; Karlsson & Zielinski, 2018).

Given the impact that relationships have in regard to women's pathways to offending, juxtaposed with the pro-social relationships with trauma counsellors, the experiences of female inmates in this study will further add support to the claims of damage that unhealthy relationships can do to individuals, and the impact that positive relationships can have in assisting them to desist from offending behaviours (Barlow, 2016; Blanchette & Brown, 2006; Chesney-Lind and Pasko, 2103). This approach requires a combination of the underpinning knowledge of desistance theories, trauma theory and research, the impact of adverse childhood

experiences, and trauma specific clinical practice, which is found in the trauma recovery process (Skuse & Matthew, 2015).

Theories of Recovery

In terms of recovery for victims of crime, Trauma Theory (Bloom, 1999) provides an excellent staring point as it provides us with not only an understanding of what psychological trauma is, but the implications it has for behaviour and (loss of) control. Van Der Kolk (1996, p.32) defines traumatisation as occurring "when both internal and external resources are inadequate to cope with external threat". As mentioned previously in this chapter, the trauma (external force) does not cause the damage; the damage is caused by an individual's response or inability (internal resources), to process that trauma (Perry, Pollard, Blakely, Baker, & Vigiliante, 1996). It is this point which underpins the current research. In terms of the actual recovery process, the first step is an evaluation of the symptomology presented (APA, 2004).

As previously stated, experiencing trauma does not necessarily result in traumatisation and subsequently require treatment. Strong support networks, such as family and friends, can often negate the need for intervention. However, there will be a high proportion of individuals who do not recover and require therapeutic intervention (Breslau, Davis, Andreski, & Peterson, 1996; Herman, 1997). In the case of violent victimisation, for some people the trauma response experienced may be considered requiring treatment from a trained mental health professional before recovery can occur. Treatments for trauma following violent victimisation normally include some form of trauma-focused psychological interventions. These types of therapeutic modalities focus on providing psychoeducation, stress management techniques (such as deep breathing techniques), and assist the individual to address the traumatic experiences/memories in a safe and controlled manner. Utilising a combination of a medico-model/trauma focussed can assist by proving psychotropic medications concurrently with the therapy (Yehuda, 2002).

There are potential differential diagnoses frequently present when trauma is seen as the root cause of symptom onset (Agaibi & Wilson, 2005; APA, 2004; Borkovec & Costello, 1993). It is then seen as the role of the clinician to begin any treatment process through initial evaluation of the presenting symptoms and evaluation of the specific trauma response (Kluft, Bloom, & Kinxie, 2000). The evaluation should include all aspects of post-traumatic symptomology, sequelae and co-morbidly deemed to be relevant (Bell, Jenkins, Taylor-Crawford, & Chalmers, 1988). This structured approach provides an appropriate method for assessing the individual, as it provides a diagnosis, and formulates a treatment plan.

Many of the supporting theories associated with recovery from trauma are complementary and generally focus on precipitating and perpetrating factors rather than pre-disposing or protective factors (Taylor, 2006). The most universal of these theories and the most applicable to the current research is the cognitive behavioural theory of recovery. This theoretical approach acknowledges cognitive processes as being central in the response to trauma symptoms and balances it with a significant rationale for helping the client to disconnect trauma symptoms with current circumstances (Cohen, Deblinger, Mannarino, & Steer, 2004; Smith, Perrin, & Yule, 1998; Taylor, 2006). However, this approach does need to be expanded to include the context of social relationships in order to fully address recovery from trauma and rehabilitation of offenders.

There is no single definition of cognitive-behavioural theory. Instead, cognitive-behavioural theories are considered to be a set of related theories, which have evolved from the vast array of research and practice. These related theories are then united by commonly agreed upon assumptions, techniques and research strategies (Saxe, Ellis, & Kaplow, 2006). Yet, they still retain individual diversification in the impact that cognition has upon specific behaviour change. The overarching theory brings together behavioural and cognitive theoretical views, each with its own theoretical assumptions and intervention strategies.

Despite that diversity, the theory as a whole reflects the need for an application of both a cognitive and behavioural approach in understanding and addressing specific needs. The alibility to utilise a range of complementary and integrative approaches under the CBT approach ensures that a fuller therapeutic intervention model can be adopted. This provides for a more flexible treatment plan. CBT and its recommended methods of interventions and approaches are considered to be extremely influential and effective in the resolution of trauma. Specifically, Trauma Focused CBT, which is widely used to address the impact of trauma stemming from occurrences of violent victimisation. Whilst the proposed study will not necessarily expand Cognitive Behavioural Theory, it will contribute to the expansion of intervention techniques as they are tested in the correctional environment.

Theories of Offending

It is important to consider how psychological trauma, or rather the resolution of psychological trauma, all fits into the concept of offending and rehabilitation. Whilst this is not the purpose of the current investigation, it will likely be a component in the development of rehabilitation planning. A range of competing theories exist to account for offending behaviour and consist of approaches stemming from: biological and psychological theories (Andrews & Bonta, 1998; McMillan & Chavis, 1986); social disorganisation theory (Pincus, 2004); learning theories (Gendreau & Ross, 1987); strain theories (Blevins, Listwan, Cullen, & Jonson, 2010; Ruddell & Gottschall, 2014); control theories (Clark-Craig, 2014); integrated theories (Barak, 1998); rational choice and routine activities theories (Siegel, 2005; Matsueda, 1988), and feminist theories (Chesney-Lind, 1989; Phillips & Harm, 1998). Each perspective presented by the varying theories suggests that no one specific theory underpins offending. However, it is also suggested (Day, Bryan, Davey, & Casey, 2006) that a multifaceted approach is required to account for human behaviour at all levels of society. Specifically, one theory alone and in isolation cannot account for offending. Hence, in the current study, a range of theories

underpinning criminal behaviour are used to provide a theoretical framework. These are important to understand, not for the therapeutic intervention required, but to give a broader understanding of the links between offending and victimisation.

There are a number of frameworks by which we can begin to process and understand offending as it relates to female offenders. By far the most popular of these theories is the Psychology of Criminal Conduct (Ward, Collie, & Bourke, 2009). This approach attempts to quantify what the psychological factors of offending are, and define those variables which are believed to be most closely correlated with offending behaviours. The "Big Four" (Phillips & Harm, 1998; Ward, Collie, & Bourke, 2009) psychological variables proposed in this theory include: anti-social behaviours across attitudes; associates; history; and personalities (Warren, et al., 2002). However, this theory does not account for interpersonal variables, such as trauma or prior victimisation.

Links Between Rehabilitation and Recidivism

"Prison is a setting of punishment, an institution of confinement and work, but for inmates, prison is also their home" (Johnson & Chernoff, 2002, p. 148). The impetus then behind any correctional rehabilitation or treatment program is to reduce recidivism (Dowden & Andrews, 1999). Depending on the offence or the inmate's circumstances, additional goals may be set including, including a reduction in drug use, social or financial independence, and/or reunification with family members (Koons, Burrow, Morash, & Byrum, 1997). However, it is acknowledged that the degree to which offending behaviour is controllable, and that rehabilitation is possible, is determined by many interconnected factors none of which alone can explain offending behaviours (McGuire, 2005). The following models provide options in which to consider conceptual approaches to the research at hand.

The risk needs responsivity (RNR) model (Andrews, Bonta, & Hoge, 1990) is currently the dominant treatment model for offender rehabilitation and has broader implications for

reducing recidivism within correctional settings. It presents a set of primary principles that need to be considered, in order to facilitate results that have been demonstrated to have significant reductions in recidivism rates (Ward, Melser, & Yates, 2006). These principles are:

- Risk - where intervention intensity is aligned to the risk level of the inmate;
- Needs - where offender characteristics are associated with reductions in recidivism are assessed and targeted in interventions; and
- Responsivity - where the intervention engages the cohort and considers characteristics (such as values, motivation) to engage the offender in beneficial treatment approaches.

This model argues that individual offenders differ significantly in terms of their motivation to participate in treatment, and also in their responsivity to treatment modalities. These factors in turn impact on the effectiveness of treatment programs and on recidivism rates in general. As a result, consideration must be given to the offender's motivation to change as part of any treatment program. Overall, providing a counselling response to the offender's needs to address prior traumatisation should impact on both the Needs component as well as the *Responsivity* component.

As a counterpoint to the RNR theory of treatment and rehabilitation of offenders, the recent focus has been on a more progressive approach, referred to as the "Good Lives Model". This positive psychology approach to rehabilitation (Ward & Brown, 2004), is a theory which posits that current risk-needs approaches have too narrow a focus in order to reduce offending behaviour. Under these risk-needs approaches, individuals are reduced to a culmination of risks (Chesney-Lind, 1995) and that any success in recidivism can be viewed as being achieved from risk reductions by acquiring specific skill sets. RNR also fails to give adequate thought to the engagement with individual motivation and the connection with the "importance of giving people positive reasons to want to engage in desistance and change not just the capacities to do so" (Polaschek, 2012, p. 16).

This literature review provides an overview of current research and relevant guiding theories in relation to trauma and victimisation, from both the general female population and a female offending population perspective. The paucity in trauma-focused research for the offending population, as highlighted in the literature review, demonstrates the need for further research into not only the trauma histories of women in custody, but also the implications for resolving those traumas through participation in a trauma-specific therapeutic intervention. Having reviewed the literature and establishing a strong case for such an intervention, a set of aims, research questions, and research hypotheses can be formulated to guide an empirical investigation into the efficacy of an intervention used by Corrective Services NSW; and are presented in the next chapter.

Chapter Summary

Female inmates often present with a significant history of trauma as a result of prior victimisation, which largely has been left untreated. Addressing this trauma history would not only serve to improve the overall mental health and wellbeing of the female inmates but can also contribute to reducing recidivism. Something governments around the world are interested in addressing as a priority. This chapter commenced with an examination of the existing literature and clinical research on trauma and victimisation. Subsequent sections examined the effects of victimisation on women and women offenders as to how it relates to their offending in particular. It further examined the need for treatment methods and treatment frameworks for victims that are based on the theory and practice of counselling modalities. The literature reviews also considered the significance those theories had for rehabilitation and recidivism, following the identification of, and intervention for, prior victimisation. This review of the literature suggested that individual trauma-informed counselling interventions are appropriate for the treatment of trauma as a result of violent victimisation. Use of the counselling program

in prison provides options for addressing this trauma, particularly for a population who are unable to access publicly available programs due to their incarceration.

CHAPTER 3

Aims and Hypothesis

"Our Jails are a mirror of our community. If it's happening in our community, it's happening in our jails"

Carrie Hill, National Sheriffs Associations

Introduction

As stated in the previous chapter, female offenders and female victims are often considered as two separate and discreet groups, despite presenting with significant histories of abuse across their lives, commencing in childhood and spanning across the lifespan into adulthood (Corston, 2007; Kerig & Ford, 2014; Salisbury & Van Voorhis, 2009; Stathopolous & Quadara, 2014). In responding to inmates' past experiences of victimisation, Victims Services and Corrective Services NSW implemented in November 2012 a TSTP which provided an opportunity to collect details of female inmates' trauma histories and conduct an empirical evaluation of the intervention using both quantitative and qualitative methodologies.

To evaluate the TSTP, a research question as to whether trauma can be effectively treated in a correctional facility was adopted? To answer this question, a set of overarching aims was proposed and three interrelated studies were developed. This chapter introduces these overarching aims and studies, along with a set of hypotheses and research questions for each of the three studies. Rationales are presented for each hypothesis and research question as a means of justification for their inclusion.

The Studies: An Overview

Overarching Aims

The overarching aims of the current investigation are to:

1. compare and contrast the self-reported trauma histories of a female inmate population with an exact matched female community sample;
2. evaluate the changes (if any) in participants' mental health following their participation in the counselling program; and
3. explore the participants' experiences in completing the counselling program from both the perspective of the program participants and the perspective of professional prison staff to gain further insight into the success of the program.

Brief Description of the Three Studies Comprising the Present Investigation

Study 1 is a quantitative study and aims to investigate the differences in the trauma histories of a sample of inmates and a cohort of exact matched community participants. This study sets out to establish what, if any, differences appear in their respective reported trauma histories. These differences relate to whether polyvictimisation is present; if multiple offenders are reported; when, across the lifespan, the victimisation occurred; and the diagnosis provided for participants. The study will be evaluated against aspects of the literature review in Chapter 2, which suggests that inmate and non-inmate trauma histories are different; specifically, the experiences of inmates would have significantly more complex trauma histories than their community counterparts.

Study 2 is a quantitative study, which utilises an experimental group and wait list control group (both comprising inmate participants) to consider if the counselling intervention provided had an impact on psychological domains (depression, anxiety, and stress). The two custodial groups were then compared to the community-based sample used in Study 1 to determine if the custodial and community groups had different responses to the intervention.

Study 3 utilised a qualitative approach to consider the experiences of participants (both the community based and the custodial groups) in the counselling intervention. It also considered the opinions and perceptions of members of professional groups (e.g., correctional officers, psychologists, programs staff, justice health staff) working with the inmate population. The opportunity to listen to inmates and community participants tell their stories, as well as listen to members of the professional groups, not only provided a rich perspective on the intervention itself, but also provided insights which may not have been captured from the previous two quantitative studies.

Research Questions and Hypotheses

A set of numbered research aims has been provided as a guide for each study which forms part of the investigation. A three-digit identifier has been provided for each hypothesis, or research as it appears. The identifier has three elements, the first number denotes the study, (either Study 1, Study 2 or Study 3), the second refers to the aim of the study, and the final number relates to the hypothesis or research being referred to. So, if the number 2.1.3 was presented, it would refer to Study 2, research aim 1 and hypothesis 3. All hypotheses have been presented in a similar fashion with clear identifiers and labels. These identify which study and aim that the hypothesis refers to.

All hypotheses provided within this chapter, have been founded on related theories and relevant research, or they have been developed after a careful review of the literature that corresponds to corresponding literature which focuses on victimisation and the resulting trauma. During the research, it was not always possible to form a hypothesis as there may have been disparities in the research. In these instances, a research question has been provided as a substitute. Regardless of whether a hypothesis or research question has been provided, each has the same purpose, to guide the research to meet the study's aims.

Study 1: Comparison of Trauma Histories Between Custody and Community Samples

Introduction

An overview of the aims and hypotheses are provided here for Study 1, as they relate to trauma histories between the two groups of custodial and community participants. Each research aim is accompanied by relevant hypotheses and where appropriate, research questions. At the conclusion of each section, a rationale has been provided for each hypothesis as they relate to Study 1.

The Problem

Are there differences in the trauma histories between a sample of female inmates and an exact matched community sample who have reported the same act of violence perpetrated against them? Which parts of the participants' trauma histories provide evidence of this difference and to what extent do they differ? For example, do female inmates report higher levels of polyvictimisation than the cohort of female community participants? After establishing if differences in histories are present, the profiles of diagnoses for the custodial group and matched community sample are contrasted. Are different diagnoses more likely or more prevalent in one group and not the other?

Aims

Study 1 is a targeted investigation which considers the major similarities and differences between the two populations. It has three aims:

1.1 To explore the nature of victimisation that the participants have experienced;

1.2 To identify the point within the lifespan that the victimisation occurred; and

1.3 To consider the differences in the diagnosis that they received as a result.

Statement of the Hypotheses

***Hypothesis 1.1.1: Trauma Histories*.** The custodial group will have a significantly greater level of trauma history, specifically more acts of violence perpetrated against them, than that of a matched community sample.

Hypothesis 1.1.2: Polyvictimisation. The custodial group will have a significantly higher level of polyvictimisation across the lifespan, including multiple occurrences, offenders and familial offenders than that of a matched community sample.

***Hypothesis 1.2.3: Victimisation Across the Lifespan*.** The custodial group will have a significantly higher report of abuse across the lifespan, than that of a matched community sample.

Hypothesis 1.3.4: Diagnosis. The profile of diagnoses for the custodial group will be markedly different from that of a matched community sample. That is, the distribution of diagnoses amongst participants in the custodial group will be notably different from that of participants in the community sample.

Rationale for Hypotheses

There is a wealth of data and research available that indicates that women experience a substantial amount of victimisation and abuse across the lifespan. For example, on a worldwide basis, approximately 35% of women experience sexual abuse by a non-partner (UNWOMEN, 2019); 70% of women experience physical violence by a partner (South African Medical Research Council, 2013); 87% of female homicide victims were killed by a family member, whilst a third was killed by an intimate partner (UNODC, 2019). To put this in context, there are an estimated 5.7 million individual occurrences of victimisation worldwide (UNWOMEN, 2019). In Australia, the data follow a similar trend, with one in four women experiencing some domestic and family violence, perpetrated by an intimate partner; one in five experiencing sexual violence since the age of 15 years old; one in six experiencing abuse before the age of

15; and two in five of women experience domestic and family violence during a period of separation from their partner (Australian Bureau of Statistics, 2017).

Considering the high proportion of women affected by violence generally, the research indicates that as a population, women in prison present with a much more significant history of complex trauma arising as a direct/indirect result of violent victimisation than the community averages (Radatz & Wright, 2017; Scott, 2004; Shaw, 1994). Covington (1998) suggests that prior histories of victimisation coalesce among female inmates with more than 57% reporting sexual abuse prior to admission (Widom & Maxfield, 2001). This trauma manifests in a number of ways including, physical, cognitive, behavioural, and emotional effects impacting on the mental health functioning of these women (Knauss & Schofield, 2009). Further research indicates that female inmates as a subset of the female population as a whole, often present with a greater history of polyvictimisation across the lifespan, primarily occurring in early to late childhood, than a comparable non-offending cohort (Radatz & Wright, 2017; Weaver & Clum, 1995). Additionally, in an Illinois prison study, it was estimated that 83% of female prisoners experienced some post-traumatic stress disorder (PTSD) symptoms, concluding that a possible 60% of inmates could be diagnosed with PTSD (Reichert & Bostwick, 2010). This highlights that the female inmate population may have trauma which is undiagnosed, misdiagnosed or simply unaddressed.

Other research suggests that the trauma histories of inmate and non-offending populations have not been directly compared as the studies focussed on either one or the other population (victim or offender), depending on the focus of the research (Baranyi, Cassidy, Fazel, Priebe, & Mundt, 2018; DeHart, 2008; DeMaris & Kaukinen, 2005).Despite this, there remain suggestions that inmate populations experienced higher rates of victimisation than their non-offending peers and that this means they experience more victimisation at the hands of

more offenders (Browne, Miller, & Maguin, 1999; DeHart, 2008; Finkelhor, Ormond, & Turner, 2007).

Further, it has been suggested that certain types of trauma are more likely to be experienced by women, such as child sexual assault, assault, and domestic violence (Gavranidou & Rosner, 2003). These events increase the risk of women developing PTSD more so than other traumatic events such as illnesses or accidents (Creamer, Burgess, & Macfarlane, 2001). This raises questions as to whether or not a female inmate population would significantly differ in terms of their trauma histories, when compared to a non-offending sample.

Traumatic experiences occurring in childhood have been linked to a range of mental health issues, which have been shown to persist beyond six months post trauma (Messina & Grell, 2006). These issues include depression, anxiety, stress, and other negatively attributable behaviour, stemming directly from the trauma experience (Bal, Bourdeauhuji, Crombez, & Van Oost, 2005; Kaplan et al., 1999). This research indicates that girls experiencing this form of trauma experience higher levels of post traumatic symptoms, which can lead to behavioural problems in adolescence and early adulthood, including offending behaviour (Appleyard, Egeland, Van Dulmen, & Sroufe, 2005; DeHart, 2008). It is likely that there would be higher incidences of victimisation in the inmate cohort, that the acts of violence would be more severe, and that there would be multiple offenders across each act of violence (Shonkoff et al., 2012). When these statistics are considered in the context of a prison-based sample, it can be seen that inmates reported higher occurrences of victimisation than their community samples and are then more likely to receive a diagnosis of PTSD (Beck & Johnson, 2008).

Summary

The aims for Study 1 set out to explore the history of victimisation between the two (inmate/non-inmate) cohorts and identify the characteristics of that victimisation. Comparing

the two cohort's experiences of violent victimisation will provide a profile of their experiences and any differences between them. It will also provide a basis for comparison in Study 2 and may identify key factors in treatment outcomes when a trauma-specific intervention is provided in a prison setting.

Study 2: Quantitative Analyses of Trauma-Specific Treatment Program

Introduction

It is acknowledged that as a practice, incarceration impacts on an inmate's ability to address historic and long-term issues related to earlier victimisation and traumatisation (Anumba, Dematteo, & Heilbrun, 2012; Blanchette & Brown, 2006; Covington, 1998). However, at the time of the introduction of the TSTP to the NSW prison system, no specific program existed in correctional centres in NSW to address these issues. While current therapeutic interventions in custody do consider some of these issues, they do so only in terms of that person's offending behaviour. This occurs without consideration of issues which may have occurred for that person commensurately, such as domestic violence or sexual assault (Heseltine, Day, & Sarre, 2011). The nature of the trauma and its association with future offending behaviour, and the lack of programs in prison to address this, indicate that higher levels of unresolved trauma in inmates are expected when compared with the community cohort (Clark, 2002).

Having explored group differences of custodial and community participants in Study 1, this second study sets out to explore how effective a TSTP was in reducing symptoms associated with the trauma across the two groups. This segment provides research aims for Study 2, it further provides the accompanying research hypotheses to support those aims, and a set of rationales for the hypotheses.

Aims

The aims of Study 2 are to:

2.1 determine how effective the TSTP was in reducing symptoms across all participant groups,

2.2 determine if the TSTP was effective in contributing to post treatment gains across all groups, and

2.3 determine if the TSTP impacted the inmates' readiness to change status.

Statement of Hypotheses

Hypothesis 2.1.1. Overall Experimental Effects of the TSTP. The TSTP will provide statistically significant post-treatment gains (T3) in DASS scores (depression, anxiety, and stress) across all three groups (ITG, WCG and Community).

***Hypothesis 2.2.1. Lasting Effects of the TSTP* (10 Weeks Post Treatment).** Post-treatment intervention effects (T3) as measured by DASS scores, will be maintained at 10 weeks after the completion of the TSTP (T4). Specifically, the DASS scores will be maintained at T4.

Hypothesis 2.3.1: Inmate Motivation. At the conclusion of the TSTP, inmates will be more likely to be ready to address criminogenic needs as a result of addressing trauma histories.

Rationale for Hypothesis 2.1.1

In terms of recovery for victims of crime, Trauma Theory (Bloom, 1999) provides an understanding of what psychological trauma is, and its implications for behaviour and subsequent emotional dysregulation. As outlined in the literature review, psychological traumatisation is defined as occurring when "both internal and external resources are inadequate to cope with external threat" (Van der Kolk, 2015, p. 1). The *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* provides information about the most effective treatments for PTSD (Phoenix Australia - Centre for Posttraumatic Mental Health, 2013). It suggests that trauma-focussed interventions are necessary to treat trauma-related mental health issues and that simply treating presenting

issues, rather than the trauma will not provide a long-term resolution to those mental health issues (Kezelman & Stavropoulos, 2012). What has been found when applying trauma-specific treatment processes to therapy is that "even severely traumatic early experience, trauma can be resolved" (Kezelman & Stavropoulos, 2012, p. 63) and the results can be seen as enduring (Rotyhschild, 2000)

Rationale for Hypotheses 2.1.2

As outlined in Chapter 2 (Literature Review), prisons were not designed as a setting for providing inmates with an emotional outlet to address their psychological needs even though they may be linked to the development of offending behaviours (Stathopolous & Quadara, 2014). That is not to say therapeutic services do not occur, rather that prisons have a focus on offending behaviours and addressing criminogenic needs. According to Bloom, Owen, and Covington (2003), prisons are based on power and control and established to maintain safety and security, often through punishment. Such an environment does not lend itself to the provision of trauma-informed services.

Despite the acknowledgement that psychological gains from trauma-informed services can be potentially beneficial for rehabilitation, the services are not in place prisons within NSW (Stathopolous & Quadara, 2014; Ward, Collie, & Bourke, 2009). However, it has been shown that despite female women offenders having high rates of victimisation and entering the prison environment with significant trauma needs (Fournier, Hughes, Hurford, & Sainio, 2011; Gleeson & Baird, 2018; Salina, Lesondak, Razzano, & Parenti, 2011), prior to the intervention, there is no trauma specific service for female inmates to access in order to resolve that trauma in New South Wales (Corrective Services NSW, 2019). This is surprising, because trauma-informed treatment programs have been shown to be effective for promoting recovery within the general population, specifically, in terms of reducing PTSD related symptoms as well as those associated with depression and anxiety (Messina, Calhoun, & Warda, 2013).

The issues associated with the treatment of trauma in correctional facilities have been noted as being problematic, as there is always a degree of stress within those facilities as well as the threat of ongoing exposure to more trauma (Phoenix Australia - Centre for Posttraumatic Mental Health, 2013). As a result, there are few studies examining the effectiveness of trauma-focussed interventions; however, from the studies which are available, there are promising results in recovery from trauma (Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2011; Patterson, Uchigakiuchi, & Bissen, 2013). Furthermore, there is a wealth of studies indicating the efficacy of treatment programs on the reduction of symptoms in general, by which it is acknowledged that therapeutic intervention will result in a reduction of symptoms, the location not-withstanding (Bogat, Garcia, & Levendosky, 2013; Covington & Bloom, 2006; Foa, Zoellner, & Feeny, 2006; Graham-Bermann & Miller, 2015).

Rationale for Hypothesis 2.3.1

This hypothesis raises the premise that inmates would be more pre-disposed to addressing criminogenic needs following completion of the program, than they would compared with a comparable non-participation sample (Dowden & Andrews, 1999; Gendreau, Little, & Goggin, 1996).

Summary

This study lists a set of research questions and hypotheses for Study 2 to determine the outcomes of inmate participants in a TSTP. It is anticipated that results for the hypotheses will make a significant contribution to the body of evidence surrounding the provision of trauma-specific services in correctional facilities.

Study 3: Qualitative Study - Experiences of Counselling

Introduction

A significant body of evidence exists from the perspective of practitioners that provides an insight into what the experience of counselling is like and what behavioural changes can be attributed to counselling and the ultimate success of the therapeutic intervention (Elliot & Williams, 2003). What there is less understanding of, however, is the client's perspective of the counselling experience. There are obvious reasons for this, particularly with victims of crime, in which there are current or pending legal proceedings, confidentiality issues, etc., which provide further barriers. When considering inmates, the problems are again heightened as they are both victim and offender. This study seeks to draw on the experiences of participants (custody and community), as well as those professionals (e.g., correctional officers, programs officers, psychologists, etc.) who work with the participants, to evaluate the TSTP.

As the study presents two separate perspectives of the TSTP, it is considered as two separate components of the same chapter, specifically Study 3a will consider the experiences of TSTP participants, and Study 3b is concerned with the views of correctional professionals who work with the inmate participants.

The Problem

To understand participants' experiences attending counselling, and how successful it was, it was important to consider why people attended counselling in the first place, what their expectations were, how they viewed the process, if they believed that the intervention actually worked, and if so, why? Identifying key strengths and weaknesses of the intervention is important for future service provision, and to determine if it was meeting the need in regard to victimisation or if it was addressing other needs. It is also useful to understand if there were broader behavioural changes as a result of the TSTP, amongst the treatment participants and

the professionals who work with them. It is also important to consider if participant experiences match those of the professionals working with them, particularly in a correctional environment.

Aims

The following aims were specific to participants of the TSTP - that is inmates and members of the community sample:

3.1 Compare and contrast experiences between the custodial and (non-offending) community group in regard to their participation in the TSTP to deal with trauma.

3.2 Illuminate emerging themes that provide an insight into the ability to address trauma issues in a correctional setting.

3.3 Illuminate emerging themes that provide an insight into the behavioural changes that may have occurred following participation in the TSTP.

3.4 Gather insights of any other relevant issues for participants pertaining to the TSTP.

The following aims were specific to professional participants. They have been separated here for ease of reading only and to avoid confusion.

3.5 Illuminate emerging themes that provide an insight into the ability to address trauma issues in a correctional setting;

3.6 Illuminate emerging themes that provide an insight into the behavioural changes that may have occurred following inmate participation in the TSTP; and

3.7 Gather insights of any other relevant issues for professionals working with participants engaging in the TSTP.

Statement of Research Questions - Treatment Participants

The following questions are used to guide focus group discussion for the participants of the TSTP (both the community group and the inmate group):

Research Question 3.1.1. What parts of the counselling program did treatment participants find most effective?

Research Question 3.2.1. Do participants believe, on self-reflection, that there is evidence of therapeutic change and effectiveness following their attendance at the counselling program?

Research Question 3.3.1. What were the perceived strengths and areas for improvement of the counselling for participants?

Research Question 3.4.1. What were the implications of attending victim-focused counselling in a correctional setting, as opposed to community settings, in terms of physicality?

Answers to these questions will provide valuable information not necessarily identifiable from the findings of Studies 1 and 2, and, therefore, provide a further window of opportunity to understand what functional changes can occur as a result of participating in a counselling program.

Statement of Research Questions - Professional Participants

The following questions provide the research focus for the focus groups for the professionals:

Research Question 3.5.1. Can professionals provide an insight into the ability of the program to address trauma issues in a correctional setting?

Research Question 3.6.1. Can professionals who work with female inmates provide an insight into the behavioural changes that may have occurred as a result of participation in the TSTP?

Research Question 3.7.1. What additional themes, that may not necessarily be identifiable from the findings of Studies 1 and 2, can be identified that provide a further window of opportunity to understand what functional changes can occur as a result of participating in the TSTP?

Research Question 3.7.2. Can members of professional groups, such as correctional officers, correctional programs staff, psychologists, and victim's counsellors, provide perspectives on program effectiveness in addition to that provided by the TSTP participants?

Chapter Summary

After discussing how abuse plays out in the lives of female offenders and victims, this chapter posed the following research question: Can trauma be effectively treated in a correctional facility? To address this research question, three overarching aims, three interrelated studies, and a series of research questions and hypotheses specific to each study were presented. The issues raised through these hypotheses highlight the advantages of adopting a mixed-method approach, in order to fully realise the outcomes of the studies and address the overarching and individual aims. The next chapter provides more details in regard to the methodology employed by each of the studies outlined here.

CHAPTER 4

Methodology

"All men by nature desire knowledge"

Aristotle (350 BCE)

Introduction

Adopting a particular paradigm guides the investigator through a specific theoretical and philosophical foundation for the research being undertaken and allows for important decisions to be made as they relate to that research (Neuman, 2013). This chapter describes the methodological approaches taken to describe and report on each study of the research. Following a justification as to why each approach was considered, a description is presented of any methodological issues relevant to each study as well as any general methodological issues relevant to the investigation as a whole.

Research designs can be categorised according to three types of research methodologies, namely quantitative, qualitative, and mixed methods (DeCuir-Gunby, 2008). These methodologies provide "a guide for the processes undertaken during research and underpins the rationale for the chosen methods of approach" (Jirowong, Johnson, & Welch, 2001, p.18). Once the initial research aims, hypotheses, and research questions are identified, researchers are "presented with significant challenges when attempting to choose the most appropriate methods for their investigations" (Blaikie, 2000). However, this is only the first stage of the process of establishing a research methodology; as once the initial research question has been identified, the method decided upon and the research design selected, other important considerations must be given (Hamidreza, Ranibar, Khorasani-Zavareh, Zargham-Boroujeni, & Johansson, 2015). These include: data collection, participant recruitment, research settings etc., as well as other important considerations such as methods of analysis

and ethical considerations. This will be discussed further in the Research Design section of this chapter.

This investigation used three related studies to address the research hypotheses and research questions outlined in the previous chapter. A mixed-methods research design was adopted, with Study 1 and Study 2, being quantitative in nature, and Study 3 (comprising parts a and b) being qualitative studies. The three studies have been described previously, but a brief overview is provided here:

Study 1: A review of literature was undertaken to compare trauma history between custody and community samples. This quantitative study aimed to explore and contrast the experiences of violent victimisation for females in custody with females in the community.

Study 2: The aim of this quantitative study was to evaluate if victims of violent victimisation who are in custody and the community, who received therapeutic intervention for issues pertaining to trauma, would see a reduction in those symptoms.

Study 3: Study 3a is a qualitative study, which explores female inmates' experiences of trauma specific counselling and compares and contrasts them with community based non-offending counterparts. Complementing this, Study 3b also looks at the same issues, but from the perspective of the professionals working with the inmates.

In the following sections of this chapter, consideration is given to the methodological issues common to all three studies. This is followed with a discussion of separate methodological issues, as they relate to each of the three individual studies.

Research Design

Underpinning Research Paradigm

Research "is a formalized and systematic empirical approach to the acquisition of

knowledge in order to increase credibility" (Hancock & Algozinne, 2006). In research, the term "paradigm is used to refer to the philosophical assumptions or to the basic set of beliefs that guide the actions and define the worldview of the researcher" (Lincoln, Lynham, & Guba, 2011, p.91). There are four major philosophical approaches that research can take which can be seen as both guiding the research question and understanding the research, these are: positivism, realism, pragmatism, and interpretivism. These four approaches, or paradigms, form the core values which establish the methodical, strategies and other techniques which are applied to research (Saunders, Lewis, & Thornhill, 2012). A positivist paradigm of research is based on the idea that the best way to gain an understanding of human behaviour is through observation and experimentation (Malhootra, Birks, & Wills, 2012). Pragmatism, the second paradigm, proposes that the best approach to research is the one which answers the research question most effectively (Maxcy, 2003). Realism, the third paradigm, relies on some independence of the human mind from reality and assumes a scientific approach to research (Saunders, Lewis, & Thornhill, 2012). The fourth paradigm, Interpretivism, emphasises that reality is complex and layered and as such, we interpret that reality and then act based on that interpretation (Hammersley, 2013).

The current research focuses on a combination of observation and experimentation, as well as understanding differences between people, not objects, and therefore fits within the positivist and interpretivist research paradigms. This approach to the research design will look at the process of participants' interactions with one another whilst allowing the research to also focus on the environmental contexts in order to obtain a better understanding of the history of victimisation of the inmates themselves. This decision was influenced by my dual role as a psychologist (practitioner) researcher.

Rationale for a Mixed-Methods Design

Having determined the research paradigm, it was then necessary to explore design options for the research. Prudence then dictates that I had to consider a range of research traditions prior to deciding which method would yield the best results, which, in turn, would assist in determining which method best answers the research questions (Kilmaz, 2013). As discussed in the preceding chapter, the research not only sets out to test a particular set of hypotheses, to look at possible causes and effects, but also to understand and interpret female inmates' experiences.

Quantitative and qualitative research designs each have their own respective strengths. The combination of these two separate methodologies to study the same phenomenon was referred to by Denzin (1978) as a mixed-methods design. As a methodology, its philosophical assumptions guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative data in a single study or series of studies. The purpose of mixed-methods research combines the strength of both qualitative and quantitative approaches in order to provide a more comprehensive answer to the research question (Andrew & Halcomb, 2006).

Of course, the mixed-methods approach is not without its limitations. One such limitation is that because two data samples are collected and then analysed, more time may be required to achieve the desired outcomes. Upon weighing the strengths and limitations of the mixed-methods design, I chose it as the approach for this thesis as I am investigating the outcomes, beliefs, opinions, and experiences of participants engaging in a TSTP. In this way, in addition to collecting quantitative data via psychometrically sound survey instruments, participants are provided an opportunity to reflect on their lived experiences as well as offering opinions on the TSTP with the expectation that it would promote more in-depth discussions.

Firebaugh (2008) has suggested that, very often, a full understanding of some phenomenon requires both quantitative and qualitative data. I believe this to be certainly true of this investigation. A mixed-methods approach was used in order to gain multiple insights into the TSTP and participants as a means for providing a more accurate response to the overarching research question of this investigation, as to whether trauma specific counselling can be effective in prison. The use of two or research methods in conducting research is referred to as triangulation by some researchers (e.g., Mathison, 1988). The value of triangulation "lies in providing evidence such that the researcher can construct explanations of the social phenomena from which they arise" (p. 15). Further, triangulation can strengthen validity and reliability (Greene, 2007; Willig, 2008) and is elaborated on later in this section when discussing validity.

Quantitative approaches are certainly valuable, and although the statistical procedures used for this thesis were appropriate, by themselves, they are somewhat incomplete. This is perhaps why Freedman (1991) suggests that what is needed is "reality tests instead of *t* tests" (p. 358). Of course, *t* tests, and quantitative methodology more generally, do reflect reality and provide a very valuable window of opportunity to view inmates' responses to the TSTP; the qualitative techniques of interviews and focus groups simply provide another valuable window of opportunity.

In Study 1, the focus was on elucidating key differences in the victimisation between the incarcerated and non-incarcerated groups providing some insight into trauma histories and how much could be addressed through trauma-specific intervention. In Study 2, the standardised measures used systematically with all stakeholders in the program will allow the researcher to identify positive, negative, or neutral outcomes for the inmates participating in the program. The qualitative approach proposed for Study 3 explicitly interprets the varying perspectives of participants engaging in the TSTP and the opinions of the professional

stakeholders associated with intervention. The unique location of the participants, namely prison, and the nature of the professionals involved with them, meant that there was a complex phenomenon occurring, which was open to different interpretations from different professional groups. The goal then would be to consider each perspective and understand what had occurred as a collective

Research Setting and Participants

The proposed investigation is looking at current female prisoners within the New South Wales (NSW) inmate population. The locations are two NSW Correctional Centres, operated by Corrective Services NSW (CSNSW). The first setting was Dillwynia Correction Centre, which is a medium security institution for females that is within the John Morony Correctional Complex, Windsor, NSW. The other setting was Wellington Correctional Centre, NSW. According to the NSW Justice Website, this is a minimum and maximum security institution for males and females (Corrective Services NSW, 2019).

Choosing these two settings provided a sample of female prisoners (n = 141), in relatively stable conditions, who could participate in the study. These participants were screened to ensure they met the criteria of having suffered prior victimisation and resulting trauma. The nature of prisons housing participants within a confined geographic area greatly facilitated the collection of data, while at the same time meeting the requirements of identifying participants. However, it must be noted that the nature of the NSW Criminal Justice System means that the ability to provide any form of long-term program of therapeutic services, including the intervention used in this study, to inmates within some correctional centres would be difficult. This is because inmates can be transferred between centres for security reasons, be on remand and transferred to and from court with the possibility of release, housed at some centres whilst awaiting a vacancy in another centre, moved for health and welfare reasons or any other number of reasons. Therefore, it is necessary to delimit the setting from which a

population for the study was drawn. Whilst it is impossible to predict transfers of inmates between prisons, selecting medium to long-term correctional centres maximised the opportunities for inmates to complete the counselling program and participate in the evaluation process.

As well as the female inmate participants, a second group of females was selected from the community (n = 423) who received the same intervention, during the same timeframe allowing for an observation in the effectiveness of the TSTP. This further allowed a comparison of the differences/similarities in trauma histories between a custodial based population and a non-inmate population. Participants from the community cohort were selected based on matches to the custody-based cohort. For example, a 22-year-old Aboriginal woman from Auburn who was a victim of sexual abuse who is currently in custody was matched against participants in the community who meet the same criteria. Based on the data provided by Victims Services, the overall size of the available community population undertaking a TSTP, allowed an exact matching process to occur for the custodial-based participants. As this occurs across all three studies, the statistical power and overall validity of the research in improved through providing a larger sample size for comparison.

Sampling approaches vary significantly and largely reflect the overall purpose of the research being conducted (Punch, 1998). For the current research, a purposive sampling method was deemed most appropriate due to the circumstances of the inmate population (Mason, 2002). This allowed me to work with the participants' treating counsellors, to identify participants who may be adversely affected through participating in the study and may not have been psychologically appropriate to participate in the study. The criteria for inclusion for inmates were: currently in custody and not currently undertaking other forms of therapeutic intervention (for the duration of the study).

Ethical Considerations

Consent to undertake the present research was obtained from Australian Catholic University Human Research Ethics Committee (Approved: 10/12/2015; Ethics Register Number: 2015-245H) (Appendix B), and Corrective Services NSW (Appendix C)**.** Support was also provided by the commissioner of Victims Rights (Appendix D). Consent procedures followed opt-in methods, whereby participants were invited to participate in the research or opt-out at any time, should they choose. The TSTP and the interviews were both voluntary. Once participating, participants could withdraw at any time with no penalty. A participants' letter confirming this was provided (Appendix G) This procedure was completed for all participants prior to the administration of each questionnaire administration.

Data Management

In accessing Victims Services information, a condition of use imposed by the Department of Justice, was that I, as the researcher, was obliged to adhere to the following legislative responsibilities. As such any and all data were collected, managed and stored in line with current legislative responsibilities that are already in place for Victims Services clients. That legislation being:

- Government Information (Public Access) Act 2009 (GIPA Act);
- Privacy and Personal Information Protection Act 1998;
- Privacy Code of Practice (General) 2003;
- Health Records and Information Privacy Act 2002;
- Workplace Surveillance Act 2005.
- *State Records Act 2000*

Data relating to individuals will be retained on their individual client files within Victims Services. Raw Data including audio recordings of the interviews with participants, were stored in line with the State Records Act in secure compactus within Victims Services

until authority for disposal is granted. Victims Services is also required to comply with the Privacy and Personal Information Protection Act 1998 (NSW) and the Health Records and Information Privacy Act 2002 (NSW). Data from CSNSW Offender & Inmate Management System (OIMS) and other databases maintained by the individual Agencies. Program documentation and relevant information obtained through Victim Services were also reviewed.

A common issue in any form of research is the possibility of missing data. There are a number of reasons why this could occur: missing items, attrition by service users and so forth. However, it should be noted that it is a condition of approved counsellors' contracts, that that they supply all data requested by Victims Services. A failure to do so results in withholding payment until the requested information is received. The benefits to this study is that there are few, if any missing data. However, to prepare for this possibility, a Restricted Maximum Likelihood (REML) was chosen for use in Studies 1 and 2. This was because it did not provide an estimation based on the maximum likelihood fit of all of the information, "rather it used a likelihood function calculated from a transformed set of data so that nuisance parameters had no effect" (Stats.stackexchange, 2011, p. 2).

Study 1: Comparison of Trauma Histories Between Custody and Community Samples

Introduction

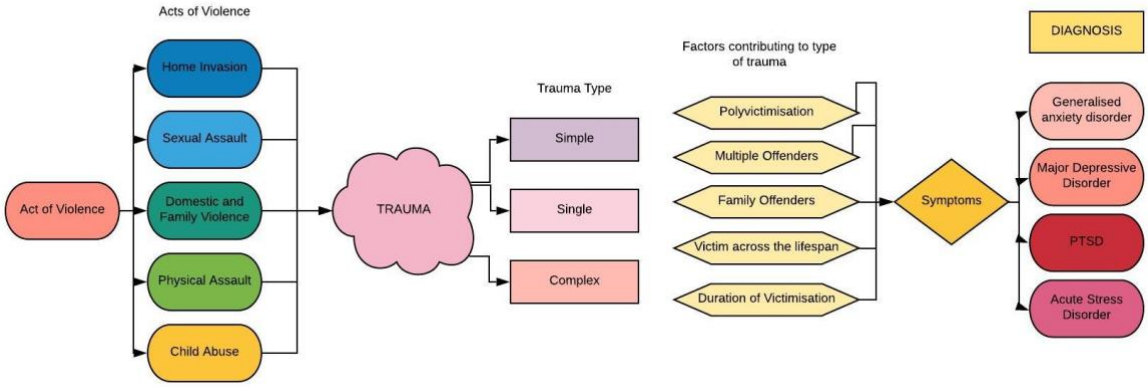
The objective of the first study was to contrast members of the custodial with their community counterparts in terms of their trauma histories and other relevant data. I decided to examine the self-reported trauma history of all participants and determine if there was a difference between the community and custodial group in terms of measures of depression, anxiety, and stress, preceding and following a trauma-specific psychological intervention. An additional aim of Study 1 was to consider differences between the two groups in terms of their mental health, particularly in regard to the diagnoses received and type of trauma experienced. To minimise any confounding and statistical noise, so as to maximise internal validity,

participants from the inmate sample were matched with participants from the inmate sample according to key variables such as act of violence, age, location etc. (Hay & Peck, 1984).

Trauma is a complex phenomenon. Figure 1 below attempts to pictorially represent this phenomenon and introduces terms to describe causes, types, and outcomes. It should be noted that the linear nature of the diagram is to provide the general concept only and, in actuality the factors, all interact across concepts at all points in time and in reality, are much less clear and more complex.

Figure 1

Pictorial Representation of the Concept of Trauma Factors and Outcomes



Data Sources

In order to obtain the trauma histories of participants with minimal invasiveness, two sources were used to gather specific information. These sources were:

1. the applicant's initial application to Victims Services for counselling, which provided: personal information and general details around the specific act of violence for which they were seeking counselling, and
2. the approved counsellors' reports, of which there are three in total for each participant. Participants complete one hour of counselling per week. The first report is completed by the approved counsellor after the first session with the client; the next report is completed at mid-point (10 weeks of counselling); and the final report completed at the

end of the counselling (20 weeks of counselling). The reports also provided details of symptoms present, a diagnosis, and prognosis.

The applications and reports provided a number of key variables for analysis, which pertained to the participant's history of violent victimisation. The nature of the act of violence was reviewed as well as how many other incidences had been self-reported by the participant. In addition, details of the offender's relationship to the participant were gathered and considered when the acts of violence occurred.

Development of Measures – Trauma Histories

Overview

In order to compare and contrast the trauma histories of female inmates with a matched community cohort, a set of measures was chosen based on the information that was available through Victims Services. These measures were:

a. if a history of multiple victimisation was present;
b. if there was a history of polyvictimisation;
c. if multiple offenders were present throughout the trauma history;
d. if a family member was the offender;
e. at which point in the lifespan did the victimisation occur;
f. what the trauma type was; and
g. what the diagnosis received was as a result of the victimisation.

The following sections present more information about each of these measures.

Developing the Measures

From the clients' application and the counsellors' reports, distinct variables relating to participants' histories of victimisation were reviewed. I developed variables for each participant in both community and custody cohorts. Commencing with information relating to the act of violence reported, Victims Services confirmed that the question of whether or not

previous violent victimisation had occurred was asked of the participants during the preparation of each report. In reviewing the material in the reports, there appeared to be a maximum of five acts of violence reported. These acts of violence were then categorised based on the descriptors of the type of victimisation provided by Victims Service, and can be found in the initial application form developed by Victims Services (see Appendix H). They include: assault, domestic and family violence, sexual assault, home invasion, and so forth. A set of dichotomous variables (polyvictimisation, multiple offender, and so forth) was then established from the trauma history and, coded as 'yes' or 'no' in regard to whether there was a trauma history.

Polyvictimisation

The reports were then reviewed to determine whether or not there was a trauma history which included multiple incidences of victimisation beyond that reported in the initial application completed by the participant. This excluded specific acts of violent victimisation, such as long-term domestic and family violence incidents, or childhood sexual assaults which were considered as long-term acts of violence rather than a single event. This is because Victims Services categorise 'long-term' as a continuous act of violence, which according to the research provided in the literature review, impacted the complexity of the trauma. Extracting this information from a review of the Reports, then provided a basis for establishing a measure of polyvictimisation by which the community and custodial participants could be compared. (Finklehor, Ormrod, & Turner, 2004). This categorisation was not to diminish the significance of such acts of violence, but to consider them in the context of continuous events, which is a pervasive, systemic form of abuse rather than a single one-off victimisation. This was in keeping with the review of the literature which suggests there may be a difference in the trauma type of the two groups (that is between community and custodial participants) involved in the TSTP, with the inmate population reporting higher levels of complex traumas

as a result of multiple traumas, when compared to the general community, which report fewer traumas (Browne, Miller, & Maguin, 1999; Chesney-Lind, 1997).

Multiple Offenders

As outlined in the literature review, female inmates are more likely than their non-offending cohorts, to have multiple offenders across their trauma lifespan (Coid, et al., 2001; Raj, et al., 2008). As such the applications and reports were reviewed to determine whether or not there were multiple offences during the participant's trauma history. Acts of violence committed by groups of people were considered as being perpetrated in the same context as a single event or act of victimisation. This was again not to diminish the severity of the violence perpetrated, but to create a method by which the two cohorts could be compared against a single event. Based on the diversity in which approved counsellors collect and report information, in which this information was captured, a dichotomous variable was established; and as with the previous variable, coded as 'yes' or 'no' in regard to whether there were multiple offenders.

Offender Relationships

The Reports also contained specific information about the offender, specifically the relationship to the victim. Reviewing the reports, I concluded that there was sufficient information to determine if the offender was a family member or not. A family member included parents, siblings, cousins, grandparents, aunts, and uncles. Only relatives of affinity or consanguinity were considered. From the specific information provided by the participants and subsequently derived from the application and reports, a new variable was derived, 'Family Member Offender'. The paucity of information as to other types of relationships were too inconsistent to derive further variables.

Victimisation Across the Lifespan

The reports and other materials also provided an insight into when the participants had various acts of violence perpetrated against them; across their lifespan. Based on the information available, distinct periods could be identified. However, there were variances in the research about how to define those timeframes or periods as different age ranges. For example, the Australian Institute of Health and Welfare (2014) considers adolescence to be between 10 years old and 24 years old whilst the Australian Bureau of Statistics (2018) considers adolescence to be between 15 years old and 24 years old. To ensure consistency, the key periods (stages) of growth and human development (Australian Bureau of Statistics, 2018) noted below were considered:

1. infancy (birth to 2 years old);
2. early childhood (3 to 8 years old);
3. middle childhood (9 to 11 years old);
4. adolescence (12 to 18 years old); and
5. adulthood (over 18 years old).

Based on how information was recorded in the reports and materials provided, for the purposes of the current study, key periods of growth and human development: infancy, early childhood, and middle childhood, were collapsed into one variable, "childhood", covering the period from birth to 11 years of age. Combining these three groups was done because these key periods were considered to be the point at which children start to explore and develop a sense of independence, it was also considered an important period should violent victimisation had occurred (Banyard, Williams, & Siegel, 2001; Cicchetti & Carlson, 1989). Adolescence remained from 12 to 18 years of age and was important as this is the stage where young people develop a sense of self, specifically self-confidence, or have self-esteem issues. Erikson (1963) stated, that the adolescent mind was "essentially a mind or moratorium, a psychosocial stage

between childhood and adulthood, and between the morality of the child, and the ethics to be developed by the adult" (1963, p. 245). This statement is important, as the impact of trauma at this stage may have significant detrimental consequences for the adult (DiLillo, Giuffre, Tremblay, & Peterson, 2001). The key period of adults remained as being over 18 years old. For this stage, it was important to note the differences in experiencing trauma as an adult as opposed to a child or adolescent, and what differences could be expected (Lamont, 2010; Van Roode, Dickson, Herbison, & Paul, 2009). For each of the stages listed, the impact of violent victimisation may have different impacts on key physical stages, which in turn affect future behaviours (Davis & Petretic-Jackson, 2000; Herman, 1992; Walsh, Fortier, & DiLillo, 2010).

From these classifications, the following three variables were then created: childhood, adolescence, and adulthood. Each was given a 'yes' or 'no' value for the time period an act of violence occurred across each of the participant's lifespans.

Diagnosis

When TSTP participants engage in counselling, their allocated approved counsellor provides specific details of the presenting symptoms of the participants when they engaged in counselling and were also provided a diagnosis. However, this diagnosis is made after the first session. The subsequent approved counsellors' reports, completed at later time periods also confirmed or even changed the diagnosis for the participants. In addition to the measures provided earlier, the inmates and community group were also compared in regard to the diagnoses received. (e.g., if a particular diagnosis was more prevalent for one group than the other).

The diagnosis/diagnoses was provided in line with the disorders and categories specified by the Diagnostic and Statistical Manual 5 (American Psychiatric Association, 2013). This manual, according to the American Psychiatric Association is "the diagnostic handbook used by health care professionals in the United States and much of the world as the authoritative

guide to the diagnosis of mental disorders" (2013, p. 5). It contains a common language approach to identifying criteria for each mental disorder (112 categories and a possible 297 diagnoses in all). In the current study, it provides consistency in determining a diagnosis (if any exists) for each participant, which allows for a comparison between the two cohorts. In the reports, only one opportunity to provide a diagnosis was available, which provides further consistency in comparing groups.

Exact Matching of Participants

To obtain a set of characteristics by which inmate participants could be matched with community participants, key demographic variables for each participant were taken from the Victims Services data provided to the researcher. With between 6,000 and 7,000 applications on average each year, it was possible to exactly match each of the inmate cohort with more than one person in the community with similar demographic profiles. Although it is acknowledged that it still does not guarantee each participant has had the same lifestyle or experiences, it did provide an opportunity to obtain two cohorts who are similar in backgrounds.

In order to better match participants, Australian Bureau of Statistics Data Cubes were used to create standardisation and allow matches to between data ranges (such as age groups) rather than use absolute values (Australian Bureau of Statistics, 2002). Participants were then matched on specific demographic variables (outlined in the table below) as well as on reported victimisation. In the quantitative study the female inmate cohort (N = 141) was matched with a community cohort (N = 423) providing on average of three community matches for every inmate participant.

Data Analysis

The objective of Study 1 was to examine between group differences in the trauma histories reported by each cohort to their respective counsellor. Initial data screening and preliminary analysis (reliability, frequencies, descriptive statistics, etc.,) was undertaken using SPSS Statistics 22.0 (IBM Corp., Released 2013). Results from preliminary analyses are presented first, with chi squared analyses used where applicable to establish whether significant differences exist between the two participant groups (custody and community) in regard to trauma histories. Before commencing any analyses in this study, the G*Power 3 software program was used to calculate the minimal sample size needed for the chi square analyses.

Summary

This section described key aspects of Study 1. This study is considered essential to the thesis as it seeks to identify any differences between the acts of violence experienced by the inmate population and the community population. Specifically, it considers the differences in levels of polyvictimisation, the number of offenders, whether the offender was a family member, the time points (lifespan) at which the acts of violence occurred and diagnosis as a result of the psychological trauma.

Study 2: Quantitative Analysis of the Therapeutic Intervention

Introduction

Study 2 used both a within-subjects design and a between-subjects design to determine the effects of therapeutic intervention on an inmate population as compared to a community population. This study uses quantitative measures, specifically the Depression, Anxiety, Stress Scale-42 (DASS), and the Treatment Readiness Questionnaire (TRQ). Both of these scales are described in the Instrument and Measurements section of this chapter. The study utilises a Randomised Waitlist Control Group (from the custody sample) to determine first:

1. if a counselling intervention was effective in reducing symptoms in a custodial group, and if it was effective in custodial- and community-based groups; and
2. whether or not participation in trauma-specific counselling had any impact on participant's readiness to engage in treatment relating offending-based issues.

Participants

Note: Participants in Study 1 from the inmate sample and the community sample were matched across specific variables and this matching process was carried across into Study 2. The only difference was that the custodial group was separated into two groups, specifically the Inmate Treatment Group (ITG) and the Waitlist Control Group (WCG). Participating inmates were randomly allocated to each group. Group 1 became the ITG (n = 69), and Group 2 became the WCG (n = 72). Group 3 was the community group (n = 423) and remained unchanged.

Study Design

The study focuses on participants who have self-reported a history of violent victimisation resulting in psychological trauma. A waitlist control group design (WCGD) or randomised controlled trial (RCT) is still considered to be the best standard for evaluating this type of research (Hussey & Hughes, 2007). Assigning participants randomly to a treatment or control group is necessary to determine treatment effect (Burton, Altman, Royston, & Holder, 2006). In these RCT studies, one group receives the intervention (counselling) whilst a second group (control group) does not receive the intervention. The two groups are then compared. However, in the current study, there were significant ethical considerations in withholding treatment from one of the groups.

To resolve this issue, it was decided that providing the treatment to the control group after a delay would allow both groups to receive the treatment avoiding ethical issues (Turner, Richards, & Sanders, 2007). This provided an ethical response to ensuring that all participants'

overall health and wellbeing needs were still met. Across the psychology and social science disciplines, the WCGD is a design which is used to study comparisons in interventions against a control group over different points in time. (Turner, Richards, & Sanders, 2007; Luttenberger et al., 2015; Gold et al., 2017). In this WCGD, participants are assigned to the control group, engaging in the intervention following a pre-determined delay (Hussey & Hughes, 2007).

Study 2 looked at whether or not the intervention was overall successful across the three groups (treatment, waitlist control, and community). It considered differences between the treatment group and the waitlist control group; analysed any lasting effects of the treatment post intervention; and compared treatment effects between the custodial and community groups. This design provided insight into whether or not prison, itself, affected the treatment outcomes. This type of design has been shown to be useful in determining treatment outcomes in other treatment-based intervention scenarios (Brown, Hendricks, Guo, & Pena, 2006).

The Therapeutic Intervention

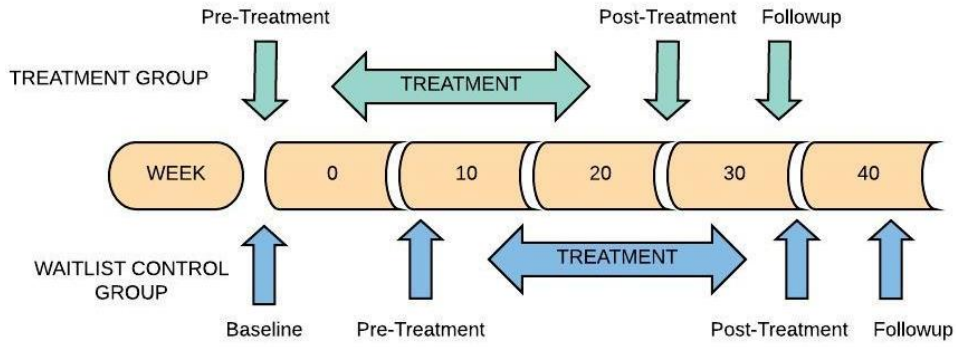
The WCGD is ideal for ethically measuring the treatment effect of a psychological intervention, as it allows all participants to eventually receive treatment (Burton, Altman, Royston, & Holder, 2006). In this current study, by utilising a WCGD, participants know that they will receive the treatment and be more likely to complete the intervention.

In this study, custodial participants were randomly allocated to either the immediate treatment group (ITG) or the waitlist control group (WCG). Community group participants, however, followed the same procedure as those used by the ITG (i.e., there was not waitlist component). Each participant completed the DASS at four equally-spaced time points: 0 weeks (baseline), 10 weeks (mid-point), 20 weeks (completion), and 30 weeks (follow up). The delay for the WCG design was a 10-week time point. Custodial participants (n = 72), were selected to receive the intervention immediately (ITG) after completing baseline measurements; whilst the remaining participants, (n = 69) formed the WCG and received intervention at 10 weeks.

The TRQ was completed by both groups at the base line point (0 weeks) and again at completion of the intervention (20 weeks). An illustration of the study is provided in Figure 2.

Figure 2

Illustration of Waitlist Control Group Design for this Study



Instruments and Measure

Depression Anxiety Stress Scale (DASS)

The DASS is a 42-item scale which measures participants' current emotional state within three separate, but related, domains, specifically depression, anxiety, and stress (Lovibond & Lovibond, 1995). The DASS was already in common use within the correctional facilities prior to the current study and provided a method of being able to establish a baseline measure for each group across each of the planned time waves.

The DASS was administered as a baseline score for all groups (at 0 hours). As the measure is being used as a pre-post-test, it was again administered at the completion of 10 hours of counselling (equating to one hour per week, for 10 weeks). Available research (Gamble et al., 2005; Hull & Corrigan, 2019; Levi, Bar-Haim, Kreiss, & Fruchter, 2015; Liebling, Davidson, Akello, & Ochola, 2016) indicates that trauma counselling is effective after 10 hours of treatment. This is consistent with Victims Services' data showing that an average of 10-12 hours is taken to resolve trauma issues associated with victimisation. To determine the intervention's effectiveness, participants' DASS scores were measured over four

time periods. Additionally, the use of the WCGD enabled a determination of whether the TSTP could be attributed to the change in those DASS scores, or whether another environmental influence, such as the actual negative impact of being in prison, affected the scores (Burton, Altman, Royston, & Holder, 2006).

Treatment Readiness Questionnaire (TRQ)

The earlier part of this study considered whether or not engaging in the TSTP reduced symptoms associated with trauma, but another relevant question to be asked is, whether engaging in the TSTP impacted on offending behaviours. There is then a practical need to assess clients' readiness for treatment for offending behaviour as opposed to victimisation symptoms. This is a criminogenic measure separate from their victimisation experiences, which is assessed both prior to, and following their participation in the program. However, it is also important to realise that participation in a treatment has no bearing on eligibility or approval for engagement in the counselling program. This is important to note, because, if inmates believe that participation in the program may result in an early release, then some of them may volunteer for treatment to gain an early release, and not because they are interested in treatment. The TRQ self-report measure is an approved psychometric measure already used within CSNSW and is widely used across the state to assess treatment readiness in offenders.

The use of the TRQ allows for the assessment of whether overall levels of treatment readiness in the inmate sample significantly improved over the course of the counselling program. It is a "20 item self-report based upon the theoretical model of offender treatment readiness" (Corrective Services NSW, 2016, p. 51) to measure the likelihood of successful intervention engagement to address criminogenic needs. Higher scores on the TRQ indicate higher degrees of readiness to participate and engage in treatment.

The TRQ measures three main areas: attitudes and motivation towards treatment; emotional reactions to the offending behaviour; offending beliefs and responsibility taking; and

efficacy in terms of belief about the ability to change. Previous research conducted on the TRQ by CSNSW illustrated that it displayed adequate levels of convergent and discriminant validity on most measures. Using the TRQ also means that the researcher could effectively evaluate the program from a victim's perspective and obtain sufficient data from TRQ scores collected by CSNSW to determine if the TSTP had any effect on inmates engaging in other programs to address their criminogenic needs.

The TRQ is an independent psychometric tool used by CSNSW and retained on their internal system OIMS. As part of the TSTP, CSNSW will provide a post-TSTP TRQ for inmate participants to compare against the pre-TRQ ratings. Following the completion of the TSTP, a request was made to CSNSW to release the TRQ data.

Data Analysis

This section describes topics related to the data management and statistical analyses used to undertake the present investigation. With regards to the reliability of the DASS, it has been shown to possess good internal consistency with Cronbach's alpha = .85 (Osman et al., 2012). The individual sub-scales of the DASS have good individual reliability, with "alpha values of .91 for the depression subscale, .84 for the anxiety subscale, and .90 for the stress subscale" (Lovibond & Lovibond, 1995, p. 336).

Tests of Multicollinearity

When preparing the data for analysis, consideration was given to whether or not variables would be compromised by multicollinearity, causing statistically incorrect inferences made about the data. These effects can sensitise coefficients (or their estimates) to small changes in the model or reduce their precision. The statistical software, Stata was used to calculate variance inflation factors to identify correlations between variables, determining the strength of the relationships and overcoming the potential problems associated with

multicollinearity. Further, as the DASS scores were simply outcome variables, and not used as predictor variables, so multicollinearity was not an issue.

Repeated Measures Mixed Model Analysis

Consistent with Study 2 aims, a repeated measures mixed model, which is an alternative to repeated measures ANOVA, was chosen for the purpose of analysing the data. This approach was chosen as Study 2 looks at within group differences as well as between group differences, providing a fixed and random effect in the same study. A main advantage to using a mixed-models approach here was that it allows time to be treated as a continuous variable, allowing for a regression line for time rather than an estimation in the means provided by other approaches such as a multivariate approach (Smith, 2012)**.**

Restricted Maximum Likelihood

Estimating the parameters is an important step within the mixed-model design. Although this is not a critical step in the analyses as Stata performs it as an internal function, it is important to note that although the default Restricted Maximum Likelihood (REML) may provide a better estimate of random-effects standard deviation, it does so by averaging over some of the uncertainty in the fixed-effects parameters.

Multi-Degrees of Freedom

In addition to the estimates of the fixed effects, it was likely that two or more random effects would occur. These are the variance of the intercepts and the residual variance which correspond to the between-subject and within-subject variances respectively. Stata was used to produce estimates for each term in the model individually. To gain joint tests (multi degree of freedom) of the interaction and main effects Stata's *contrast* command was used. Stata was then used to undertake tests of simple effects to understand the significant interaction between variables.

Bonferroni Correction

Statistical significance was inferred using a nominal *p* value of < .05. However, as I was using a mixed-model approach, an adjustment was made to minimise the probability of encountering a Type I error, that is obtaining a false positive and thereby rejecting the null hypothesis. This adjustment made was the Bonferroni correction. This correction alters the *p* value to a more stringent level, reducing the possibility of obtaining a Type I error when conducting multiple comparisons. The Bonferroni adjusted *p* value is obtained by dividing the original α-value by the number of comparisons on the dependent variable. For example, in the current study, there would be analyses involving three comparisons (time) on the same dependant variable ($\alpha_{altered}$ =.05/3) = .016.

Summary

This study used a quantitative design to determine the effects of therapeutic intervention on both an inmate population and a community population. This study was crucial to the overall thesis as it helped confirm if the counselling intervention was effective in reducing symptoms in a custodial group; whether or not there were differences between the custodial and community-based groups; and whether or not participation in trauma-specific counselling had any impact on participants' willingness to engage in treatment around offending-based issues.

Study 3: Qualitative Analysis of the therapeutic intervention

Introduction

Study 3 is a qualitative study which uses both interviews and focus groups to obtain insights into the TSTP. Interviews were conducted in order to obtain insights into participant's experiences of participating in a TSTP (*n* = 30) in a correctional facility. Members of the community sample who participated in a community based TSTP (*n* = 30) were also interviewed for comparative purposes. Those experiences of participants were then

complemented with insights and opinions gained from focus group discussions with correctional professionals (n = 27), who work directly with the inmate participants.

Given the voluminous nature of the material which necessarily results from both interviews and focus groups, Study 3 will be separated into two separate components for ease of reading and, to better present and interpret the results. Study 3a will provide the results of participant experiences of undertaking the TSTP in community and custodial settings; whilst Study 3b will provide results for an alternative perspective of the TSTP experiences, that of the professionals working with inmate participants in a correctional facility.

This section sets out to provide a comprehensive overview of the qualitative methodology employed to investigate the aims and research questions for this study posed in the previous chapter. It provides a rationale for adopting this methodological approach and the procedures used within it. It details the participants involved and the interview questions used to collect participant responses. The nature of the study is exploratory and therefore qualitative nature, and as such, is guided by research questions arising from the literature review in Chapter 2 (Literature Review). The study seeks to generate information that can be used to gain insight into female inmates' experiences of trauma-specific counselling.

Why Use a Qualitative Research Approach?

A qualitative research approach was used for this study to address the contextualised and experiential nature of the data in a holistic and extensive manner (Liamputtong, 2009). Further, it allowed participant responses to be considered from a human perspective by discussing the actual experiences of the participants, rather than just looking at data-based outcomes (Teram, Schachter, & Stalker, 2005). Given the nature of the research focus and in particular the nature of trauma histories, it was necessary to take into consideration the fact that the congruence between qualitative analysis and the ontological belief that each participant's reality is not only subjective but also multiple (Creswell, 2003). A qualitative approach assisted

both the researcher and participants to socially locate themselves, address biases and limitations, and build relationships essential for construction of candid and thoughtful narratives (Creswell & Clark, 2007). The need for a qualitative approach, specifically when considering the participants' trauma history, is because "of the need to empower individuals to share their stories, hear their voices, and minimise the power relationships that often exist between a researcher and the participants in the study" (Creswell, 2007, p. 40). Additionally, a qualitative approach provides for a contextual analysis of narratives and allows for a description of the dynamic, relational processes between participants and their trauma (Denzin & Lincoln, 2003).

Overall, a qualitative research approach allowed the researcher to gain insight into counselling and its relationship to recovery specifically from the inmate's perspectives versus those from non-custodial participants. "Qualitative research is especially helpful when it provides us with someone's perceptions of a situation that permits us to understand his or her behaviour" (Krathwohl, 1998, p. 230). Focusing on people's experiences, allows the researcher to explore what meanings participants give to their trauma events and how they view their participation in the intervention (Van Manen, 1977). This is essential given the variation in responses to trauma, as well as any experiences and potential recovery from that trauma (Boyd, 2011; Briere & Jordan, 2004).

Validity of Qualitative Studies

While validity is routinely considered with quantitative designs, it is also highly relevant to qualitative designs. For both designs, the concept generally refers to the confidence in conclusions regarding the phenomenon being studied. For this research, we are concerned with whether a trauma-informed counselling program is effective in helping female prison inmates deal with their trauma histories. Eby, Hurst, and Butts (2009) assert that qualitative and quantitative conceptualisations of validity differ due to their philosophical differences. In

quantitative research, the criteria for validity are well established and quite specific (Markus & Borsboom, 2013) and usually relate to notions of causality. In qualitative research, the criteria converge on the notion of trustworthiness of findings (Noble & Smith, 2015). The validity of the qualitative results is discussed in Chapter 9 (Discussion).

Looking for Meaning from Experiences

As a society, we tend to construct particular meanings for events in our lives and then share them with others, or at least share interpretations of those events with others (Blaikie, 2010). In keeping with the need to construct meaning from experiences, I utilised my professional experiences as both practitioner (psychologist) and researcher to consider the most appropriate qualitative designs that could be used in this research. Within the qualitative component of the study, the meaning and experiences of the participants of therapy were considered as crucial components of understanding their own perspectives, which result in a more comprehensive interpretation of the phenomena being studied (Daher, Carre, Jaramillo, Olivares, & Tomicic, 2017). The need to derive meaning from what participants have to say, as well as the complex, detailed understanding of the issues that they face, is critical to allow people to tell their own stories which are often characterised by complex phenomena (Skaggs & Barron, 2006; Sofaer, 1999). This approach means that participants should not merely be presented with an opportunity to answer questions from the researcher's perspective or based on a literature review, but provide an overview of their own experiences and realities as they believe them to be (Strauss & Corbin, 1990).

In qualitative research, it is necessary to differentiate between a lived experience, such as participation in a therapeutic intervention and an accumulated experience, such as the trauma requiring that intervention (Schultz, 1972). This difference is in part due to the fact that people's experiences do not occur in isolation, they attribute meaning to them to make sense of their world (Mason, 2002). Those experiences are as varied as the people who encounter

them, but their interpretation is considered specific to the person who lives the experience (Blaikie, 2000). Regardless of whether or not the connection between experience and meaning can be separated, the data gathered from such an approach can strengthen social constructs and provide insight into the nature of the experiences of inmates participating in the current intervention (Mason, 2002).

Participants for Interviews

In the qualitative study, the first group of participants were from the inmate population who completed the therapeutic intervention (N = 141) with (n = 30) participants interviewed. The second group of participants were drawn from the community-based sample (N = 423), of which a total of (n = 30) interviews were conducted.

Recruitment Procedures

For the custodial participants, following approval from the General Manager of each of the Correctional Centres, the researcher, in the company of a nominated CSNSW research representative, met with the female inmates. Consent for the participation in the study was gained on admission into the TSTP and confirmed in writing through consent forms (stored at Victims Services). CSNSW programs staff approached the inmates and briefed them about the purpose of the study and advised them of what their participation would involve. The Manager Offender Services and Programs (MOSP) assisted in coordinating both the briefings to Services and Programs Officers (SAPO) and the inmates on behalf of the researcher. To ensure that the inmates were supported, both SAPOs and the approved counsellor allocated to the inmate were available on the day of the interviews to assist with debriefing and any clinical issues that may have arisen through the course of the interviews.

For the community participants, a similar process was used. Initially an email (see was distributed to approved counsellors seeking potential participants who were identified as being from the community group sample. Flyers with details were provided as initial background

reading. A briefing session was then organised to occur with the community participant, which was undertaken either face to face, online or by phone, depending on the preferences of the participant. For these sessions, the approved counsellor was on hand to mitigate against any psychological reactions by clients.

Ethical Considerations for Interviewing

The interviews with inmates only focused on the outcome of the TSTP and the effectiveness that the individual believes it had on addressing their issues. The participants were not questioned about any history of victimisation. This minimised the possibility of re-traumatisation, distress or personal discomfort to the participant, especially where trauma histories had not been completely resolved. Questions were focused on the program to determine what worked or did not work. It was agreed prior to permission being given to interview the participants, that any issues of discomfort/distress would result in the interview being suspended/terminated and the person being referred to their counsellor.

The approved counsellor attached to the prison was on site during the interview process. The inmates were advised of their presence should they require their assistance. Likewise, the approved counsellor attached to the community sample was available on the day of interview for the same purposes. This was to minimise any trauma related issues and ensure that the inmate could return to their daily routine with little impact as a result of the interview (Briere & Jordan, 2004).

Interviews

Interviews are considered vital to any interpretivist research and are arguably the most appropriate method for gathering rich individual narratives about participants' experiences (Dingwall, 1992). Effectively, they are "initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused on content specified research objectives of systematic description, prediction or explanation" (Cohen & Manion, 1989, p. 307).

Through the interview process, the researcher sought to describe central themes relating to the participants whilst understanding the meanings provided (Kvale, 1996) and understand what the participants have experienced, what they believe, and what they think (Britten, 1995). As the researcher was unable to be in the counselling sessions, the interviews provide an opportunity to explore specific ideas or concepts as they relate to the participants' experiences (Patton, 1980).

A semi-structured interview format is useful for gaining rich ideas and data (Robson, 1993), and so was used for this study. A set of open-ended interview questions for participants was developed (Appendix E). The use of semi-structured, open-ended questions allowed for questions to be modified, shift in order or omitted as required (Madill & Gough, 2008). As interviews are conducted face to face, visual/non-visual cues enabled the interviewer to modify questions as required to elicit relevant and appropriate information (Robson, 1993). Imposing one's framework or assumptions or own biases on the participants' responses is always a very real risk, however, using open-ended questions allows the participants more control over how they chose to answer the questions rather than being predominantly interviewer driven (Mcleod, 2001). All interviews were audio-recorded and transcribed, so as an in-depth analysis could be conducted (Lofland, Snow, Anderson, & Lofland, 2006). Field notes were recorded and used to allow for reflection on any pertinent issues raised during the interview.

Focus Groups

Often seen as synonymous with interviews (Parker & Tritter, 2006), focus groups were used to uncover the experiences, perceptions, and values of participants, with the researcher adopting more of a moderator role, rather than engaging in one-to-one dialogue (Bloor, Frankland, Thomas, & Robson, 2001). Focus groups comprising professionals working within the prisons, were chosen as they provided an opportunity to gain in-depth knowledge more economically than individual interviews (Berry & Kincheloe, 2004), were less limiting than

using surveys (Krippendorff, 2012), and offered an opportunity to garner information about differing, if not competing paradigms or worldviews (Gubba & Lincoln, 1994). It allowed for the opportunity to obtain varying viewpoints from a professional group who work directly with inmates in a correctional environment.

There is a concern that focus group methodology is not necessarily reliable for authentic opinions as social norms can impact responses whereby participants state what they believe the researcher wants to hear, rather than providing honest responses (Krueger & Casey, 2000). This impact can be a very real concern, however the focus groups used similar open-ended questions to those used in the interviews with TSTP participants (i.e., female inmate and community samples) in an attempt to ensure that the researcher could reframe questions to seek honesty rather than perceived opinions. Attempts to minimise demand characteristic bias was done by providing an open environment where participants respected each other, their responses considered as confidential, and anonymity assured. Focus groups provided opportunities for participants to work together during the sessions, in order to provide consistent responses, even if that meant participants did not agree with one another in their opinions or beliefs. This invited openness and helped to minimise bias that comes from social norms (Sutherland, Dicks, Everard, & Geneletti, 2018).

Recruiting Focus Group Participants

Focus groups were conducted with approved counsellors, correctional officers, services and programs staff, psychologists, and managers. A total of 23 professionals participated in three focus groups (n = 7, n = 7, and n = 9), with each focus group containing at least one representative from each profession.

Ethical Considerations for Conducting Focus Groups

All participants were provided with opportunities for access to free counselling from Victims Services, their own Employee Assistance Program or Lifeline, with details provided

beforehand. This was in case they should experience any discomfort from participation. This was facilitated by the general manager at each of the correctional centres. All participants could choose to withdraw at any point in time with no repercussions.

Participants for Focus Groups

Approved Counsellors. Approved counsellors within the correctional system are either registered psychologists, social workers (current member of Australian Association of Social Workers) or psychiatrists. They are approved to participate within the Approved Counselling Scheme (delivered by Victims Services) following evaluation and agreement by the Professional Advisory Panel (PAP). The PAP is comprised of representatives from Australian Health Practitioner Regulation Agency (AHPRA); the Australian Association of Social Workers (AASW), NSW Ministry of Health, Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Victims Services. The approved counsellors were recruited to this specific program (TSTP) following an Expression of Interest (EOI) available to all approved counsellors (N=364) currently under contract with Victims Services. Their involvement in this study was considered as compulsory by victims Services and specified within Schedule 6 of their Memorandum of Understanding (MOU) with Victims Services. A such, the Commissioner of Victims' Rights, Ms Mandy Young, confirmed that no further formal consent was required from the counsellors to participate in the evaluation process.

Correctional Services Officers. According to the CSNSW website, correctional services officers' "are active participants in the NSW Corrective Services management of inmates, ensuring the security and safety of correctional centres and working closely with other employees, including health workers, probation and parole officers and industries officers who oversee inmates working in Corrective Services Industries" (Corrective Services NSW, 2019). Given their close proximity to the correctional officers' workplace, their observations of the inmates' interactions and daily life in custody, their feedback about the TSTP was valuable for

gaining a better understanding the factors for success, barriers and limitations, and the impact on individual inmates.

Services and Programs Officers. Programs and services for each offender are set out in an individual case plan. Services and Programs Officers (SAPOs) implement these for individual inmates within the correctional facility. This can include services and programs that aim to:

> develop skills, behaviours and attitudes that lessen the likelihood of re-offending; contribute to the offender living in society after release from custody; and promote the health, safety, and well-being of the offender (Corrective Services NSW, 2019, p. 3).

Services and programs address:

> For CSNSW, their Duty of Care contributes to reducing re-offending and their obligation to assist with resettlement into the community. Because they have limited freedom, particularly in custody, offenders may be unable to address a range of needs in the way that another person could. For this reason, CSNSW has a duty to provide reasonable access to healthcare, education, counselling. These services contribute to a safe environment for offenders and those who work with them. The Counselling Trial is one of those services. There are SAPOs at each of the correctional centres participating in the program and they assist in promoting the program and assist inmates in completing application forms (Corrective Services NSW, 2019, p. 5).

Manager Offender Programs and Services. The role of the Manager Offender Programs and Services (MOSP) is to manage, coordinate, review and report on the Offenders Services and Programs across the correctional facility in which they are attached. MOSP's are integral to the success of the TSTP and provide the daily conduit between CSNSW, Victims Services,

the counsellors, and the inmates. The MOSP is responsible for coordinating the referrals and endorsing the inmates' applications to participate in the program. MOSP's are aware of the background of the inmates, their offending history, as well as their history of victimisation and the inmates' current history during their incarceration. They provide a unique insight into the person beyond the nature of the offence which led to their entry into prison. To enlist the assistance of these positions, consent was required to be obtained from the respective positions' senior officers, namely the General Manager of each Correctional Centre. The protocol developed between Victims Services and CSNSW provides an agreement to engage these stakeholders. Importantly however, interview times need to be negotiated around maintaining operational capacity.

Justice Health Staff. Essentially Justice Health are responsible for looking after all of the health needs of inmates in NSW Correctional Centres across the state. According to the Justice Health website, the Justice Health and Forensic Mental Health Network is:

> a Statutory Health Corporation established under the Health Services Act (NSW) 1997. The Network is part of the broader health system reporting to the Minister for Health through the Network Board and the Secretary, NSW Health. The Network delivers health care to adults and young people in contact with the forensic mental health and criminal justice systems, across community, inpatient and custodial settings. The provision of health care by Justice Health entails a holistic and person-centred approach that occurs across three key domains: pre-custody, custody, and post-release (Justice NSW, 2019).

This network provides the first response to inmates' health concerns and provides a unique insight into the health, and mental health, of inmates. Quite often they are an invaluable resource in referring inmates to the TSTP.

Psychologists. Corrective Services NSW employs three psychologists at Dillwynia

Correctional Centre and two psychologists at Wellington Correctional Centre, and senior psychologists across different areas of custody and community corrections. The role of psychologists in Corrective Services NSW is to assist with the safe, secure and humane management of offenders and people on remand by providing advice and direct service provision for vulnerable people who are in custody or under supervision of Corrective Services NSW. These people include those with mental health and cognitive impairments (including those at risk of self-harm or suicide), and those who pose a risk of harm to others in their immediate environment. Psychologists are also responsible for reducing risks of re-offending through specialist service and program delivery. The feedback from psychologists, by way of focus groups, provided additional insight of how the program integrates with existing programs; what some of the barriers and limitations of the program are; and what their observations were when working with inmates who are engaged in the program.

Transcription of Interviews and Focus Group Data

Transcription of interview data was undertaken to prepare for analysis (Bazeley, 2009). Transcription services were initially trailed, however issues with accents, the participants as well as the researchers made for a high number of transcription errors. As such, interviews were transcribed by the researcher using 'Dragon" software and stored at Victims Services in line with *Government Information (Public Access) Act 2009 (GIPA Act)* and the *State Records Act 2000.*

Thematic Analysis

Overview

Thematic analysis is one of the most popular methods of qualitative analysis (Braun & Clarke, 2006), and has previously been used to identify themes within the context of counselling experiences (MacIntosh & Johnson, 2008). The purpose of thematic analysis is to "identify and describe patterns of meaning in a dataset" (Joffe, 2012, p. 210). The themes are

not based on pre-set measures as they would be in quantitative approaches, rather they are based on their significance to the research question/s (Joffe & Yardley, 2004).

According to Braun and Clarke (2006) thematic analysis is either inductive or theoretic; where the former is an analysis of the data with no theoretical perspective underpinning. For the purposes of this thesis, the thematic analysis undertaken is inductive as it seeks opinions rather than theory. Despite significant research on trauma experiences of female inmates, there is still a paucity in research regarding their experiences in trauma-specific counselling. By allowing participants to explore issues they feel are relevant to their own experiences of therapy, this may in turn assist in providing advice on improving the TSTP into the future. The thematic analysis was guided by the six-phase procedure suggested by Braun and Clarke (2006). The six phases are given in Table 1.

Table 1

Phases of Thematic Analysis (Braun & Clarke, 2006)

Phase	Description of the process
1. Gaining familiarity with the data.	Transcription of interview (data), reading and re-reading, noting down initial ideas.
2. Generating initial codes.	Coding interesting and important features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes.	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes.	Checking if the themes work in relation to the coded extracts to tell an interesting and cohesive story.
5. Defining and naming themes.	Specifics of each theme are refined, generating clear definitions and names for each theme.
6. Producing the report.	This phase involves weaving together the analytic narrative and data extracts, and contextualising the analysis in relation to existing literature.

Using NVivo for Thematic Analysis

The ability to make connections between codes, categories, and sub-categories provides an opportunity in an effective and efficient manner, to create opportunities to differentiate between relationships, experiences, and histories (Lee & Fielding, 1995). Analysis was undertaken using NVivo version 12 (QSR International, 2018). NVivo assisted greatly in the management of codes by arranging them in a manner suited to the research and aided themes

to be derived for final analysis (Saldana, 2009). Should this be completed manually, the entire analysis process would take up significant time. NVivo provided significant assistance and ensured the necessary quality required for thematic content analysis in an academic context (Kelle, 1995). Whilst the interpretive phase required the researcher to undertake a significant and time-consuming interpretation, NVivo provided the ability to track data within specific contexts.

Procedures for Thematic Analysis using NVivo

As the researcher, I undertook data analysis, "to develop conclusions" (Schneider, Whitehead, LoBiondo-Wood, & Haber, 2013, p. 394). NVivo assisted in managing the data, allowing it to be grouped into themes then analysed using thematic analysis. The transcribed data sources were manually coded by two coders—the researcher and a Victims Services research officer. Categories were developed and then analysed, which formed the basis for collaborative discussion and refinement of initial coding categories in relation to the issues of concern in this component of the study.

Summary

Helping people who have experienced trauma is complex. While existing clinical measures, typically of a quantitative nature, are useful for assessing the effectiveness of therapeutic interventions, the complexity of trauma, and how it affects individuals differently, mean that other approaches are necessary for a thorough evaluation of an intervention's effectiveness. In considering outcomes purely from the perspective of quantitative data or reports, we reduce the likelihood of illuminating the human element of people's experiences, or to put it more simply, we fail to provide an opportunity for participants to tell their own story. A qualitative methodology was used to address these concerns and gain further insight into participants' lived experiences of engaging in therapeutic intervention.

Conclusion

This chapter described the methodology for three separate but interrelated studies. Study 1 looked at a comparison of the trauma histories of two participant groups and considered the differences that arose and provided some insight into the types of trauma that were experienced. Consideration was given to the prevalence of the victimisation that they have experienced, the point within the lifespan that the victimisation occurred, and the differences in the diagnosis that they received as a result.

Study 2 extended the work done in Study 1 by looking at the differences in reported symptoms, by use of the DASS, to determine if a therapeutic intervention (the TSTP) was effective for each group and whether that could be achieved in a prison setting. Finally, Study 3 used a qualitative methodology to investigate the experiences of custodial and community groups, who underwent a therapeutic intervention, as well as a group of professionals associated within the prison system. These key stakeholders provided complementary experiences which will add to the findings of the quantitative studies.

The results from the studies described in this chapter are provided in the following separate results chapters:

- Chapter 5, Study 1, Comparison of Trauma Histories Between Custody and Community Samples;
- Chapter 6, Study 2, Quantitative Analysis of the Therapeutic Intervention;
- Chapter 7, Qualitative Analysis of Interviews with Inmate Participants and Community Participants; and
- Chapter 8, Qualitative Analysis of Focus Groups with Key Stakeholders.

CHAPTER 5

Results for Study 1: Comparison of Trauma Histories Between Custody and Community Samples

"Violence is violence. Trauma is trauma. And we are taught to downplay it, even think about it as child's play."

Tarana Burke 2018

Introduction

This chapter reports the results for Study 1, which investigated the self-reported trauma histories of a female inmate population and a community sample. The aims of Study 1 are specific and focused. Its primary aim is to provide a basis for Study 2 by establishing that consistent with the literature, female inmates experience greater levels of trauma than a matched community sample. However, this study is an important investigation in its own right. Further confirmation of the elevated levels of trauma in inmates should alert researchers and practitioners that not only is a prison-based counselling intervention needed, but also, and more importantly, that intervention is needed long before women end up in prison—an issue that is elaborated on in Chapter 10 (Discussion).

As outlined in Chapter 4 (Methodology), an exact matching process was undertaken to provide a more robust model under which to draw conclusions. The data used for this study came from a range of resources which included Victims Services application forms and counselling reports in order to compare and contrast inmate and community samples.

The following trauma-related variables which were used, are provided in Table 2. These variables are important as they substantiate these findings in Chapter 2 (Literature Review) that

suggested that the custodial group would report more complex trauma and report a significantly broader trauma history than that of the community group.

Table 2

Trauma Variables and Descriptor

Trauma Variable	Variable Description
Act of violence (AOV)	The reported act of violence perpetrated against the victim
Duration of AOV	The reported duration of the reported act of violence
Additional AOV	Additional acts of violence that may have occurred across the lifespan
Polyvictimisation	Multiple types of AOV's
Multiple Victimisation	Multiple occurrences of AOVs'
Multiple Offenders	Whether more than one offender was reported as causing AOV
Familial Offender	Whether the person was identifiable as a family member
Lifespan	At which point of the lifespan the AOV occurred
Diagnosis	The diagnosis received as a direct consequence of the reported AOV

Participants

As discussed in Chapter 4 (Methodology), Study 1 used an exact matching technique to pair inmate participants with community participants. The participants for the inmate population group had a total of 141 participants with ages ranging from 25 years old to 68 years old (M = 40.97, SD = 8.77). For the community group, there were 423 participants (M = 40.54, SD = 9.02) with ages ranging from 22 years old to 71 years old (M = 40.54, SD = 9.02).

Power

Before commencing any analyses in this study, the G*Power 3 software program was used to calculate the minimal sample size needed for the chi-square analyses. Using conventional statistics (α = .05, power = .8) and three degrees of freedom for the comparison

of two groups to detect a medium effect of d = 0.3 (Cohen, 1988), the required total sample size required is 122. With sample sizes in the vicinity of 70 (inmate sample) and greater than 400 (community sample), sufficient statistical power was assured.

Statement of Hypotheses

The research hypotheses for this study are described in detail in Chapter 3 (Aims and Hypotheses) but are summarised here for convenience. The results for each hypothesis are given in the sections that follow.

Hypothesis 1.1.1: Trauma Histories. The custodial group will have significantly greater reported levels of trauma history than that of a matched community sample.

Hypothesis 1.1.2: Polyvictimisation. The custodial group will have a significantly higher level of polyvictimisation, including multiple occurrences of victimisation, multiple offenders, and familial offenders, than that of a matched community sample.

Hypothesis 1.2.3: Victimisation Across the Lifespan. The custodial group will report higher levels of abuse across the lifespan, than that of a matched community sample.

Hypothesis 1.3.4: Diagnosis. The profile of diagnoses for the custodial group will be markedly different from that of a matched community sample. That is, the distribution of diagnoses amongst participants in the custodial group will be notably different from that of participants in the community sample.

Hypothesis 1.1.1: Trauma Histories

Overview

Based on the literature review conducted in Chapter 2, it was thought that the vast majority of women in prison have experienced some violent victimisation across their lifespan (Hackett, 2009; Chesney-Lind, 1997; Walker, 2019), with some estimates as high as 90% (Correctional Association of New York, 2006). The first hypothesis of this study posited that

the custodial group will self-report a significantly greater trauma history than that of a matched community sample.

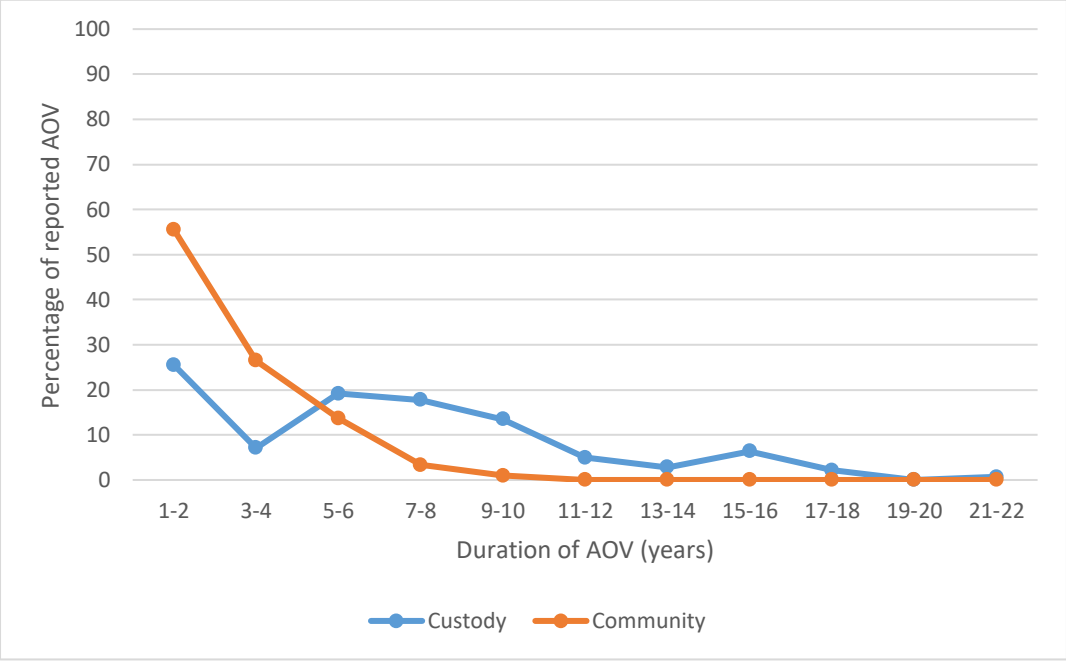
Results

Duration of AOV

As the custodial and community groups were matched on key demographic variables, including the type of victimisation, in order to minimise confounding, the type of victimisation was not used as a variable of interest, as it was used for matching purposes. What was of interest, was the duration of the reported victimisation. In a comparison of the two groups, Figure 3 below, shows that 55.55% of the community sample report the duration of the reported acts of violence spanning a 1 to 2-year period, compared with 25.53% of the custodial sample for the same period.

Figure 3

Reported Duration of Act of Violence Between Custodial and Community Cohort, in Years



Whilst there is a significant downward trend commencing at the 5 – 6 year period for the community sample, it is noticeably different form that of the custodial sample. There is a

downward trend for the custodial sample commencing at the 5 – 6 year period, however, it is less pronounced, indicating that the custodial group members on average, have longer trauma histories.

Additional Reports of AOV

The two groups were then compared in regard to additional reports of acts of violence (AOV). Table 3 below, shows the numbers of additional AOV's (not including the original reported AOV) reported for the two groups. Within the community group, only 27 participants (6.38%) reported one additional AOV, whilst within the custodial group, 100% of the group reported an additional three AOVs with 95 participants (67.37%) reporting a fourth AOV.

Table 3

Comparisons of Additional Reported AOV's Between Groups

	Number of Additional Reported AOVs			
	1	2	3	4
Community	27	0	0	0
Custody	141	141	141	95

An analysis was also undertaken on the trauma type likely to be exhibited by the participants. This looked at three main trauma types, specifically single, simple, and complex trauma. More detail is provided in the literature review, however complex trauma is seen as "a result of exposure to multiple events and the wide-ranging long-term effects of that exposure, which are severe and pervasive" (NCTSN, 2019, p. 3). The analysis showed that all (100%) of the custodial cohort had a typology of complex trauma. In contrast, the majority of community participants reported having simple traumas, whilst only 11.34% of this cohort identified as having a complex trauma typology. A chi-square analysis was undertaken and showed that there was a statistically significant association between trauma type and group (i.e., custody

and community), (x^2 [3, $N = 564$] = 125, $p < .05$) with members of the custodial group more likely to be found with complex trauma. Using Cramer's V, the effect size was $V = .47$. This is indicative of a large effect size (Schafer & Schwarz, 2019).

Conclusion

Hypothesis 1.1.1 predicted that the trauma histories reported by the custodial group, would be significantly different from those reported by a matched community sample. The results from the analyses inferred that the custodial group did on average have longer histories of violence, were more likely to have complex trauma, and more likely to report having additional AOVs than the community group, thereby providing support for Hypothesis 1.1.1. This is consistent with the literature, which suggests that inmates in general will have higher rates of trauma than a non-offending population (Reeve & Van Gool, 2013; Wolff, Shi, & Siegel, 2009).

Hypothesis 1.1.2: Polyvictimisation

Overview

The second hypothesis surmises that the participants in the custodial group will have a significantly higher level of polyvictimisation, that is, they will have experienced higher levels of different acts of victimisation (e.g., sexual assault, domestic violence, and physical assaults) across the lifespan, than that of a matched community sample.

Results

Polyvictimisation

The data shows that 100% (n = 141) of the custodial group reported multiple occurrences of victimisation across the lifespan, compared with 5.2% (n = 22) of the community sample. Consistent with this observation, a chi-square analysis confirmed a statistically significant association between multiple occurrences of victimisation and group

(i.e., custody and community), x^2 (1, $N = 564$) = 462.50, $p < .05$. The effect size as measured by Cramers V, was $V = 0.90$, reflecting a large size effect (Schafer & Schwarz, 2019).

Multiple Victimisation

The focus for the previous hypothesis was on acts of violence, or rather the number of violent victimisation events they experienced and reported. For this hypothesis, the focus is on the number of offenders. An analysis of the data showed that, much like the previous hypothesis, 100% (n = 141) of the custodial participants reported experiencing violent victimisation by more than one offender. In contrast, for the community cohort, 22 participants (5.2%) reported having had experienced violent victimisation by more than one offender. A chi-square analysis confirmed a statistically significant association between the number of offenders and group (i.e., custody and community), x^2 (1, N = 564) = 1264.5, $p < .001$, confirming that the community sample was less likely to have multiple offenders than their custodial cohort. The effect size (as measured by Cramer's V) was $V = .49$, indicating a large effect size (Schafer & Schwarz, 2019).

As discussed in the literature review (Chapter 2), inmates generally experienced more instances of multiple victimisations such as sexual abuse, physical abuse, bullying, and exposure to family violence (Barnes et al., 2016). The results highlighted that this was indeed the case, but what was surprising was the extent to which polyvictimisation occurred.

Perpetrator Identity

In the next component of this hypothesis, the groups were considered in terms of who the perpetrator was of their reported experiences of violent victimisation, specifically, was the perpetrator a family member or not. An analysis of the two groups showed that the custodial groups reported a higher rate of familial offenders (41.8%) than their community counterparts, of which only 10.4% of the community sample reported familial offenders relating to their reported experiences of violent victimisation. A chi-square analysis confirmed a statistically

significant association between perpetrator identity (i.e., family member) and group (i.e., custody and community), x^2 (1, $N = 564$) = 70.03, $p < .001$ confirming that the community sample was less likely to have familial offenders than their custodial cohort. The effect size (as measured by Cramer's V) was $V = .35$ indicting a medium effect size (Schafer & Schwarz, 2019). The research suggests that women's intimate relationships are consistently characterised by trauma and victimisation, which in female inmates, are then a characteristic of their offending behaviour (Giordano et al., 2002; Maruna & Mann, 2019). As a result, women who experience trauma, are more likely to have poorer developed relationship skills, characterised by damaged attachments, higher levels of vulnerability, fear, and mistrust (Ansbro, 2008; Bui & Morash, 2010). The implication then being that these experiences would impact the participant's ability to form a positive relationship with the therapist, prevent safety and trust from being developed, thereby undermining the development of an appropriate therapeutic alliance to resolve the trauma (Stathopoulos, 2012).

Conclusion

In line with the literature, Hypothesis 1.1.2 predicted that the participants in the custodial group would have a significantly higher level of polyvictimisation across the lifespan, than that of a matched community sample (Boyd, 2011; Stathopoulos, 2012). The results from these analyses provide support for this hypothesis, with all of the custodial group reported that they had experienced high levels of polyvictimisation. The inmate group also reported elevated levels of multiple victimisation, whilst only a small percentage of the community group reported experiencing either polyvictimisation or multiple victimisation. The findings also showed that the custodial population have higher levels of multiple offenders, than that of the community sample. This was an unsurprising result given that the literature suggests that there would be higher instances of polyvictimisation in inmates, as they were expected to have higher trauma histories than their non-offending counterparts (Barnes et al., 2016; Garner et al., 2012).

The hypothesis also predicted that the participants in the custodial group would be more likely to report that they experienced violent victimisation by a family offender than that of the matched community sample. The results from the analysis demonstrated that the custodial group had reported a significantly higher number of acts of violence by familial offenders than the community group. Again, this was in line with the literature that suggested that the types and occurrences of trauma experienced by the inmate population, would have been grounded in childhood and continued across the lifespan by a familial offender (Day & Bowen, 2015; Mackay, Gibson et al., 2018).

Hypothesis 1.2.3: Victimisation Across the Lifespan.

Overview

The third hypothesis predicts that the custodial group will have a significantly higher report of victimisation across the lifespan**,** than that of a matched community sample.

Results

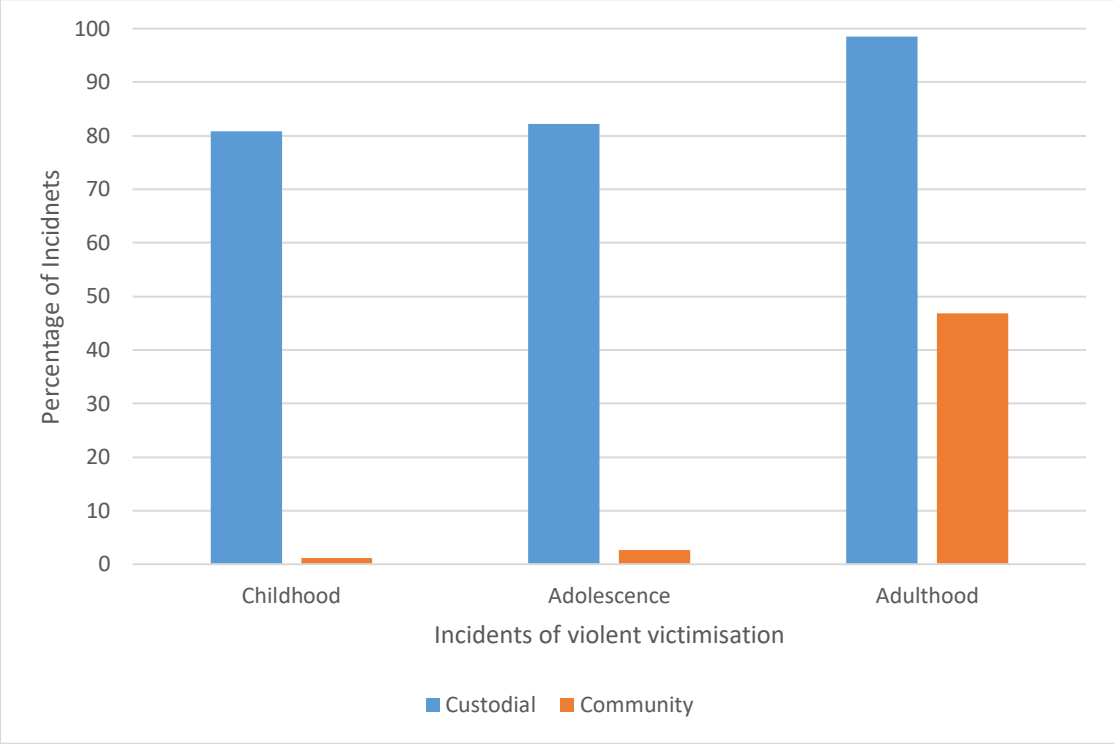
When commencing the TSTP, inmates self-referred to the program. As such, they presented with a range of presenting AOV's. As discussed in Chapter 4 (Methodology), the community sample was then matched to the inmate participants using the reported AOV. The history of additional AOV's which were recorded by approved counsellors, were used to identify different points of victimisation across the lifespan.

The participants' reports of when victimisation occurred was compared between the two groups across three separate timeframes in line with the key periods or stages of growth and human development: specifically, childhood, adolescence, and adulthood (see Chapter 4). It should be noted here, that whilst the three time periods are mutually exclusive, the ability for participants to appear in each category is not; and as such participants may be counted in more than one lifespan time period, or none of them. The findings are pictorially represented in Figure 4, from which it can be clearly seen that members of the custodial sample are more

likely to report victimisation across all three lifespan stages. This is consistent with the Adverse Childhood Experiences (ACEs) Study findings, that suggested that the people who experienced complex trauma in early childhood, would likely come into contact with the criminal justice system during their life, and be at risk of further trauma across the differing points of the lifespan (Day, Van Lieshout & Vaillancourt, 2017; Ford & Delker, 2020; Gilbar & Ford, 2020). Findings are discussed for each of these three lifespan stages next.

Figure 4

Comparisons of Victimisation Between Custodial and Community Cohorts Across the Lifespan



Childhood

When analysing the data for victimisation in childhood, it was revealed that 80.85% (*n* = 114) of the custodial cohort reported an act of violent victimisation occurring during that period, compared with less than 2% (*n* = 5) for the community sample. A chi-square test of independence yielded significant results, x^2 (1, *N = 564*) = 403.19, $p < .001$, confirming that the community sample was significantly less likely to have reported violent victimisation in

childhood, than the custodial sample. The effect size, as measured by Cramer's V was $V = .84$, indicating a large effect size. This was as expected, given the literature that suggested that women entering the criminal justice system would present with higher levels of childhood abuse experiences (Annda et al., 2006; Grasso et al., 2016)

Adolescence

Violent victimisation in adolescence was reported for both the custodial and community groups. An analysis of the data shows that a similar trend emerges to that found in childhood between the two groups. For adolescence, the custodial group data show that 82.26% ($n = 116$) reported violent victimisation, whilst only 2.6% ($n = 11$) of the community sample reported that it had occurred during adolescence. A chi-square test of independence yielded significant results, x^2 (1, $N = 564$) = 384.70, $p < .001$, confirming that the community sample was significantly less likely to have reported violent victimisation in adolescence, than their custodial counterparts. The effect size, as measured by Cramer's V was $V = .82$, indicating a large effect size. Given that childhood abuse was a reliable predictor of future risk levels, it was unsurprising that inmates expressed that they had experienced higher levels of trauma in adolescence, given the results for childhood trauma (Costello, Erkanli, Fairbank & Angold, 2005).

Adulthood

Finally, the two groups were compared in relation to victimisation which occurred in adulthood. For the custodial group, 98.58% of participants ($n = 139$) reported violent victimisation occurring in adulthood, compared to 46.80% ($n = 198$) for the community sample. Chi-square test of independence results show that the community sample was significantly less likely to have reported violent victimisation in adolescence, than the custodial cohorts, x^2 (1, $N = 564$) = 117.86, $p < .001$. The effect size, as measured by Cramer's V was $V = .45$, indicating a medium effect size. Again, reflecting on the literature, the childhood and adolescent abuse

histories reported by inmates, were a clear predictor that they would experience abuse in adulthood (Centre for Disease Control, 2016). It also indicates that certain factors linked to their concept of self and ability to develop safe and secure relationships, are likely to have been damaged, due to the trauma experienced across each stage of the lifespan and the fact that the trauma has been thus far, unresolved (Hughes et al., 2017).

Conclusion

Hypothesis 1.2.3 predicted that the participants in the custodial group would report that they experienced significantly higher reports of violent victimisation across three different stages of the lifespan compared to the matched community sample. The findings reported here provide support for this hypothesis.

Hypothesis 1.3.4: Diagnosis

Overview

The final hypothesis predicts that the profile of diagnoses for the custodial group will be markedly different from that of a matched community sample. That is, the distribution of diagnoses amongst participants in the custodial group will be notably different from that of participants in the community sample.

Results

The consulting clinician provided each participant with a single diagnosis, where that diagnosis was determined to be a direct result of trauma sustained as a result of the reported victimisation. The standardised format used by Victims Services' clinicians only allows for one diagnosis to be given to each client - that is, multiple diagnoses are not permitted. As discussed in Chapter 2 (Literature Review), it was predicted that custodial group members would be more likely to receive a diagnosis of post-traumatic stress disorder (PTSD) than the community cohort. Consistent with the literature, the inmate population had a high prevalence

of unrecognised, undiagnosed, and misdiagnosed trauma-related mental health issues which remained untreated within the prison (Bailey & Brown, 2020; Wood, 2019).

The descriptive statistics in Table 4 shows how the custodial sample compare with the community sample for PTSD, as well as for generalised anxiety disorder, acute stress disorder, and major depressive disorder. Most notably, members of the custodial sample were more likely to have a diagnosis for each of the four listed diagnoses, except for generalised anxiety disorder, where approximately four out of five (84.39%) of the community had a diagnosis of generalised anxiety disorder, and nobody in the custodial sample reported having this diagnosis.

Table 4

Comparisons of Diagnosis Between Groups

	Diagnosis				
	GAD	ASD	MDD	PTSD	TOTAL
Custody	0 (0%)	13 (9.21%)	33 (23.40%)	95 (67.37%)	141
Community	357 (84.39%)	11 (2.60%)	33 (7.80%)	22 (5.20%)	423
TOTAL	357	24	66	117	564

Note. GAD = Generalised Anxiety Disorder, ASD = Acute Stress Disorder, MDD = Major Depressive Disorder, PTSD = Post Traumatic Stress Disorder.

A chi-square test of independence yielded significant results, x^2 (3, $N = 564$) = 246.33, $p < .05$, showing a statistically significant association between group (custody and community) and diagnosis. The effect size, as measured by Cramer's V was $V = .27$, indicating a medium effect size.

Conclusion

Hypothesis 1.3.4 predicted that the pattern, or profile of diagnoses for the custodial group, would differ from that of the community group. For example, from the literature, it was expected that the custodial group would receive overwhelmingly more diagnoses of PTSD than the community group. The chi-square analysis confirmed that the diagnoses profile for the custodial group was different from that of the community sample, thereby providing support for Hypothesis 1.3.4. These reported diagnoses were consistent with a higher percentage of posttraumatic stress disorder symptoms in an inmate population, which provide good grounds that a trauma-specific intervention service may be required in a custodial setting.

Chapter Summary

This chapter sets out to compare the differences in reported trauma histories between the two groups (custodial and community) across key areas of trauma and victimisation. The analyses examined both the custodial and community groups in terms of key variables (see Table 2). The analyses support all the hypothesis posited in this chapter, demonstrating that the trauma histories of the custodial group differed significantly in terms of severity, from that of the community group. These findings support the need for a trauma-specific intervention service in correctional settings and the importance that it has for that population. The following chapters will expand on these findings.

Chapter 6

Results for Study 2: Quantitative Analysis of the Therapeutic Intervention

"You may never know what results come of your actions, but if you do nothing, there will be no results".

Mahatma Ghandi

Introduction

Repeated Measures Mixed Model Research Design

This chapter provides the results for Study 2, which investigated the effects of the Trauma-Specific Treatment Program (TSTP) for female inmates with a history of violent victimisation. The research design is described fully in Chapter 4, but the essentials are provided here to assist in understanding the results presented in this chapter. The design utilised a repeated-measures mixed model approach. This procedure analysed results from the repeated measures design in which the outcome measures (DASS scores) are assessed at four different time points. The procedure used the standard mixed model calculation engine in Stata v.15 to perform all calculations. The analyses examined overall treatment effectiveness of the program, the experimental effects of the program, and sustained post treatment experimental effects of engaging in the treatment program.

There were three groups used for Study 2. Group 1 (n = 69) was a sample of randomly assigned inmate participants who received immediate treatment. Group 2 (n = 72) was also a sample of randomly assigned inmate participants, who were delayed in receiving treatment. They are referred to hereafter as the waitlist control group (WCG). The WCG was utilised to provide an ethical way of comparing the ITG with a control group to establish a baseline measure for comparison. Group 3 (n = *423*), was a matched pair group of community female participants, used to compare treatment outcomes. Group 1 and Group 3 commenced in the TSTP at the same time, whilst Group 2 commenced after a 10-week delay.

Statement of Hypotheses

Data were collected at the following four time points, detailed in Table 5.

Table 5

Data Collection Points

Time	Group 1 (ITG)	Group 2 (WCG)	Group 3 (Community)
T1: 0 Weeks	Commencement of TSTP	Baseline Measure	Commencement of TSTP
T2: 10 Weeks	Midpoint of TSTP	Commencement of TSTP	Midpoint of TSTP
T3: 20 Weeks	Completion of TSTP	Midpoint of TSTP	Completion of TSTP
T4: 30 Weeks	Follow-up Post TSTP	Completion of TSTP	Follow-up Post TSTP
T5: 40 Weeks	N/A	Follow-up Post TSTP	N/A

These time points are mentioned in the hypotheses summarised below, and more fully explained in Chapter 4.

*Hypothesis 2.1.1. Overall Experimental Effects of the TSTP***.** The TSTP will provide statistically significant post-treatment gains (T3) in DASS scores (depression, anxiety, and stress) across all three groups (ITG, WCG, and the Community Group).

Hypothesis 2.2.1. Lasting Effects of the TSTP (10 Week Post Treatment). Post-treatment intervention effects (T3) for the WCG, it is hypothesised that DASS scores, will be maintained at 10 weeks after the completion of the TSTP (T4). Specifically, the DASS scores will be maintained at T4. For the WCG, scores will be maintained across the period T4 to T5 given that the WCG commenced 10 weeks after the other two groups.

*Hypothesis 2.3.1. Inmate Motivation***.** At the conclusion of the TSTP, inmates will be more likely to be ready to address criminogenic needs as a result of addressing trauma histories.

Depression, Anxiety, and Stress Scale (DASS)

The DASS is a 42-item self-report inventory with three subscales: Depression; Anxiety; and Stress (Lovibond & Lovibond, 1995). For this study, the internal consistencies of the DASS subscales were high, with Cronbach's alphas of .91, .89, and .91 for depression, anxiety,

and stress respectively. The reliability and validity of the DASS have been well documented (Basha & Kaya, 2016; Le, et al 2017; Szabo, 2010). Research has also shown that the DASS is suitable for use in some clinical environments as an effective measure of the evaluation of wellbeing, including the association with PTSD symptoms (Allen & Annells, 2009; Berle, et al., 2018; Guest, Tran, Gopinath, Cameron, & Craig, 2018).

Power

Before commencing any analyses in this study, the G*Power 3 software program was used to calculate the minimal sample size needed for the contrast analyses. Using conventional statistics ($\alpha = .05$, power = .8) for the comparison of two matched groups to detect a medium sized effect of .5 (Cohen, 1988), the required total sample size is 34. With sample sizes in the vicinity of 70 (inmate sample) and greater than 400 (community sample), sufficient statistical power was assured. A medium sized effect was assumed based on the literature describing the effectiveness of cognitive behavioural therapies for PTSD (e.g., Watts et al. 2013). However, G*Power's effect size calculator, which uses sample means and standard deviations at different time points, can be used to provide an estimate of effect size. The data for this study have mean scores and standard deviations in the vicinity of 15-20 and 2-5 respectively. With these values, the sample sizes for this study are sufficient for the comparisons investigated, even for a higher level of statistical power (e.g., .9).

Mixed Model Preliminary Outputs

The design for this study has both between-subject and within-subject effects - that is, it is a mixed effects model. Prior to considering the hypotheses for Study 2, it was necessary to conduct a series of preliminary analysis in order to provide the basis for between-group and within-group analysis.

First, in order to maximise the number of cases and increase the statistical power of the analysis, the data was converted to long form (UCLA: Statistical Consulting Group, 2018). As

a total of 564 participants contributed responses at T1, T2, T3, and T4, the repeated measures mixed model option was used to adjust standard errors, and account for the fact that each participant had contributed multiple sets of responses. In this approach, the error terms do not necessarily need to be specified for either the between-subject and within-subject effects. However, for clarity, there was one single error term for all of the between-subject effects and a separate error term for each of the within-subject factors, and for the interaction of within-subject factors (UCLA: Statistical Consulting Group, 2018). The following section provides an overview of the preliminary analysis undertaken for each of the DASS subscales.

Results for Regression Analysis

Overview

A mixed-effects REML regression was used to commence the analysis in Stata. Appendix I shows the initial mixed-model output for depression. Whilst this part of the output is not very informative, it created several internal variables and summaries needed for the next steps in the mixed-model process. It should be noted here that the REML option in Stata was chosen, so that the random effects could be estimated. In this way, the results could be compared as to how they differed in any random effects that were produced. The chi-squares were then interpreted much like the *F* values are in an ANOVA.

A test of simple effects was then used to understand the significant interaction effects. In addition to the estimates of the fixed effects, two random effects were produced. These are, the variance of the intercepts and the residual variance, which correspond to the between-subject and within-subject variances, respectively. As the analysis produced estimates for each term in the model individually, Stata's *contrast* command was used in order to obtain joint tests (multi degree of freedom) of the interaction and main effects.

Depression Subscale

The results of the joint tests of interaction and main effects for depression are shown in Table 6.

Table 6

Joint Tests of the Interaction and Main Effects for Depression

Depression	df	x^2
Group	2	2603.82*
Time	3	8811.04*
Group X Time	6	4476.46*

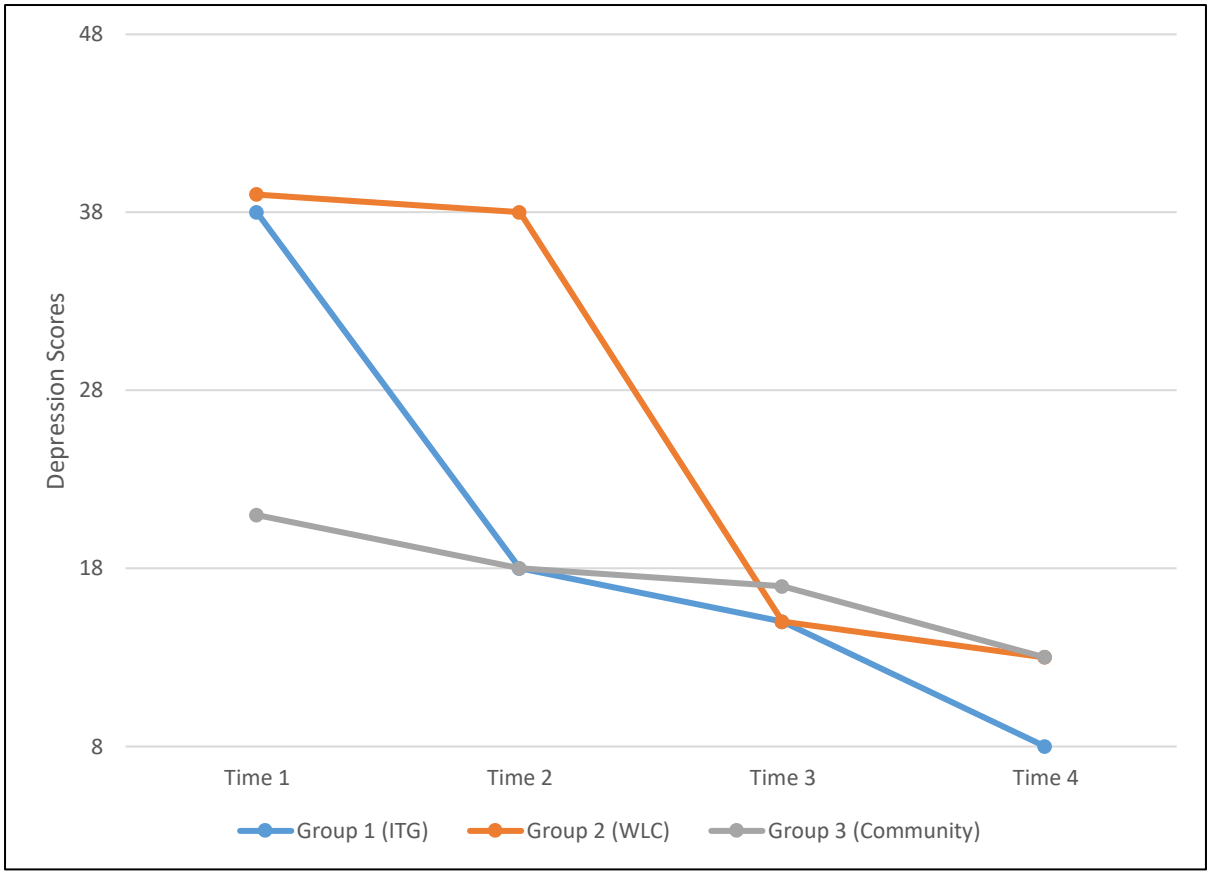
Note. N = 564. df = degrees of freedom.

*$p < .05$.

As the main effect (group and time) is the effect of one of the independent variables on the dependant variable, an interaction effect then occurs if there is an observable interaction between the independent variables that affect the dependant variable (Williams, 2015). As shown in Table 6, the result for the Group X Time interactions was significant x^2 (6, N =564), 4476.46, $p < .001$. As the interaction is significant, the main effects were ignored (i.e., group and time). A graph of the interaction is shown below in

Figure 5

Adjusted Predictions for Depression for the Three Groups Across Each Timepoint



A significant interaction indicates that there is a significant difference between at least two time points in the scores for the groups across T1 to T4. It is important to note that between T1 and T2, Group 2 (WCG) received no treatment intervention while Group 2 (ITG) and Group 3 (community) did. As the WCG is the waitlist control group, its participants only commenced the TSTP at T2. This result is expected and is reflected in Figure 1 where there is little change in depression subscale scores for the WCG. Prior to proceeding to the next stage of analysis, this process will be replicated for the anxiety and stress subscales.

Anxiety Subscale

As with the depression subscale, a mixed-effects REML regression was performed. The results can be found in Appendix I. Joint tests (multi degree of freedom) of the interaction and main effects for anxiety were undertaken with the results shown in Table 7. As mentioned previously, Figure 2 reflects that Group 2 (WCG) received no treatment intervention between T1 and T2, which is illustrated by little or no change in scores between T1 and T2 for the anxiety subscale.

Table 7

Joint Tests of the Interaction and Main Effects for Anxiety

Anxiety	df	x^2
Group	2	2964.27*
Time	3	10391.18*
Group x Time	6	5190.51*

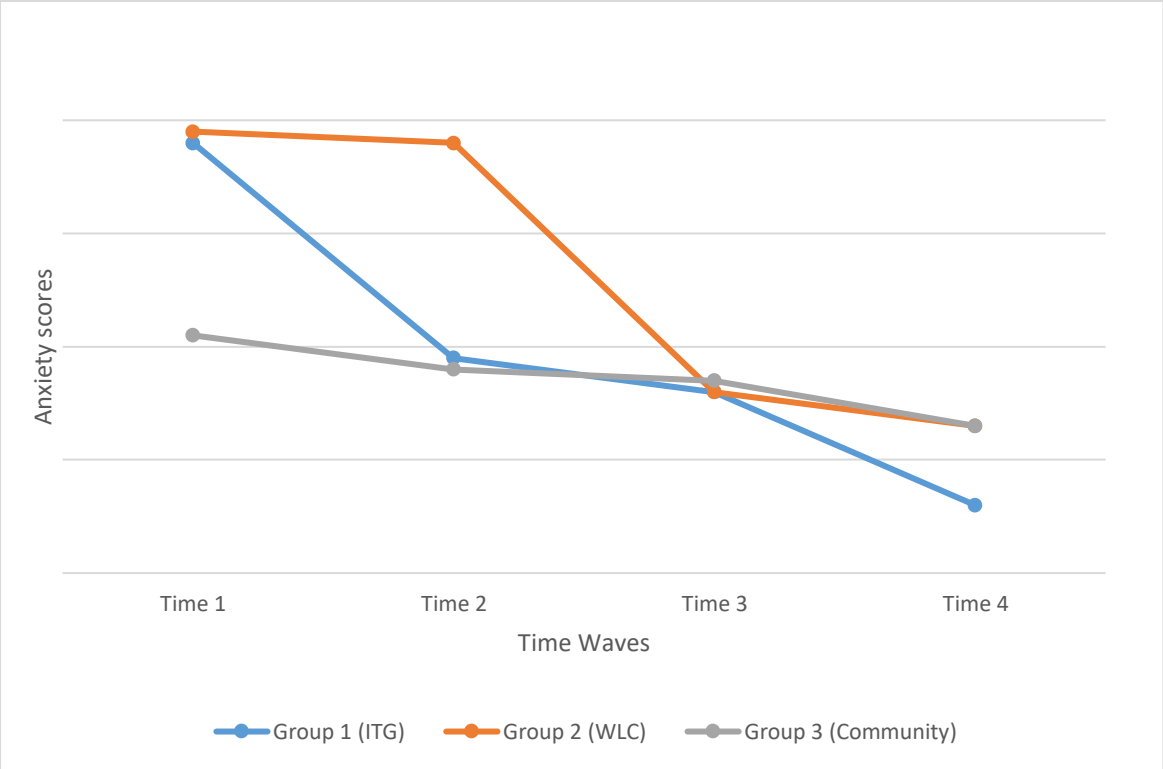
Note. $N = 564$. df = degrees of freedom.

*$p < .05$.

Like the depression subscale, the Group X Time interaction for the anxiety subscale is significant (x^2 [6, $N = 564$] = *5190.51*, $p < .001$). As the interaction is significant, the main effects are again ignored, and the interactions analysed. A graph of the interaction is shown as Figure 6. As with the depression subscale, Figure 2 also reflects that Group 2 (WCG) received no treatment intervention between T1 and T2 which is illustrated by minimal change in scores between T1 and T2 for anxiety.

Figure 6

Adjusted Predictions for Anxiety for the Three Groups Across Each Timepoint



A significant interaction indicates that there is a significant difference between at least two time points for the anxiety subscale.

Stress Subscale

A mixed-effects *REML* regression was performed for the stress subscale, and the results shown in Appendix J. Again, joint tests (multi degree of freedom) of the interaction and main effects for the stress subscales were undertaken and the results shown in Table 8. Similar to the depression and anxiety subscales, Figure 6 reflects that, in regard to the stress subscale, any change in stress subscale scores between T1 and T2 for Group 2 (WCG) is minimal. Again, this is because Group 2 received no treatment intervention between T1 and T2.

Table 8

Joint Tests of the Interaction and Main Effects for Stress

Stress	df	x^2	$P > x^2$
Group	2	2836.89*	0.00
Time	3	8108.73*	0.00
Group x Time	6	4247.73*	0.00

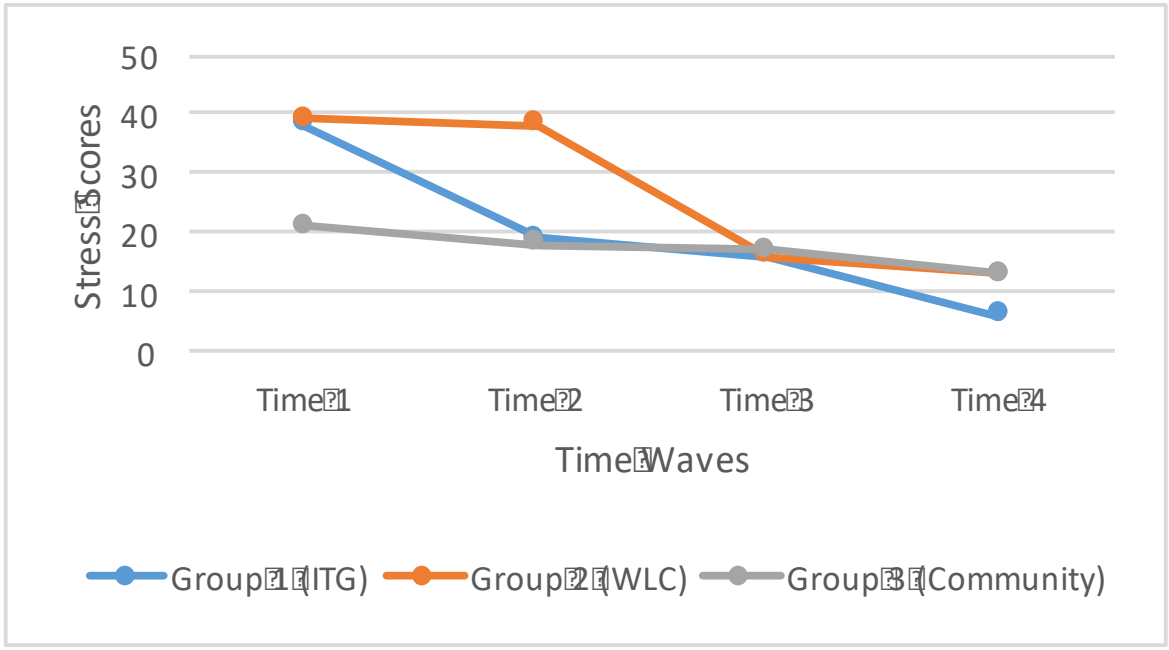
Note. N = 564. df = degrees of freedom.

*$p < .05$.

Like the previous subscales, the Group X Time interaction for the stress subscale is significant (x^2 [6, N =564] = 4247.73, $p < .001$). A graph demonstrating the interaction is shown in Figure 7.

Figure 7

Adjusted Predictions for Stress for the Three Groups Across Each Timepoint



Summary

This section provided an overview of the preliminary analysis which was required to test Study 2 hypotheses. Each of the subscales of depression, anxiety, and stress showed significant interactions for the time and group variables. This means that there were changes in DASS subscale scores for each of the three groups (ITG, WCG, and Community) across the four time points (T1-T4) of the TSTP. Analysis of the data show that after 10 weeks of treatment, the ITG (Group 1) and the community cohort (Group 3) had shown a significant reduction in scores on the DASS subscale, while the WCG had shown no or minimal changes in DASS subscale scores, providing strong evidence that the TSTP was having a positive effect. Having established this, each of the remaining hypotheses can now be tested.

Concerns were raised throughout the literature (Chapter 2) that prison can either create, or at the very least exacerbate mental health problems of the inmates which reside there (Baldry, 2008; Collier, 2015; Covington, 2007). However, the results show that prison, as a contributing variable, did not have the predicted effect on inmate's mental health.

Hypothesis 2.1.1 Overall Experimental Effects of the Intervention (T1-T3)

Hypothesis 2.1.1 considered the experimental effects of the intervention (TSTP). It was hypothesised that for all groups (ITG, WCG, and community) there would be statistically significant decreases in the DASS subscale scores of depression, anxiety, and stress at the completion of the intervention. Specifically, under this hypothesis, it is expected that there will be a decrease in each of the subscale scores across the three time points of T1 (0 weeks), T2 (10 weeks), T3 (20 weeks) for Group 1 (ITG) and Group 3 (community). For Group 2 (WCG), due to the 10-week delay in commencing with the TSTP (see Table 5), decreases in the DASS subscales can be expected across the three time points of T2 (10 weeks), T3 (20 weeks), and T4 (30 weeks).

Results

Overview

In order to determine which group differences are statistically significant for each DASS subscale, pairwise comparisons were undertaken for each subscale utilising a Bonferroni adjustment to protect against Type I errors. The contrast scores in each table are used as unstandardised beta values (or beta coefficients). Therefore, they show the degree of change in the DASS scores for each group, when each time point is compared with another. For all subscales for each group, the contrasts are all negative, though not necessarily statistically significant. Effect sizes are reported for all contrasts, even for statistically non-significant results.

Negative contrast scores indicate that with each successive time period, the DASS subscale scores have decreased by the corresponding contrast value shown in the tables. Higher scores on each subscale indicate higher levels of severity for that subscales. Therefore, a decrease in subscale scores indicate a lessening of severity. Tables and a brief explanation are provided for each of the three groups in light of this interpretation of DASS subscale scores.

Group 1

Tables 9, 10, and 11 provide the data for Group 1 (ITG). All contrasts are negative and statistically significant, indicating a decrease in the subscale scores of depression, anxiety, and stress, across successive time periods of the TSTP intervention period (T1 to T3). Table 9 shows that the greatest drop in scores between successive time periods for the depression subscale occurred from T1 to T2. This was also true for anxiety and stress (see Tables 10 and 11). The effect sizes of these contrasts using Cohen's *d* are also provided in Tables 9, 10, and 11. The drop in scores from the midpoint of the TSTP to its completion (i.e., T2 to T3) was not as great as the drop from T1 to T2.

Table 9

Pairwise Comparisons Within Group 1 (ITG) Depression

	Delta Method		Bonferroni [a]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-19.51	0.46	-41.98*	5.09
3 vs 2	-3.11	0.46	-6.69*	1.18
3 vs 1	-22.62	0.46	-48.67*	7.83

Note. n = 69. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Table 10

Time Comparisons Within Group 1 (ITG) Anxiety

	Delta Method		Bonferroni [a]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-20.34	0.45	-45.17*	5.09
3 vs 2	-2.76	0.45	-6.14*	1.57
3 vs 1	-23.11	0.45	-51.31*	7.14

Note. n = 69. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Table 11

Time Comparisons Within Group 1 (ITG) Stress

	Delta Method		Bonferroni [a]	
Time	Contrast	SE	z	Effect Size [b]
2 vs 1	19.13	0.47	-40.26*	5.34
3 vs 2	-2.8	0.47	-5.90*	1.02
3 vs 1	-21.94	0.47	-46.17*	7.71

Note. n = 69. SE = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Group 2

Prior to commencing the results for Group 2 (WCG), it is important to summarise some of the information in Chapter 4 (Methodology) as a means for providing some relevant context and to facilitate understanding and interpretation of results. Group 2 was used as the waitlist control group for this study, meaning that at T1, its members completed the DASS. However, unlike Groups 1 and 3, they did not commence the TSTP until T2. They still, however, had a DASS administered at 10 weeks, 20 weeks and 30 weeks of actual treatment.

This design means that Group 2 had an additional time point to allow them to complete the same TSTP as Groups 1 and 3 (Refer to Figure 4, Chapter 4, Methodology, as well as Table 1 in this chapter). For this reason, T4 has been included in the results section for Group 2 only, to allow a more comprehensive comparison of the results between the time points.

Tables 12, 13, and 14 provide the data for Group 2 (WCG). T2 vs T1 across all subscales shows that, even though the contrast scores were negative, they were not significant.

This means that there was no significant difference for Group 2 when comparing T2 to T1. This is unsurprising, as no treatment (TSTP) was provided between these two time points for Group 2. It showed that during the period without any treatment (i.e., between T1 and T2), DASS subscale scores remained relatively static.

However, in relation to the other time points, where Group 2 participants did engage in the TSTP, those contrasts were negative and significant. Similar to Group 1, Tables 12, 13, and 14 show that improvements were observed in all subscales, across successive time periods of the TSTP intervention period. When considering the time points T2 to T4, it was apparent that the severity of symptoms (DASS subscale scores) reduced across the 20-week TSTP intervention period. The effect sizes of these contrasts using Cohen's *d* are also provided in Tables 12, 13, and 14.

Table 12

Time Comparisons Within Group 2 (WCG) Depression

	Delta Method		Bonferroni [b]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-0.86	0.47	-1.83	0.46
3 vs 2	-20.71	0.47	-43.61*	4.96
4 vs 3	-20.14	0.47	-41.45*	1.60
4 vs 2	-4.65	0.47	-3.78*	8.23

Note. n = 72. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Table 13

Time Comparisons Within Group 2 (WCG) Anxiety

		Delta Method	Bonferroni [a]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-0.43	0.46	-0.94	0.34
3 vs 2	-21.78	0.46	-47.34*	5.56
3 vs 1	-22.21	0.46	-48.28*	1.87
4 vs 2	-3.79	0.46	-3.29*	6.03

Note. n = 72. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Table 14

Time Comparisons Within Group 2 (WCG) Stress

		Delta Method	Bonferroni [a]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-0.85	0.48	-1.76	0.39
3 vs 2	-20.08	0.48	-41.37*	4.80
3 vs 1	-20.94	0.48	-43.13*	1.60
4 vs 2	-4.52	0.48	-3.69*	6.03

Note. n = 72. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Group 3

Similar to Group 1, Tables 15, 16, and 17 provide the data for Group 3 (community). Mirroring the results for Group 1, the contrast scores for the depression, anxiety, and stress subscales, are all negative and statistically significant. This reflects a reduction in scores across successive time points of the TSTP (T1 to T3). Comparing contrast scores across all subscales for T1 to T3 shows the greatest drop in scores between successive time periods for all subscale scores occurred from T1 to T2. By contrast, the drop in scores from the midpoint of the TSTP to its completion (i.e., T2 to T3) was not as pronounced. The effect sizes of these contrasts using Cohen's *d* are also provided in Tables 15, 16, and 17.

Table 15

Time Comparisons Within Group 3 (Community) Depression

	Delta Method		Bonferroni [a]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-3.45	0.19	-18.00*	1.13
3 vs 2	-0.98	0.19	-5.13*	0.37
3 vs 1	-4.43	0.19	-23.12*	2.34

Note. n = 423. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Table 16

Time Comparisons Within Group 3 (Community) Anxiety

	Delta Method		Bonferroni [a]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-4.4	0.18	-23.71*	1.56
3 vs 2	-0.58	0.18	-3.13*	0.26
3 vs 1	-4.98	0.18	-26.84*	2.40

Note. n = 423. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Table 17

Time Comparisons Within Group 3 (Community) Stress

	Delta Method		Bonferroni [a]	
Time	Contrast	*SE*	z	Effect Size [b]
2 vs 1	-2.87	0.2	-14.63*	0.97
3 vs 1	-3.76	0.2	-19.18*	0.32
3 vs 2	-0.89	0.2	-4.54*	2.29

Note. n = 423. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Conclusion

The results from the analyses show that, for all groups, there were decreases in the DASS subscales from the commencement of the TSTP to its completion. Therefore, the hypothesis is accepted and provides support for the effectiveness of the TSTP. Despite the debate in the literature the general consensus in the literature which suggests that trauma-specific therapies in prison would show little impact on trauma symptomology (e.g., Baldry, 2008; Pollock & Brezina, 2006). However, the outcomes of this study indicated that the intervention for inmates was notably similar, to their community counterparts.

The research also suggests that despite initial improvements in outcomes, inmates would likely struggle to maintain any lasting effects of the therapeutic intervention and so the long-term retention of gains would be challenging at the very least (Gaudino & Miller, 2013; Huhn, et al., 2014). This belief then leads to the post-treatment hypothesis (Hypothesis 2.2.1) to determine if the effects of the intervention would be maintained.

Hypothesis 2.2.1 Lasting Effects of the Intervention (10 Week Post Treatment)

Overview

This hypothesis suggests that treatment intervention effects will be maintained at 10 weeks post treatment across all groups. This means that the effects of the TSTP, as indicated by the DASS, will be observed over the post-treatment interval, with group scores on depression, anxiety, and stress being maintained.

Results

Once the intervention had been completed, the DASS was administered as a follow-up measure to each group after an additional 10-week post treatment interval. This was done in order to determine if the effects of the TSTP persisted after the treatment phase had been

completed. Pairwise comparisons were undertaken between groups in order to measure the effects.

Group 1

The results for Group 1 (Table 18) show a negative contrast score for each of the DASS subscales during the non-treatment period (10 Week Post Treatment)**.** This provides evidence that the effects of the TSTP for Group 1 were maintained at a 10-week follow-up period suggesting that the effects of the TSTP were durable and persisted in a non-treatment period.

Table 18

Time Comparisons Between T3 and T4 – Group 1

		Delta Method		Bonferroni [a]	
Subscale	Time	Contrast	*SE*	z	Effect Size [b]
Depression	4 vs 3	-4.11	0.46	-8.84*	2.00
Anxiety	4 vs 3	-6.61	0.45	-14.68*	3.18
Stress	4 vs 3	-5.38	0.47	-11.34*	2.07

Note. n = 69. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Group 2

As with the results from Group 1, the results for Group 2 (Table 19) showed negative contrast scores across each of the subscales during the 10-week non-treatment period. This showed that the effects of the TSTP were maintained during a period where no treatment was provided; and that the severity of DASS subscales remained low. As previously explained, the

WCG received a delayed intervention, instead commencing their treatment at T2. In order to compare Group 2 at the post-intervention follow-up time point (T3-T4), time points T4-T5 were compared, as they represented the true follow-up period for Group 2.

Table 19

Time Comparisons Between T4 and T5 – Group 2

		Delta Method		Bonferroni [a]	
Subscale	Time	Contrast	*SE*	z	Effect Size [b]
Depression	5 vs 4	-3.97	0.47	-8.72*	1.60
Anxiety	5 vs 4	-3.39	0.46	-14.26*	1.87
Stress	5 vs 4	-3.8	0.49	-12.01*	1.60

Note. n = 69. *SE* = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Group 3

Similar to Groups 1 and 2, a comparison was undertaken for Group 3 to determine if the effects of the TSTP were maintained 10 weeks after treatment concluded. Table 20 shows that the contrast scores for Group 3, across all subscales, were negative and statistically significant, providing support that the effects of the TSTP were maintained during a non-treatment period.

Table 20

Time Comparisons Between T3 and T4 – Group 3

		Delta Method		Bonferroni [a]	
Subscale	Time	Contrast	SE	z	Effect Size [b]
Depression	4 vs 3	-2.54	0.19	-13.26*	0.97
Anxiety	4 vs 3	-2.58	0.18	-13.90*	0.97
Stress	4 vs 3	-2.74	0.2	-13.95*	1.03

Note. n = 69. SE = Standard Error.

[a] Tests of the a priori hypotheses were conducted using Bonferroni adjusted alpha levels of .016 per test.

[b] Cohen's *d.*

*$p < .016$.

Conclusion

Hypothesis 2.1.2 predicted that the ITG would provide statistically significant treatment gains on completion of the intervention program (T3) in scores for depression, anxiety, and stress when compared to the WCG. The findings of reduced DASS subscale scores for all groups at 10 Weeks Post Treatment supports this hypothesis.

Hypothesis 2.3.1. Inmate Motivation

Overview

This hypothesis posited that at the conclusion of the TSTP, inmates will be more likely to be ready to address criminogenic needs as a result of addressing trauma histories.

Results

Inmates completing the Treatment Readiness Questionnaire (TRQ) fall into one of two categories, either "program ready" or "program preparation" (Casey, Day, Howells, & Ward,

2007). Receiving a rating of program ready indicated that the inmate was therapeutically ready to address their offending behaviours; whilst a rating of program preparation meant that they were not ready to address that behaviour. As discussed in Chapter 2 (Methodology), the TRQ is a tool used by CSNSW and as such was administered by them. The TRQ was administered by an appropriate CSNSW staff prior to commencement in the TSTP and again following completion of the program and the results are held centrally by CSNSW.

Following the completion of the TSTP, a request was made to CSNSW to release the TRQ data. The results showed that prior to engaging in the TSTP, all inmates (n = 141) were categorised as "program ready" and that this rating remained unchanged at the completion of the TSTP. This showed that inmates were already considered to be ready to engage in programs designed to address offending behaviours before the commencement of the TSTP.

Because the data was received from CSNSW at the conclusion of the TSTP, an assumption was made at the commencement of this investigation, that inmates would be in a "program preparation state". Accordingly, a hypothesis was developed based on this assumption. However, because the inmates were program ready before the present investigation, this hypothesis is not applicable.

Conclusion

This hypothesis was not applicable as the data indicated that pre-treatment and post treatment scores were both at the same program ready level. This will be discussed further in Chapter 8 (Discussion).

Chapter Summary

Study 2 sets out to evaluate the effectiveness of a 20-week TSTP on female inmates in a custodial setting. At the end of the program, all program participants, in both of the inmate groups (experimental, and the waitlist control groups) showed a decrease in scores across the DASS subscales of depression, anxiety, and stress. When considering the results for

community-based participants, they too showed a decrease across depression, anxiety and stress scales. Analysis of follow up effects, showed that participants maintained the effects of the intervention program after completing the program, providing support for the effectiveness of the program. This is despite the literature suggesting that trauma-specific therapies, would either not be possible or at the very least be only modestly effective in prisoners for depression and anxiety outcomes (Baldry, 2008; Pollack & Brezina, 2006; Yoon, Slade & Fazel, 2017).

The study also demonstrated that despite the location of the intervention, whether it be custody or community, there were significant reductions in the DASS subscale scores, providing evidence that location was not a barrier to treatment. It was assumed, based on the literature, that a number of factors would negatively impact any therapeutic interventions, such as: the re-traumatising practices of the prison (Piper & Berle, 2019; Pollack & Brezina, 2006); an inability to create an environment to establish therapeutic safety and trust (Levenson et al., 2014; Piper & Berle, 2019). These findings provide support that the TSTP is effective in reducing DASS scores for both inmate and community groups with benefits that were sustained, beyond the treatment period.

CHAPTER 7

Results for Study 3a: Qualitative Analysis of Interviews with Inmate Participants and Community Participants

"Each of us is more than the worst thing that we have ever done".

(Stevenson, Just Mercy, 2014)-

One of the last frontiers of our society is the lack of realisation about the extent of trauma.

(Middleton, 2011)

Introduction

This chapter provides the results for the first qualitative component of this research, Study 3. Interviews were conducted with two participant groups: female inmates who had participated in the custodial Trauma Specific Treatment Program (TSTP) and female participants from a community sample who participated in a community-based TSTP. The interview transcripts were subjected to a thematic analysis, described in Chapter 4 (Methodology), resulting in a set of main themes and accompanying subthemes, shown in

The results provided are necessarily voluminous but framing them in terms of themes and subthemes will ensure that the discussion (Chapter 8) will be more focused. It should be noted that the themes raised were not necessarily discrete themes, nor were they perfectly compartmentalised and, as a result, there was a degree of crossover and overlap among them. This is equally true with the subthemes. Both themes and subthemes were 'researcher constructed' based on participants' responses (using a thematic analysis).

Table 21

Emerging Themes and Subthemes from Interviews

Themes	Subthemes
1. Effectiveness of Counselling	1.1 Disclosing the trauma
	1.2 Validation of the trauma
	1.3 Overcoming shame
	1.4 Practical intervention
	1.5 Choice and Collaboration
2. Evidence of change	2.1 Effective change
	2.2 Self-injurious and suicidal behaviours
	2.3 Emotional regulation
	2.4 Self-blame
	2.5 Rediscovery of the self
	2.6Alcohol and other drug use
3. Strengths and weaknesses	3.1 Acknowledging the trauma
	3.2 Safety
	3.3 Psychoeducation
	3.4 Coping skills
	3.5 Self-perceptions
	3.6 Self-worth and blame
	3.7 Areas for improvement
4. Physical and Psychological Impacts	4.1 Access to services
	4.2 Trust
	4.3 Shame

Due to the variation in the environments, characteristics, and experiences of the participants (inmates and community), there was often considerable variation in the responses to the interview questions. Therefore, often it was neither useful nor helpful to use a standard format consistently to develop and report on themes and subthemes. Sometimes, one or more subthemes were exclusive to only one of the participant groups, while, at other times they were

common to both groups.

A sample of quotations from the participants is given to better illustrate themes and subthemes, followed by a summary for each theme. Where participants refer to the counsellor, their name has been replaced with 'the counsellor' to ensure anonymity. Also, when participants refer to specific trauma, rather than detail it, it has been replaced with the words 'the trauma' (or similar) to provide consistency and not distract from the general nature of the theme and subtheme.

In order to represent the participant being quoted and make for ease of reading, direct quotes, from custodial-based participants are indented, italicised and identified with a code CUSP1-CUSP30 and community-based participants are also indented, italicised and identified with a code COMP1-COMP30.

Results

Theme 1: Effectiveness of Counselling

The first theme provides details of what participants found useful for themselves, when completing the TSTP. Participants' responses give an insight into what participants believe is effective for them in regard to the TSTP, irrespective of the location of the TSTP (custody or community). This is particularly important given that research presented in Chapter 2 (Literature Review) indicates that prison cannot be a therapeutic milieu, particularly when attempting to resolve psychological trauma.

Subtheme 1.1: Disclosing the Trauma

During the interviews, several subthemes emerged in regard to the custody group's perceived effectiveness of the counselling program. The first subtheme centred on the belief that counselling provided an opportunity for all participants to tell their story, essentially a disclosure of their trauma in full, not just the events but the emotional impact of the trauma. As CUSP26 shows,

"*I wasn't silenced. I had time to talk and be heard. I've never had that before. From anyone*".

The research (see Chapter 2) suggests that, often, individuals in treatment do not recognise the significance of their trauma histories on their lives and do not connect the trauma with presenting problems. In this way, they may not disclose their trauma. Treating practitioners who are not trauma-informed may also not ask questions around an individual's trauma history, which may mean that the experience remains unaddressed or misdiagnosed Substance Abuse and Mental Health Services (2015). It is acknowledged that the absence of trauma-informed practices may be due to a lack of organisational directions or even operational constraints. However, regardless of the reason why the trauma remains unaddressed, the participants were not previously provided with an opportunity to tell their story. When asked to tell her story, CUSP3 said,

"*Tell me your story. That's what (the counsellor) said to me. That made such a difference to me. I remember giving evidence about it (the trauma) before and all I did was answer the questions that the police and lawyers asked. I never realised that I had never just sat down and told my story*".

In relationship to her experience of addressing trauma issues CUSP1 said,

"*Definitely … definitely, as I've never really spoken about most of the stuff before, never mind dealing with it. It's weird after counselling, it's like I had control over it rather than it (the trauma) controlling me".*

While CUSP 7 recalled her session with the counsellor, saying:

"*I remember sitting down with (the counsellor) and just unloading. I had meant to test her and not give her all the information right away, but she just … got it … not what happened … what it actually meant … to me".*

Subtheme 1.2: Validation of the Trauma

A significant number of participants spoke about having someone validate their trauma and accept it, rather than immediately shut them down when trauma is raised. This subtheme of validation of the trauma was linked to participants feeling more empowered in the actual process of counselling, rather than counselling being seen as a process where the counsellor had control. This was described as often being the case for inmates, when they were receiving counselling from the prison psychologists. Validation of the trauma and subsequent responses is essential to recovery from trauma. From the sessions CUSP21 learned:

> *"It's all about choice. I had no choice in being raped or being bashed, but I do have a choice in how I recover. I may never completely heal but I can choose how I start to heal or how far I can go".*

Research (see Chapter 2) indicates that validating feelings and emotions assists the client to understand their emotions, develops effective coping mechanisms and helps make sense of what has occurred and allows for the trauma to be integrated meaningfully into the client's life story (Briere & Scott, 2014; Herman, 1992; Park & Ai, 2006; Van der Kolk, 2015). A sample of responses from the custodial group to illustrate this theme follows. As CUSP6 pointed out:

> *"It wasn't my fault. There you go. That was the best thing about counselling. It was such a relief to stop blaming myself. I have done lots of messed up stuff in my life, drugs, crime … whatever. But what he did to me (the trauma)? Not my fault. It was his".*

In relationship to owning one's own emotions, CUSP14 commented,

> *"(The counsellor) said to me 'it's not my job to fix you, it's my job to give you the skills to fix yourself. Weird, right? When she said it, but I get it now. It's all about me. I need to control what was happening to me. It was so liberating. I couldn't control what happened to me, but because of (the counsellor), I knew it couldn't control me".*

CUSP25 said:

> *"There was no judgement from (the counsellor). She accepted what I told her and actually explained to me why I acted the way I did. It was like a light bulb going off. It was a definite turning point for me, that understanding made me believe that I could get a handle on things more and control myself".*

Subtheme 1.3: Overcoming Shame

Dealing with the shame of victimisation during counselling was another key theme that arose as a consistent theme amongst both participant groups. The research presented in Chapter 2 shows that the feelings of shame, associated with trauma, often act as a barrier to treatment for clients (Black, Curran, & Dyer, 2013; Dorahy, et al., 2013; Tull, 2019). The same research shows that many victims of violent crime feel intensely shamed and quite often embarrassed. In addition, organisational cultural factors often also provide a barrier to treating trauma and developing successful interpersonal and therapeutic relationships, such as corrections are about safety and security, not trauma. (Hundt & Holohan, 2012; Leska, Dieperink, & Thuras, 2005; Stone, 1992). Yet despite the importance of addressing shame after trauma, it appears that it is often neglected, particularly within the prison environment. Inmates reported feelings of not being deserving, feelings of worthlessness and generally being unaccepted or unloved. Not necessarily by other inmates, but by the staff within the prison. Often participants reported that those feelings were so well disguised, that they themselves did not realise what it was. A sample of responses from the custodial group to illustrate feelings of shame is clearly articulated by CUSP2 who said,

> *"For the longest time I felt so ashamed. When we (the counsellor) spoke about previous relationships I realised that I had settled for what I got. Even when he was abusive, I just believed that I deserved it".*

CUSP6 also said:

> *"Shame came up a lot. I honestly didn't even realise it or think I was ashamed. I denied it for weeks, but then started thinking about why I felt so worthless or for how long I felt that way".*

In talking about shame, it became clear that self-esteem was very important as elucidated by CUSP7,

> "*No one loved me. I was in relationships for years and never felt loved. Working through my issues with (the counsellor) it just clicked, I didn't love myself so how could anyone else love me?".*

While CUSP12 went further saying:

> *"I was blamed for everything that ever happened to me. Every time I was hit as a child, every time I was abused by my husband, it was my fault. Always my fault. I carried that around with me. For years. When I look back, I realise how low my self-esteem was and how miserable I was".*

During the interviews, participants also provided clear links to feelings of betrayal and being discredited by others. For participants, shame takes the form of identity and affects their overall sense of self. The resolution of shame is critical in treating/resolving the trauma. For example, CUSP19 said,

> "*When the people who are supposed to love you, screw you over instead, you never get over the feelings of … betrayal? … no that's not strong enough".*

For CUSP13 said,

> "*It's hard enough to go through it, but when no-one believes you? When your own mother doesn't believe you and picks him over you …?".*

CUSP1 also confessed,

"*Do you know what it's like to have your father abuse you? Then when you get the courage to tell, no one believes you. I can't even begin to tell you how that feels*".

CUSP28 said:

"What happens when you get blamed for the abuse, even though as a kid, it couldn't have been your fault? You feel the guilt and shame of it more than ever. When they actually blame you, you never really get over it".

Subtheme 1.4: Practical Intervention

Another common topic to emerge during interviews, was the provision of strategies to the participants by the counsellor, to assist with specific issues. Inmate participants reported that the therapy provided through the counselling intervention was much more than just talking therapy. The counsellor provided specific strategies and responses, in conjunction with the participant, to respond to specific symptoms they disclosed. For example, CUSP27 said,

"I loved the fact that she (the counsellor) helped me work out what was actually happening in my own body and give me strategies to help manage them".

Importantly, these practical interventions were specific to prison life and could be used only within a correctional setting. Research establishes not only that "the majority of people who seek treatment for trauma-related problems have histories of multiple traumas, but that those who experience complex trauma may react adversely to current, standard PTSD treatments" (ASCA, 2013). As such, the levels of dysfunction and dysregulation experienced by the participants, require more than traditional approaches to treat PTSD symptoms (Dass-Brailsford, 2007; Schnyder & Cloitre, 2015; Walker, 2019;). According to Courtois and Ford (2009, p. 441), designing and adapting an array of evidence-based models to address "multiple dimensions of complex trauma" improves clinical outcomes for survivors of trauma. The following quotes from inmates provide some insights to the recommendations from counsellors. CUSP3 noted that:

"One of the best things that (the counsellor) did was to help me manage my anger. It wasn't just anger management, it was to show me to control my anger, look at my triggers and what to do … it was so practical".

For CUSP5,

"It was so hard to manage things like sleep and depression, especially on the inside (the counsellor) worked with me to come up with things that worked".

CUSP19 said:

"Being in gaol sucks. OK so that wasn't meant to be funny, but it really does. All the things that you would do when you get stressed on the outside, you can't do in here. You can't go for a walk, take timeout, light a candle and meditate. Working with (the counsellor) really helped and she was so creative. Giving me something practical to do was what I needed. It meant that there was more to counselling than just talking once a week".

Subtheme 1.5: Choice and Collaboration

In keeping with the previous subthemes, a number of participants raised another key topic, specifically around choice and collaboration as an effective component of counselling. They believed because they had control over the counselling process and worked in collaboration with the counsellor, which in turn made the TSTP more effective. The following comments show how choice and collaboration impacted the custodial participants. CUSP8 said,

"When I think about the most effective part of counselling, I think about how I was in control of it. Counselling wasn't something that was happening to me, it was something that wanted to do, I needed to do and that I worked with (the counsellor) on".

For CUSP5 it was about choosing,

"I chose to be in counselling, I chose to stay in it. I chose to make it work. Choice. That's what worked best about counselling"

and CUSP7 it was about self-worth,

"For the first time that I felt like I was part of what was happening. It was a partnership between me and (the counsellor)".

This feeling of worth was also articulated by CUSP26 who said,

"Normally when you do counselling, it's because you have to. There's always someone else making you do it for their reasons. Victims counselling was for me and only for me".

Community participants of the TSTP reflected on similar themes as those in the custodial participant group. They indicated that issues of consent, choice, and collaboration in counselling, were what made it most effective. Again, this is consistent with research which indicates that these issues are necessary to resolve trauma (ASCA, 2013). Community participants saw these points (consent, choice, and collaboration) as important, as they assisted them to balance out the loss of control they felt when they were victimised and suffered the initial trauma. Like custodial inmates, they too felt that the process of therapy was one of choice, rather than something that they had to do. A sample of responses from the community group to illustrate this theme follows. COMP3 felt,

"Seeing the counsellor was a choice for me. I felt safe and comfortable, I think the fact that it wasn't rushed meant I could work through things at my own pace".

COMP6 continued in this theme saying,

"The counsellor worked with me, directing and guiding me, rather than telling me what to do, which in all honesty I was actually expecting him to do".

COMP8 felt that working together assisted the process of healing saying,

"We worked hard to build up trust and make sure I felt safe to work through the issues I wanted to. It was almost like I was giving my permission to move through the sessions".

COMP13 said,

"It was reassuring to actually feel like we were working together to address everything I was going through".

Within the confines of the TSTP, counsellors provided trauma-specific services which meant that there was a high focus on safety and establishing trust in the therapeutic alliance. This was reflected in the community participants' views. They spoke in terms of being physically safe as well as psychologically safe and viewed it as a necessary part of counselling. This concept of safety and trust appeared to underpin the effectiveness of the counselling process, making it an important aspect within the theme 'Choice and Collaboration' in understanding what factors make the counselling successful. As COMP4 explained,

"I had never seen a counsellor before. I have more than a few preconceived ideas about what would happen. I think I saw it more of an interrogation than counselling. I was surprised about how much we focussed on safety. Even letting me move the chairs and sit near the door. It was so calming. We worked together to build trust before we even broached the subject of my trauma".

COMP6 said,

"I was worried about trusting my counsellor. I shouldn't have. She was so kind and worked hard to make me feel safe. It really made the difference".

Whereas COMP17 similarly recounted,

"I don't think I would have been as successful in resolving my issues if (the counsellor) hadn't spent time working on my trust issues. I felt safe and believed she could help. That was the best thing."

COMP18, said,

> *"I felt unsafe in public, on my own, even in my own body. If (the counsellor) hadn't made me feel safe, I wouldn't have gone back".*

The community group believed that the focus of the TSTP was on them as a 'whole person', rather than on an event, namely the victimisation. For example, COMP22 said:

> *"I was so glad I got the counsellor I did. When I saw my GP, she diagnosed me, suggested antidepressants and told me I need to see someone. My referral just listed stuff wrong with me. But the counsellor focused on me. I felt like someone actually got it and could make improvements overall, not just in one area".*

Focusing on them was important as it considered their presenting issues holistically, rather as disjointed points across their life span. This focus additionally helped resolve broader behavioural issues resulting from trauma, rather than simply acknowledging single symptoms as they present. The following represents the community group participants' experiences. COMP2 disclosed,

> *"I think that I felt like I was going to go to counselling with a shopping list of symptoms and they would be fixed one by one. After a few sessions we worked out where I wanted to be and used strategies to get me there. This helped with a few things not just one symptom".*

COMP 4 said:

> *"I had seen another counsellor who said she didn't do a lot of trauma. She was just focused on what happened. She kept saying 'sooner or later we'll have to talk about it (the trauma). But when I went through Victims Services, that counsellor looked at everything that was happening for me and we worked out ways to fix them. That helped me fix some major issues in my life".*

While COMP13 imparted:

"In my first few sessions, I spoke about what had happened and what was wrong with me. But rather than deal with the depression and anxiety, the counsellor worked through a plan to make me feel better overall. I was so surprised it worked. She thought about me as a person, not a symptom".

Another key issue to emerge for the community group, centred on the levels of empathy demonstrated by the counsellor. Community participants believed that this was a key factor in their psychological improvements and something that they believed made the TSTP sessions more effective. COMP7 said,

"Empathy is so important. I was so lucky that (the counsellor) understood what that was and how to work with it so it didn't make me feel like it was just empty sympathy".

Further, COMP10 said,

"Having someone who gets it? That's what makes counselling effective".

Further sample of responses from the community group to illustrate this theme follows:

"Having told my parents about what had happened, they just kept telling me that it would be all right and that things would get better. Most other people did the same thing but mainly because they didn't know what to say. But with (the counsellor) they were so empathetic. They really understood what was happening and why it was happening". (COMP3)

"What made the difference for me, was the levels of empathy shown by the counsellor. It wasn't hollow or fake. They knew when to push and when to back off. They knew where my boundaries where and how much I could handle. It made all the difference. I felt so much stronger". (COMP23)

"She was my rock. She was just there for me. She listened. There was no judgement, she just sat with me a listened". (COMP17)

Summary

In reviewing what made counselling effective, it was considered, based on Chapter 2 (Literature Review), that the location of the counselling would present specific barriers for inmate participants as prison was not deemed an appropriate location to provide trauma. However, this was not the case. Rather than the location of the intervention (prison), participants, both community and custody, instead focused on the type of intervention provided. Both participant groups essentially provided an overview of trauma-informed principles in their responses and participant groups determined that establishing safety and building trust were effective components for establishing the therapeutic reliance and commencing the work. Being able to tell their stories and validating their trauma made all of the difference to participants in the TSTP.

Theme 2: Evidence of Change

Study 2 considered the question of whether there was change in symptoms associated with Depression Anxiety Stress Scale (DASS) scores after participating in the TSTP. What this theme reflected on, was the what the actual changes participants believed occurred following participation. It considered this beyond the changes to depression, anxiety and stress that were measured.

Subtheme 2.1: Effective Change

Overwhelmingly, both the custodial and the community groups believed that there was evidence of effective change in themselves following participation in the TSTP. An important theme to emerge was in relation to increased confidence and improved self-worth. A sample of responses from the custodial participants to illustrate this theme is as follows:

> *"What I worked out was, that if I can improve my overall self-esteem, I'll be more confident. If I can do that, it's a long-term thing that I can apply to so many other areas of my life".* (CUSP12)

"I've been called strong-willed before and it has never been a good thing. But even the officers notice I've improved. The strong will became confidence and I believed in myself more. It was seen as much more positive". (CUSP19)

"It was weird finding out that the things were practiced in counselling could be done anywhere and in lots of different situations. We worked on being able to things so that no one else knew I was doing it". (CUSP4)

A sample of responses from the community participants to illustrate this same theme is as follows:

"My moment of personal change happened when my kids told me I was much more like my old self. They said I was walking more upright and seemed more in charge. When I think about it, I think my self-esteem was improving and was even noticeable by others". (COMP17)

"You know you've broken the cycle when you start believing in yourself. I slowly gained confidence back little by little. I still have my moments and off days when I feel like crap, but instead of feeling like crap all the time, I only feel that way now and again". (COMP29)

"Everything changed. Actually, no I changed. I started looking at everything very differently. It's hard to explain but I found I could do things, go places. I found that I just thought about everything in a different way ... you know, I was just able to challenge my negative thinking." (COMP3)

Subtheme 2.2: Self-Injurious and Suicidal Behaviours

Another key topic, though more prevalent in custodial participants than community participants, related to self-injurious behaviours or self-harm. There was no explicit question on this, and responses may have something to do with prison culture and acceptance of it as normal. CSNSW do monitor it amongst the inmate population for health reasons, highlighting

its prevalence. Inmate participants were more open to naming it as a trauma response and develop their own insight into why they did it. Inmate participants also credit the TSTP with ways of developing alternative ways to cope with the triggers and emotional pain connected with that particular behaviour. For example, CUSP12 said,

> *"I blamed myself for not … doing anything … for being … weak … so I cut myself. I don't know if it was punishment or not, but it made me feel better". While CUSP8 "Having someone help you see your life differently is incredible. (the counsellor) helped me understand why I cut myself and how I could change".*

CUSP3 explained:

> "*When I talked about what I was ashamed of in counselling, I kept rubbing my arms (the counsellor) could see the scars and knew I self-harmed. That made me ashamed too. Not in here, it's pretty common, but for someone from the outside to see it … It was one of the big things we worked on, stopping me doing it".*
>
> *"When the pain got too much and I was losing control, I would cut. It … I don't know how to describe it … relieved me? I don't know, but the pain brought me back to reality".* (CUSP20)
>
> *"It's normal in here … not accepted … just normal. Lots of people do it. The officers say we're just seeking attention but it's more than that … I used to do it as a teenager and the first few times I was locked up. But no-one knew. I never used it to get attention".* (CUSP15)
>
> *"Oh yes … self-harm. Everyone denies it but loads of people do it. I used to do it. It's nothing to do with wanted it die. It's about wanting to feel something. [the counsellor] told me it was because I hadn't developed … something … but it helped me regulate my emotions and stopped me from spacing out".* (CUSP21)

It is also worth noting that no community participants mentioned this type of behaviour in their interviews.

Subtheme 2.3: Emotional Regulation

Linked with the previous subtheme, participants from both groups revealed that their ability to self-regulate their emotional capacity had also improved. The capacity for participants to link emotional regulation to their trauma and look at ways of improving it was also raised. This was a much more noticeable effect of how participants felt before and after participating in the TSTP, particularly as it was something others, friends, family, and staff (for those in custody) noticed, rather than just the participant. A sample of responses from the custodial group to illustrate this subtheme is as follows:

> "*Maybe it's not as obvious to staff but when certain things get challenging, you can see the change. I get less angry during the day; I sleep much better. Okay no one really sees that but still. I am not as emotional as I was either. I don't mean I am less emotional, just have better control of my emotions. Also, I think I am much nicer to be around. Some of the officers will tell you that. I think that said everyone realises I'm much more in control of myself, than I was".* (CUSP2)
>
> *"(The counsellor) and I often spoke about how impulsive I was and how much of a short fuse I had. I'd just blow up the minute anything went seven slightly sideways. But with counselling, I was able to slowly reduce this, and my fuse has gotten a lot longer.* (CUSP8)
>
> *"Learning to stop. Stopping, breathing, then deciding. It sounds easy but it was so hard, and in the beginning it didn't even work. But I kept at it. It worked. I still lost it occasionally, but I stayed in charge of my feelings".* (CUSP30)

For community participants, emotional regulation seemed to be linked to relationships and how the participant's emotional dysregulation affected others. In this way the responses

were externalised more than the custodial participants. A sample of responses from the community group to illustrate this subtheme is as follows:

> *"My family suffered from my temper. I would lose it at a moment's notice, especially with my kids, even though I knew it wasn't their fault. Then I'd end up in my bedroom in tears, crying uncontrollably about what a bad mother I was. (The counsellor) understood and we worked on strategies to manage it. Now I'm not saying I'm cured, but I am so much better than I was, and my kids are much happier".* (COMP9)
>
> *"(The counsellor) told me in the very early stages that we would work on emotional regulation. I wasn't convinced until I realised how badly I had managed my emotional outbursts up to that point. It was only when I was better at self-managing, did I realise how effective counselling had been".* (COMP14)
>
> *"Insight into what your body is telling you is crucial. Counselling helped me to learn how to listen to my body so that I could think through emotions, identify them and manage them appropriately".* (COMP30)

Subtheme 2.4: Self-Blame

Another key theme common to both groups was the reallocation of blame and the responsibility for the abuse, from them back to the offender. Self-blame was common across both participant groups, and they believed that the TSTP was effective in changing their perceptions of who was actually responsible for the victimisation. Whilst this is linked with themes of self-esteem, it is a common issue raised by both participant groups as a stand-alone issue. A sample of responses from firstly the custodial group to illustrate this subtheme is as follows:

> *"I blamed myself for staying in the relationship. I should have been stronger and just left, if not for me, then for the kids … you know? But it took so long for me to realise it was because of the trauma".* (CUSP12)

"*What I found important was … well … I took the blame for his abuse, time and time again. But it was a defence mechanism … it calmed him down and protected me for just a little while longer…but it became part of my behaviours and soon I believed it. (the counsellor) helped me change my thinking about that … well about a lot of things really"*. (CUSP17).

A sample of responses from the community group to illustrate this subtheme follows:

"*My counsellor was awesome, and we bonded over cheesy movies. Sorry … it really is relevant … just wait … umm … she would use movie quotes to reinforce whatever message she was trying to get into my thick head … the one that stays with me most is from that movie … Good Will Hunting? Where Robin Williams says to Will … Matt Damon … 'it's not your fault' and then Matt just loses it and cries. That's what I needed to hear, and what I needed reminded of … sometimes more than others"*. (COMP3)

"*You can't say … 'my husband is abusive'… it's too hard … you say instead, 'it's my fault', it's easier to make sense of things that way. You need a good counselling to reprogram your thinking. That's what counselling did for me*". (COMP7)

"I blamed myself, because everyone blamed me. It made sense. My mother blamed me for wrecking the family, my sister cried because our dad left. I was responsible. But it wasn't my fault. It was his. (the counsellor) helped me get that. It wasn't easy but we did it". (CUSP28)

Subtheme 2.5: Rediscovery of the Self

Another common theme to emerge, which again was common to both groups, was a recognition that the abuse had changed them in some way and that the TSTP was an opportunity for them to rediscover who they had been before the trauma. There was recognition by the participants that the physical, emotional, and psychological aftereffects of trauma, could be categorised into short-term or long-term changes. Participants from both groups attributed

these changes to engagement in counselling in the TSTP. A sample of responses firstly from the custodial group to illustrate this subtheme is as follows:

> *"It eats away at you. I stopped talking to my friends, I only saw my family when I needed something, like looking after the kids. It always felt like I was hurt in some way, my face, my ribs … and I always seemed to be sick, like the flu … but it never went away … (the counsellor) is the one who helped me change, helped me to get me back"*. (CUSP3)

> *"The fear was what changed me. I was so depressed. I avoided everything that reminded me of (the trauma), then avoided things that didn't remind me of (the trauma), then I'd have a billy before bed to take the edge off, then I was doing ice. Even though I'm in here, I wouldn't have changed if I hadn't have seen (the counsellor)"*. (CUSP11)

> *"I wasn't me … everything who I was after (the trauma) happened was just gone … I thought gone forever … when that shit happens to you as a kid … it just changes you forever … at least that's what I thought*". (CUSP25)

A sample of responses from the community group to illustrate this subtheme is as follows:

> *"What people don't get, even my family, was that the changes are so small that you don't even notice. They just eat away at you. The anger turns to anxiety, the anxiety turns to fear … you just slowly lose control of who you are, then one day you wake up and you don't recognise yourself. You can't fix that sort of thing on your own, you need someone to help you"*. (COMP1)

> *"Everything annoyed me, especially all the things I used to like, music, TV, I just couldn't find it in me to like them anymore … That's what we (the counsellor) used to check if I was getting back to normal"*. (COMP2)

"It was like I was acting a part on TV. I was the same on the outside but just in pieces on the inside. I thought I hid it really well, but when I started to get better and was able to talk about it, everyone already knew … guess I didn't hide it very well". (COMP7)

However, one key point of difference between the groups, was that the custodial participants found it harder to connect with who they were before the trauma, than the community participants. For many inmate participants, they experienced traumas when they were children. Hence, it is more likely that changes as a result of trauma, were more ingrained into their sense of self. A sample of responses from the custodial group to illustrate this subtheme is as follows:

"When I think about who I was before (the trauma) I can't honestly say that I know. I think I was happier, a bit more trusting, but I'm not sure if that's who I was or who I want to have been". (CUSP1)

"I had a shit life as a kid. Parents never around other than to fight with each other and us kids. Never enough food, no one really cared. That had to have changed me, right? But how would I know". (CUSP10)

"(The counsellor) and I have spoken about my childhood, mainly because of how I feel and why it has been happening for so long. I'm sure my life would have turned out different if (the trauma) hadn't have happened. Surely I wouldn't have started out this screwed up?". (CUSP14)

Subtheme 2.6: Alcohol and Other Drug Use

The use, misuse or abuse of alcohol and other drugs were another shared common theme between the two participant groups. From the participants' comments, it appears that this may be linked to self-medication to escape the reality of the trauma, relieve stress, and manage emotional regulations or to just try and forget (the trauma). There are clear indications

of symptoms that the drugs or alcohol were used to manage trauma symptoms and that the overarching motivation for their use was self-medication. A sample of responses from the custodial group is as follows:

> "*I was so depressed all the time, I couldn't get out of bed. A friend gave me some Dex [Dextroamphetamine]. It worked but then I was using it every day. Then I couldn't sleep so I took some Valium. Before I came in I was doing Ice every day. I just lost control*". (CUSP5)
>
> *"The fear was what changed me. I was so depressed. I avoided everything that reminded me of (the trauma), then avoided things that didn't remind me of (the trauma), then I'd have a billy before bed to take the edge off, then I was doing ice. Even though I'm in here, I wouldn't have changed if I hadn't have seen (the counsellor)".* (CUSP11)
>
> *"Oh I changed … big time … and because of one thing … drugs … it made the pain go away … at least for a while … but who they turned me into? That was just scary. That's one of the reasons I'm in here.* (CUSP22)

A sample of responses from the community group to illustrate the same subtheme follows:

> *"I never thought I would be the girl that needed a fix to get through the day, but I did. I was so anxious. I got some Xanax and Valium from the GP but he reduced it in case I became dependant on it. When he did that I just replaced it with something else. It made me able to focus on other things not just (the trauma)".* (COMP3)
>
> *"I used for a while, it … soothed me … that's the best way I can describe it.* (COMP13)
>
> *I started with a drink in the evening to calm me down after work, then it was a glass of wine with dinner, then a nightcap before bed, then a quick drink at lunch. I thought I was becoming an alcoholic".* (COMP24)

"My boss pulled me up at work one day. I stank of stale alcohol. I was unfocussed, I was tired. That was a wakeup call. I couldn't afford to lose anything else. I broke down and told her what had happened (the trauma). She was great though and the main reason I got into counselling". (COMP29)

Summary

Participants from both the custodial and community groups believe, on self-reflection, that there is evidence of therapeutic change and effectiveness following their attendance in the TSTP. Both groups shared common themes which illustrated improvements following participation in the TSTP and also some of the background to the occurrence of their pre-TSTP selves. Firstly, they provided insight into how the trauma changed their sense of self as well as overall self-esteem, and how participation in the TSTP helped return it. The participants also considered how improvement in emotional regulation helped them regain control of certain behaviours. Both participant groups spoke of how they believe their self-esteem was affected by trauma, but also how they saw themselves change through participation in the TSTP.

Self-blame was another common theme to emerge across both participant groups and how the TSTP helped address this problem. Participants also discussed how they believe the trauma had changed them and that counselling had assisted them to return to some sort of normalcy. However, in the case of the custodial population, responses suggest that those suffering from childhood trauma had a more difficult time in contemplating pre-trauma states; this may reflect the higher levels of complexity in the trauma experienced. The use of alcohol and other drugs to self-medicate to cope with symptoms was also raised by both groups. An expected theme to emerge for the custodial population, based on the literature was in regard to self-harm or suicidal behaviours. While the inmate participants were open about it, the community participants did not mention it. This group focused instead on shame and self-medication through drugs and alcohol as the main issues.

Theme 3: Strengths and Weaknesses

In considering the perceived strengths and areas of improvement of the TSTP, participants were effectively being asked, "what worked?" and "what didn't work?". As trauma counselling is a deeply personal experience in which participants explore the worst moments of the participants lives, these are fundamental questions in determining the effectiveness of the TSTP. This concept of being personal, related to the first common theme that arose between both groups and was in regard to the nature of the TSTP.

Subtheme 3.1: Acknowledging the Trauma

Both participant groups reported that having someone that was dedicated to managing the trauma was one of the biggest strengths of the intervention. This was presented in terms of having someone acknowledge and validate the trauma and provide an opportunity to be heard. This overlaps with a previous subtheme (1.1) of being able to tell their story. Participants also reflected on the counsellor having no agenda or need to deal with other issues as very important. First, a sample of responses from the custodial participants is provided:

> *"It's one way. It's all about me, you don't have to wait? ... fight? ... for the other person's attention, you get it ... them ... to do what you need them to do. (CUSP4)*
>
> *It's not like talking to friends or your family, it's easier, you know? You both know why you are there and don't have to pretend ..."* (CUSP8)
>
> *"It's having someone acknowledge that (the trauma) did happen, the way I said it happened."* (CUSP17)
>
> *"The fact that (the counsellor) didn't tell me to get over it and brush over it. They listened to me and believed me."* (CUSP22)

Next, a sample of responses from the community participants which illustrates the same subtheme is as follows:

"Counselling starts as being terrifying and ends up being a lifeline. What makes that a strength is that the counsellor is there with you and for you?" (COMP1)

"No judgement, no split attention. It's all about me and my issues". (COMP3)

"I get to stop and focus on me, with no guilt." (COMP13)

"The biggest strength is that I feel like I am actually achieving something but focusing on myself rather than the individual problems." (COMP25)

Subtheme 3.2: Safety

Another key subtheme identified was in relation to safety, specifically when participating in the TSTP. This was in relation to both the physical and psychological safety, which is specific to the provision of effective trauma-specific services. Both groups equally considered safety as an important factor and as a necessary starting point to commencing and maintaining the therapeutic intervention. A sample of responses from the custodial group to illustrate this subtheme is as follows:

"When I first started, my anxiety was through the roof. But (the counsellor) made me feel so relaxed and safe, I actually looked forward to going back." (CUSP5)

"(The counsellor) kept checking in with me, she never pushed … it made me feel safe. It was like that the whole way through and helped me open up bit by bit." (CUSP9)

"We always spoke about the counselling room as a safe space. That helped me associate going there with being safe, it reinforced that counselling was safe." (CUSP14)

"When I started counselling, I was a mess; I didn't think I could do it. (The counsellor) had a little piece of paper stuck down on the table in front of us with numbers going from 1-5. That was my safety monitor. I touched the number as we discussed things about (the trauma), if I couldn't do it, I touched the number 1 and we stopped, if it was

OK I touched 5 and we went on. It really made me feel safe enough to raise things in counselling that I could stop whenever I needed to." (CUSP25)

Like the custodial participants, the community participants provided examples which illustrated this subtheme. These are presented as follows:

"(The counsellor) made me feel competent … or like I had some control … that made me feel safe." (COMP2)

"I know it sounds weird, but we made a first aid kit to keep me safe. It had a note from (the counsellor), some chocolate, which doesn't last long, a picture of my dog, because that made me happy … that kind of stuff, things that make me smile and calm down." (COMP6)

"Every session started with some mindfulness exercise. It only took a minute but made me feel calm. I use them to feel safe when I get overwhelmed." (COMP18)

Subtheme 3.3: Psychoeducation.

A further recurring subtheme across both participant groups related to psychoeducation. Both participant groups expressed, that often the strengths of the TSTP were in the ability of the counsellors to explain the nature of the symptoms and in some cases, the diagnosis. Finding out more about why their bodies and minds reacted to trauma in the way it did, provided the initial basis for treatment in participants, and demystified the symptoms themselves. This was again a consistent theme across both custodial and community groups. A sample of responses from the custodial group that illustrates this subtheme follows:

"If I had to pick one strength of the counselling program, it would be going over the myths about what it is. I mean I always thought that if you were a victim of DV you would end up doing DV yourself." (CUSP6)

"looking at what the 'normal' responses to trauma are were really important for me." (CUSP7)

"Do you know what happens when you have an anxiety attack? Do you know why your body reacts in the way that it does? I do. That was so good for me, just to understand." (CUSP20)

A sample of responses from the community group further illustrates this subtheme:

"(The counsellor) sat down with me on the first session and told me that education was part of the treatment. I was surprised because I didn't think that's what they do. But it was great. I learned about trauma, diagnosis, symptoms … it actually helped … a lot." (COMP4)

"Understanding what was happening, and what was going to happen was something that had a huge impact on me. The more I understood, the more I was able to look at my issues rationally. It helped me maintain control." (COMP9)

"Having someone explain what and why things happened to me in the past helped me negotiate what was happening to me in the present. Knowing made it easier." (COMP24)

Subtheme 3.4: Coping Skills

Coping skills was identified as a key subtheme across both participant groups. Emotional dysregulation, anxiety, depression, anger, and so forth, are only just some of the trauma symptoms that can overwhelm participants and affect how they are able to function in daily life. Establishing a range of coping skills to deal with the practicalities of day to day life was reportedly another of the strengths of the TSTP. A sample of responses from the custodial group that illustrates this is as follows:

"I needed the practical stuff. What was going to stop the tears, control the anger, stop the sadness … that sort of thing." (CUSP7)

"I thought counselling was just talking. But (the counsellor) was pretty practical. She gave me strategies to work through my issues. She called it my toolbox. I still use them all the time and share them with friends who I think need them." (CUSP16)

"Ways to get through the day. That's the biggest strength of counselling, helping me do that in the easiest and simplest way possible." (CUSP18)

The community group's appreciation of the coping skills gained from participation in the TSTP is demonstrated in the following comments:

"Strategies to manage the stress and keep me sane. That's the biggest strength." (COMP5)

"Everybody needs ways to manage the stress of (the trauma). I used to drink to do that, now I meditate, go for walks, even hit the gym." (COMP14)

"Knowing what is happening and importantly what to do about it. That's the biggest strength of counselling." (COMP27)

Subtheme 3.5: Self-Perceptions

Carl Rogers (1961, p. 108) states: "It seems to me that at bottom each person is asking, 'Who am I really? How can I get in touch with this real self, underlying all my surface behaviour? How can I become myself?". Consistent with Rogers' hypothesis, regaining a sense of self, was a recognised issue recognised by both participant groups. From discussions raised by the participants, it was noted that the trauma had damaged their overall perception of the world and their place in it. The TSTP provided an opportunity for participants to regain the sense of who they are, and in line with research (e.g. Cherry, 2018), therapy enabled them to reshape themselves in a way that they believed to be a better version of themselves. Participants also believed that this change in perception enabled them to improve their internal state of

mind. A sample of responses from the custodial group that illustrates this subtheme is as follows:

> *"The real strength of counselling is being able to find me again. The person that existed before (the trauma) happened."* (CUSP7)
>
> *"When you peel away the layers of trauma, you find the real you. That's what I found anyway. It wasn't a perfect me, but it was a good start."* (CUSP10)
>
> *"I used to think of the world as a bad place, dangerous … you know? But not anymore. With counselling I started to feel normal again, not that I ever felt not normal … but when I think about what was wrong with me … anyway, the world became better, little by little."* (CUSP25)
>
> *"Finding me again … and realising that I liked that version of me. That was important for me. Focussing on me was important … it was the first time in a long time I did something just for me."* (CUSP28)

A sample of responses from the community group which illustrates this subtheme follows:

> *"When you lose yourself through (the trauma) you have to be careful about how you put yourself back together. You don't want to hold on to the bad stuff, only the good stuff."* (COMP5)
>
> *"Counselling's biggest strength is letting go of the trauma and getting control of your life. Life isn't all doom and gloom and you need to be the stronger version of you to find it."* (COMP11)
>
> *"(The counsellor) said that you can either see the world as inherently good or inherently bad. The choice you make defines how you will see yourself. Bad things happened to me, but that doesn't make the world bad … or me bad."* (COMP19)
>
> *"You need to find out who you are and what you are worth, not what the trauma made you think you were, but the real worth."* (COMP28)

Subtheme 3.6: Self-Worth and Blame

Both participant groups identified the topics of (low) self-worth and shame as key issues (see Subtheme 1.1). However, it was only the community group that acknowledged the need to resolve those issues. A sample of responses from the community group highlights this:

> *"Not being ashamed. Not being made to feel ashamed. Not believing it was my fault."* (COMP8)
>
> *"I always thought that I had good self-esteem until (the trauma), then it all but vanished. Getting it back, feeling better about myself. That was priceless."* (COMP15)
>
> *"No one can make you feel inferior without your consent. Lies. Try going through (the trauma) and see if you still believe that. But you can get that self-esteem back. You can get back to normal. That's what counselling was for me."* (COMP21)
>
> *"Self-esteem. Getting it back. But finding out it was actually gone in the first place. That's what's most shocking."* (COMP23)
>
> *"Not letting shame control me. Not feeling bad about it. Feeling good again, positive."* (COMP30)

Subtheme 3.7: Areas for Improvement

There were few, if any, weaknesses of the TSTP reported by both groups. However, the community group participants did have some suggestions for how to improve the service. The inmates did not mention any areas of improvement or weakness, however this may because they were reluctant to be seen as complaining about the service, rather than them reflecting any actual areas of weaknesses. A sample of responses from the community group are presented below:

> *"No-one around after hours. I get that counsellors work normal hours, but it's so hard to get to see them."* (COMP2).

"Finding the right counsellor. I saw a few before I found (the counsellor). You need a connection to make it work. But I thought I didn't realise I had a choice. More information about that would be good." (COMP8)

"Getting a counsellor on the weekend. I had a job, that I was barely holding on to, and I had to make time to see (the counsellor) It was the right decision but it could have been made easier by having people work weekends." (COMP12)

Summary

As with the previous subtheme, both participant groups illustrate similar concepts of strengths that they associate with the TSTP. These appear to be very practical, covering a sense of safety, psychoeducation, coping skills, validation of trauma and its symptoms, and having someone to listen to them. Finding a new sense of self was also raised by both groups, however, only the community group spoke of improving self-worth and resolving shame as key strengths of the TSTP. Participants mentioned little in the way of weaknesses of the TSTP, other than a mention of some practical and relevant ways to improve the service overall. It is interesting to note that the strengths that all participants highlighted were specific to trauma survivors overall. This is important for inmate participants, as this group saw themselves as victims of trauma, rather than categorising themselves inmates. Again, the location of the intervention was not considered relevant, rather the intervention provided was the focus.

Theme 4: Physical and Psychological Impacts

Provision of a dedicated TSTP in a prison presents a number of logistical challenges, starting with connecting an inmate in a prison with an independent counsellor, who is effectively a visitor to the prison. Then there is the problem of identifying a suitable location for a room/location that can be accessed by both parties. Finally, the room has to meet the standards for an appropriate trauma counselling space. Across both prisons, CSNSW organised

for the TSTP to occur in the visiting areas. This provides a solution to the logistical problems and provided, in theory, an appropriate therapeutic space. In the community locations, there are differing spaces counsellors use according to their own personal preferences. However, they meet specific standards for Victims Services to ensure they are appropriate for engaging in trauma work with clients.

Subtheme 4.1: Access to Services

The first subtheme to emerge from the custodial participants' responses in relation to counselling locations, was the fact that accessing the TSTP is relatively simple. Everything is onsite, within walking distance, and easy to access, particularly since they are escorted to and from the TSTP by correctional officers. Participants raised this point repeatedly. A sample of responses from the custodial group that illustrates this subtheme is as follows:

"Haha! pretty easy to get there given we're escorted there. (CUSP1)

It's in the visits area so we are all used to going there for one reason or another. They have put a bit of effort into making it comfy, especially since so many kids come here." (CUSP3)

"It's simple. We know we are booked into counselling on what day and time. We are on the movements list and the officers come get us and bring us there. (CUSP10)

I don't do any other programs, so it's easy." (CUSP17)

Community participants however, had very different experiences to the custodial participants. They reported that they had to manage the daily life of work, life, school, shopping and others. If they wanted access to the TSTP, they had to prioritise their attendance over other activities. They also had to wait until an appointment became available in the counsellors' appointment schedules, which was challenging. A sample of responses from the community group that illustrates this subtheme of prioritising is as follows:

"It's so hard, (the counsellor) only has certain time slots free and you have to fit into them. It's never after work or weekends. I have to get a neighbour to pick up my daughter from school so I can go. It's worth it but painful." (COMP1)

"You have to fit in a time that'll work and go. It sounds easy bit when you have to organize time away from work, travel there, find parking and so on and so on. It can be a bit stressful." (COMP3)

"This is something I actually complained about. (The counsellor) is great and I don't think I'd see anyone else, but no-one works evenings, late nights or weekends. Do you know how hard it is to organise and appointment when you have kids?" (COMP15)

"I'm lucky I have an understanding boss, otherwise I'd never make it to counselling. The only time they have available is during work hours." (COMP22)

Both participant groups regarded the rooms as appropriate, with soft furnishings that were conformable, and a location which afforded a degree of appropriate privacy. There was little differentiation between the physical rooms when in either custody or community. A sample of responses from the custody group that illustrates these findings follows:

"The room's nice. It's actually better than I'm used to. We come in, make a coffee, sit in the comfy chairs and have a chat." (CUSP12)

"I like the room. Makes me feel like I'm not in Gaol, for what, a whole ... hour?. (CUSP15)

The room was funded by volunteers so the families have somewhere nice to meet, especially on important occasions. There's not many like that around so we're pretty lucky." (CUSP27)

A sample of responses from the community group that illustrates these findings follows:

"The rooms are OK. The waiting area is what you'd expect. The rooms are nice, some armchairs, soft lighting, very relaxing." (COMP9)

"I like going there, It's always peaceful. The colours are nice and relaxing and she plays this new age forest music. It's actually a very calm place." (COMP19)

"It's pretty standard. Lounge, and arm chair … what else … soft music, it bright, it's nice comforting." (COMP30)

Subtheme 4.2: Trust

Research (e.g., DeHart, Lynch, Belknap, Dass-Brailsford, & Green, 2013) suggests that many victims of crime who are in custody, acknowledge that at some point, reports were made about them, to appropriate welfare agencies. But because of their previous negative experiences with those agencies, victims in general were often more fearful of those agencies' responses, than the abuse. These victims report losing trust in these agencies because of either the agencies' actions or inaction. The research also suggests that most inmate victims admit to underreporting their abuse, but most victims claim that this was a safety mechanism to protect them or a sibling, rather than an overt act of omission. In many instances, the agencies involved were aware that something had happened to the victims, but not the true extent of the abuse. This background is important, because custodial participants report that in prison, they have learned to only disclose what they have to, as there is a belief by them, that information tends to be shared amongst staff as well as other inmates. This culture of suspicion and mistrust prevents them from fully disclosing their trauma histories to professional staff. Many believe that knowledge, regardless of what it is can affect their safety and wellbeing during their time in custody.

Custodial participants spoke openly about their capacity to be able to develop trust with a professional. Inmates frequently have limited ability to trust anyone, given the betrayal of trust they experienced at the hands of caregivers or family members, which is often linked with their own experiences of trauma. This lack of trust was also linked to TSTP participants'

feelings or beliefs of a lack of safety, both physical and psychological. A sample of responses from the custodial group that illustrates this theme is as follows:

> *"You learn pretty quickly, you don't trust anyone, especially in here. They use information against you. It's so not safe."* (CUSP1)
>
> *"You have issues? This is not the place to share them. They'll use it to fire you up, set you up or just try and break you. It's dumb, especially since they all have their own shit."* (CUSP13)
>
> *"I haven't told anyone about half the stuff that's happened to me. When I was younger, they'd report it and make things worse, especially if the welfare got involved. They can't be trusted to do the right thing."* (CUSP17)
>
> *"When everyone has betrayed you, it's really difficult to find it in you to trust anyone."* (CUSP23)

Again, in relation to trust, another key subtheme to emerge from the collected interview responses was in relation to the independence of the counsellor, as this was an important factor to enable inmate participants to build trust with him or her, in order to successfully engage in the TSTP. Having a contracted, independent, private counsellor, with no connections or pre-existing relationships in the prison, meant that there was more likely to be a basis, in which inmate participants could establish a relationship with the counsellor. A sample of responses from the custodial group that illustrates this subtheme is as follows:

> *"When I first heard about the service, I flat out said no. Great idea but no more psychs. Then the MOSP said it was an outsider being contracted into the Gaol. That made me think that I could at least give them a chance. It worked out well."* (CUSP3)
>
> *"The fact that (the counsellor) was independent made all the difference. It was a chance to have someone that we could finally work with."* (CUSP5)

"I wasn't sure till I met (the counsellor). When she said where she worked and that she wasn't employed at the gaol, I knew I would give it a shot. It may take a while but I thought that I might have been able to trust her with some things." (CUSP9)

"Truthfully? I wanted to trust someone, I needed to trust someone. Someone independent from the outside was my best chance at that." (CUSP29)

In contrast, the community population appeared to display a much higher ability to develop trust, than their custodial counterparts. Community participants reported that because a government agency referred them to the counsellor, this meant that they were more likely to trust the counsellor. A sample of responses from the custodial group that illustrates this finding is as follows:

"Oh I think (the counsellor) was pretty trustworthy. Why would Victims Services send me if they weren't?" (COMP4)

"Why wouldn't I trust them (the counsellor)? They're a professional after all. (COMP6) Of course I would trust them. It may take a few sessions, but yeah … I'd like to think so." (COMP9)

"Trust is earned, but I think I would trust them with my information. That's what they're trained to do." (COMP12)

Subtheme 4.3: Shame

One shared theme across both participant groups, when considering trust in both custody and community settings, was that of shame. Whilst overcoming shame was discussed previously in the context of the effectiveness of counselling (Subtheme 1.3), shame was again raised in the context of trust. Both participant groups identified the theme of trusting the counsellor with the shame of their experiences. Establishing a relationship was important to building that trust. A sample of responses from the custodial group is as follows:

"When you say trust, you know we have to trust the other person with what happened? Sometimes the shame of what happened makes that hard. I'm not sure I trusted myself at that time." (CUSP6)

"When you have to trust someone with the deepest, most horrible moments of your life, it's so hard. I haven't ever told anyone any of the things I told (the counsellor), even my husband." (CUSP15)

"It's like starting a new relationship. You want to trust them, but they have to prove they can be trusted. Only in this case, you are starting with all the bad stuff up front." (CUSP21)

A sample of responses from the community group that illustrates this theme is as follows:

"The shame of (the trauma) was what stopped me from getting help in the first place. Now I had to trust that a stranger wouldn't judge me for it, for what I did." (COMP3)

"When I first told about (the trauma), I was made to feel dirty, ashamed, like it was my fault. And that was from my family. I had to trust that a counsellor wouldn't do the same thing and help me move past it." (COMP7)

"You build a relationship with your counsellor like you would with anyone else. It's not going to be easy, but you have to try. The first conversation is the hardest, where you are waiting for the judgment, but it never came. That's when I knew it would work out." (COMP17)

Summary

Shame featured highly in the discussions with the participants. There was a high degree of self-blame and fear that they may have brought shame upon their family. Surprisingly, the inmate and community sample both believed that the TSTP assisted in the resolution of feelings of shame. It also would appear that both groups found the locations conformable and

appropriate. Where the differences appeared was in terms of the ready and convenient access inmates had onsite in the prison compared to the scheduling and travelling issues for their community counterparts. Further, based on participants' responses, it appeared that establishing trust was considerably harder for the inmate population compared with the community population. The culture within the prison was at the core of the trust issue, but participants' past experiences and histories of complex trauma also play a part (Boyd, 2011; Briere & Jordan, 2004; Chesney-Lind, 1997). From what the participants have shared, it would appear that trust still has to be earned by both groups, but it appeared that community participants are more willing than custodial participants to take the risk. However, the independence of the counsellor in the prison was crucial to participants even attempting to engage.

Chapter Summary

This chapter presented the qualitative analysis of interviews with inmate participants and community participants. Two interviewee groups, participants of the TSTP in custody and participants of the TSTP in the community were interviewed for Study 3, in order to provide an insight into the ability to address trauma issues in a correctional setting. The research questions focused on participants' experiences to determine how effective the TSTP could be, and compared the experiences across the two groups. The personal experiences reported by participants, the nature of the intervention provided, and the diversity of the settings in which they took place, provided useful insight into what worked and what did not. Whilst both participant groups had very similar views on some key issues, such as the effectiveness of the TSTP in addressing key symptoms, they differed in their views on the practical access they had to the TSTP, and their level of trust with the counsellor. The subsequent chapter is the second section of Study 3, and will present the qualitative analysis of focus groups with key stakeholders.

CHAPTER 8

Results for Study 3b. Qualitative Analysis of Focus Groups with Key Stakeholders

"The degree of civilisation in a society can be judged by entering its prisons"

Dostoevsky

Introduction

This chapter follows on from the previous study and adds to the qualitative component by analysing the TSTP from the perspectives of professionals and key stakeholders who work with the inmate participants on a daily basis. The focus groups consisted of the following professional staff: approved counsellors, correctional officers, services and programs staff, Justice Health staff, psychologists, and managers. Focus group participants' responses were analysed to draw out themes and subthemes, consistent with the thematic analysis method described in Chapter 4 (Methodology). Table 22 provides a summary of these themes and subthemes. As with Chapter 7 (Study 3a), the results were again voluminous, but framing them in terms of themes will ensure that the discussion (Chapter 9) will be more focused. As with Chapter 7 (Study 3a), there was a degree of crossover and overlap among themes and subthemes. Both themes and subthemes were 'researcher constructed' based on participants' responses (using a thematic analysis).

A sample of quotations from the participants is also provided to better illustrate the themes and findings, and these have been italicised for ease of reading. In order to represent the participant being quoted, direct quotes from participants are identified with a prefix then a

number to determine which group they came from. These are represented by the code FG1 for Focus Group 1, FG2 for Focus Group 2, and FG3 for Focus Group 3. As some of the participants could be easily identifiable due to their positions, specific occupational groups have not been specified.

Table 22

Emerging Themes and Subthemes from Focus Groups

Themes	Subthemes
1. Organisational Issues	1.1. Rehabilitation, recidivism and links to trauma
	1.2. Decision-making
	1.3. Coerced services
	1.4. Money
2. Service Delivery	2.1. Absence of a formal Trauma Informed
	2.2. Demand and Resources
	2.3. Outcomes and Measures
	2.4. Prison Environment
3. Professional Issues	3.1. Role clarity
	3.2. Diagnosing trauma
	3.3. Interventions
	3.4. Training and preparation
	3.5. Disconnect between services
	3.6. Non-Corrective Services Professionals
4. Clients	4.1. Victims or Offenders?
	4.2. Trauma Histories
	4.3. Why do trauma counselling?
	4.4. A Sense of Self

Results

Theme 1: Organisational Issues

Participants were asked to reflect on their beliefs that prisons could be a place where inmates were able to address their trauma histories. Research presented earlier in this thesis tells us that prisons are based upon an "ethos of power, control and surveillance (Bloom, Owen, & Covington, Gender-responsive strategies: Research, practice, and guiding principles for women offenders., 2003), effectively providing an opportunity for containment and punishment only. The purpose of focusing on this theme was to determine if key professional groups could provide insight, into whether the prison could be used to address prior histories of trauma, despite researchers suggesting that any meaningful therapy in a correction setting is almost impossible (Baldry, 2008; Pollack & Brezina, 2006).

From the outset, the focus groups consistently returned to policy and procedure, citing the legal or professional mandates that they had. Whilst there was acknowledgement that one of the main purposes of prison was to provide some rehabilitation, most retuned to suggesting that the organisation had been set up for punishment, deterrence, and some degree of retribution. The ability to establish a trauma-informed model was limited by the individual roles of each professional group. What follows then, provides a clearer discussion of the organisational issues and organises them into sub-themes for clarity.

Subtheme 1a: Rehabilitation, Recidivism, and Links to Trauma

As a whole, the correctional environment was described as challenging and in a constant state of flux. Participants believed that programs and responses were perceived to be dictated by internal policy, political responses, and outside forces, such as the Royal Commission into Institutional Abuse. Members of each focus group recognised that each inmate had diverse needs which impacted their behaviour in the Centre, as well as any rehabilitation that occurred. As a whole, focus groups saw trauma as just one small facet of a much larger system but one

that was very much disconnected with the larger system, which they saw as being focused on rehabilitation and recidivism. One member of FG1 noted, "*If we fix the trauma, then they should function better, isn't that right? Then where is the evidence that shows this and why isn't it linked to our rehabilitation program?*"

The need to link the TSTP to rehabilitation was a consistent theme raised across the groups. There was a belief that policies, procedures, and programs currently in the correctional system were linked to something else, whether that be drug and alcohol programs, gambling programs, or work industries as an example. There were some focus groups members who believed that, these programs had a purpose, and a place in the system. However, in stark contrast some others believed that they were just for show. Several participants also admitted that they had a lack of knowledge in the area of trauma, but also acknowledged that trauma was important for the organisation (CSNSW), even if it was not explicitly acknowledged. However, it was believed that knowledge was in relation to the need to have some trauma-informed practices in place, but the focus was not on the wellbeing of inmates, rather the practices were in place to protect the organisation. For example, the focus groups generally believed that the TSTP sat outside that rehabilitation process and "*there were no clear linkages to what was occurring elsewhere*" (FG1), or what it actually meant. It was clear that the TSTP was seen by professional participants as a standalone program and completely independent. For example, one group member in FG3 stated: "*We are told that inmates' experiences contribute to their pathways to offending and that it should form part of the Risk-Needs-Responsivity framework. So why aren't there policies in place which link everything*?"

The lack of an organisational link for the TSTP to the broader aspect of CSNSW core business was consistently highlighted by each of the focus groups. The professional participants consistently had a need to underpin their discussions in relation to the TSTP, by referring to CSNSW core business, and then referencing the CSNSW safety and security

policy. It was acknowledged by a small group of participants, albeit in a light-hearted manner, that the need for them to follow policies and procedures was simply evidence of their own institutionalisation. However, it was a sticking point for many people, who still needed the TSTP validated in some way that connected to their own programs or work. This was summed up by one group member in FG2 who added, *"I can tell you that this is an external program … OK one which is needed … but still external. That means it's not linked to recidivism targets or research done by corrections"*. From professional participants' feedback, it would appear that without a clear and concise program guide, they did not believe that the TSTP fitted in with existing CSNSW programs and practices. Professional participants went on to state that they did not believe that the TSTP would work or be as effective as it could be.

Subtheme 1b: Decision-making

Another key theme, decision-making, was raised in each group and formed part of almost every conversation. When this theme was initially raised, it came with the repeated mantra of "*no-one ever asked us" or "it just happened without discussion*" (FG1). Overall, the general belief from the professionals was that the decision to introduce the TSTP was not consultative, it was something that "*we had to make it work, like it or not*" (FG2). Interestingly the perceived lack of consultation seemed to be, for many of the focus group participants, more important than whether the TSTP was needed or actually worked.

The lack of the professional groups' involvement in the decision-making process, was also raised as it related to their professional work with the inmate participants of the TSTP. The professionals felt that things were done in isolation and no opportunity arose for them to contribute to the process. A common response in the focus groups was voiced by an individual in FG3 as, *"Once the girls get referred to counselling … that's it. We don't get any feedback on how it went, what else we need to do or what's next".*

The process for an inmate to receive counselling was that she be referred to the TSTP

and the purpose or content of that process was kept confidential from other professionals within the prison. Professional groups believed that this impacted their decision-making capacity as they were only advised if there was a crime disclosed or an intent for the inmate to hurt themselves or others.

In the focus group discussion, it appeared that there are quite robust processes in place for information sharing between the professional groups as they shared all relevant information within the confines of their roles. However, they saw the TSTP as sitting outside of that information sharing process and the referral process, and as a result were unsure about how to manage the lack of information being provided or if it was relevant to their roles. Commonly, focus group participants suggested that, "*we should at least be informed of progress or if there was anything we need to do in order to our jobs" (FG2).*

The decision-making theme is important as it shows the different perspectives between professionals and inmates in regard to information sharing. However, the professional groups need for information was in direct contrast to opinions of the inmate participants of the TSTP (see Chapter 7), who believed that the TSTP was successful, precisely because information resulting from their participation in the TSTP would not be shared with correctional professionals. Members of the focus group also raised the absence of any guidelines or how they were supposed to, "*integrate trauma counselling into our day to day work*" (FG1). Again, the focus groups believed that this perceived lack of guidelines impacted on their ability to integrate trauma outcomes or responses into their planning, thereby affecting decision-making. Professional participants also suggested that they were not provided with the necessary prerequisite information; nor were they provided with guidelines informing them as to how to manage their decision-making process in the absence of such information. As a member of FG2 said, "*Mushrooms, that's what we are … no-one tells us what's happening, just what to do."*

An example of how an absence of communication from the TSTP counsellor to professional staff impacted their day to day decision making in the prison was professional group participants believed that they may be undermined if competing instructions were provided to inmates by both the TSTP counsellor and professional staff. This could cause not only confusion, but also behavioural problems. A member of FG2 provided an example whereby a decision to not allow an inmate to have some time out for operational reasons may conflict with the TSTP counsellor's instructions to take time out; which may result in escalating negative behaviours by the inmate. One member of FG3 stated, "*we don't know what they do or what they are telling them, so if we have to do an assessment or report, we can unwittingly provide competing instructions*".

The FG3 group members went on to further emphasise that they *"work and communicate with other teams involved in working with the inmates to ensure that they were making the best decisions possible, especially where there are complex or competing needs".*

The lack of decision-making capacity for professionals in relation to the TSTP, could not be isolated to one key component as they had all experienced a lack of decision-making capacity throughout the implementation of the TSTP. Further, from the conversations in the focus groups, what appeared to be occurring was actually a loss of perceived control over their clients and a degree of professional powerlessness or even a lack of autonomy.

The focus of the professional participants on decision-making for specific processes, whereby the inmates' needs were best met, were at the centre of their professional roles and decision-making capacity. This is important as it reflects one of the key issues raised by inmates themselves in Chapter 7, where they saw trauma counselling as being theirs. Sharing information from the TSTP, even for the purposes of decision-making by the professional participants, would be in opposition to why inmates supported the program as it was one of only a few things they did not have to share with other professional groups.

Subtheme 1c: Coerced Services

The TSTP itself was developed by Victims Services NSW and provided to NSW Corrective Services, which are both part of the NSW Department of Justice and Communities. Third party community contractors delivered the TSTP, the reasons for which have already been provided discussed (see Chapter 7). In implementing the TSTP, high level consultation had previously occurred between the two agencies and a Deed of Agreement was signed by both agency heads. However, the focus groups in their conversations, believed that they were not adequately consulted with, in regard to the TSTP. Group participants viewed the implementation of the TSTP as being a direction from management, based on a political decision rather than an operational one. Professional participants believe that they were instructed to, "*make the program work*" (FG1), irrespective of its effectiveness or connection to custodial goals. This was a constant and consistent theme across the groups with the common belief being that they were being coerced into utilising the TSTP. As one participant in FG1 stated, "*this counselling thing has just been foisted onto us"*.

Participants clarified that they believed that there was a need for the TSTP, but the implementation was done without regard for what programs were already occurring within the prisons. The concern that it was a standalone program, "*with no oversight or transparency"* (FG3), meant that staff just had to accept it and not challenge it. The professionals agreed that more should have been done to introduce the TSTP and define what it meant for their own work and job demands. Ironically, it was interesting to note that professionals working with coerced clients on a daily basis, would raise non-consultation as an issue. This was also interesting, considering that inmates discussed counselling in the TSTP as separate from custody where they had a choice to participate or not and were not forced into it (see Chapter 7). Again, this further reinforced that perhaps some form institutionalisation was occurring with professional participants. Some participants believed that they were coerced into

delivering the TSTP, which further ensured that there was, "*resistance to the program, not because of what it was, because it seemed so political*" (FG1). As mentioned previously, the focus group expressed concern that there was an unwritten or unspoken, "*direction to make the program work*" (FG2) and that no matter what the outcome was, it was in everyone's best interest to "*make it work*" (FG1). The discussions then centred around the belief that some groups "pushed back" against this direction. This was not because they believed that the TSTP was ineffective, just that, "*the push for it to be successful seemed to be more important than the program itself or the outcomes for the inmates*" (FG3).

Again, it would appear that the loss of control for professional participants, particularly in being told that the TSTP was to be introduced and that they, in a professional capacity had to make it work, has made the professionals feel like the TSTP is an imposition. Further, they seemed to be of the opinion that it was an infringement of their autonomy, professionalism, and overall authority. This was ironic as the inmates saw the TSTP as effective precisely because it sat outside the prisons need for policies and procedures and was not controlled by CSNSW staff.

Subtheme 1d: Money

Participants opined that money was seen as "the bottom line" in government agencies generally, and Corrective Services specifically. The focus groups were of the opinion that funding for programs was only ever linked to issues, *"that were the flavour of the month" (FG2)* and that once the public interest waned, so did the funding. One professional in FG1 summed up a number of other participants' feelings, by stating: *"If you don't join the dots and show your program is linked to recidivism, you will lose your funding and the program will cease to exist, no matter how good it i*s" (FG3). They saw the current TSTP being linked to the Royal Commission into Institutional Abuse and believed that once recommendations had been made, the impetus would fade like it did with so many other programs. The groups also

speculated that they thought being that the program may have been implemented to stop CSNSW "*being liable for civil suits*" later (FG1). The general feeling among FG1 members was that the TSTP was "*just another flash in the pan program, which wouldn't last and, quite frankly, wasn't worth investing our time in"*.

Some members of FG2 suggested that the interviewer refer to The *Guiding Principles for Corrections in Australia (2019)*. They went on to explain that these principles represented a national intent around which each Australian state and territory will develop its practices, policies, and performance standards. When queried as to why this was important in the current context of trauma counselling, it was explained that the outcomes on which these principles are based, are seen as critical to achieving results, specifically in reducing reoffending and providing value for money across corrections in Australia. The TSTP did not achieve those outcomes.

All of the focus groups were concerned that there were more important and relevant priorities and associated funding that needed to be put into other programs, before they considered the delivery of trauma-specific programs in general. From the conversation that ensued, it would appear that each participant had vested interests in their own professional areas that were limited due to a lack of funding. As another professional said, "*Maybe it's just sour grapes, maybe we just want our own areas to succeed in the same way we've been told to make this program work" (FG2).*

Overall, the message from the focus groups was clear: money is required to make progress in the delivery of any service. However, unless that funding is linked to a current priority (such as rehabilitation), programs which are seen as non-correction priorities mean that they will be held in reserve. Specifically, those outside of what is seen as "core business" of Corrective Services NSW.

Conclusion

From a review of the discussion by the focus groups, there were a number of organisational issues raised that were considered to be barriers in implementing the TSTP. The first concern, organisational links, showed the need for all programs to be linked with policies and procedures and what is effectively CSNSW core business, namely rehabilitation. It was believed that not having these links in place, meant that day to day decision making practices by professional groups could be affected. Whilst broad examples were provided by the groups, there were few specific examples of occurrences where this proved to be an issue. Participants also held beliefs that the TSTP needed to be integrated existing program structures, instead of being an independent program that they just had to implement. The discussions centred around mainly a loss of control for them, in regard to their clients (inmates) and was framed as them being coerced into making a program work, rather than the program being referred on its own merits. Lastly, there appeared to be a degree of animosity held around the funding for the TSTP to be implemented, when the focus groups saw other programs as being higher priorities. Again, there was a suggestion that many professional participants were unable to run their own programs due to a lack of funding, so this may impact their motivation to accept new programs they were not invested in.

Theme 2: Service Delivery

Service delivery is key to the success of any program. In order for this success to occur within the prison system, a collaborative approach must occur. Overall, the professionals were proud of the way they work together to provide a successful continuum of service. For the current study, the focus was on how the TSTP fitted in with the existing correctional processes. Of interest was how or if, it interacted with other programs. As discussed in Chapter 2 (Literature Review), substance abuse and mental health issues are often treated separately, despite the fact that they are therapeutically linked. This is unfortunate, considering that the research indicates that a substantive number of female inmates have experienced trauma as a

result of violent victimisation. If we consider that trauma is linked to their pathways to offending, then despite remaining unrecognised within the prison, it should be a focus of services delivery (Bloom, Owen, & Covington, 2003).

Subtheme 2a: Absence of a Formal Trauma Informed Model

One of the more robust conversations, which occurred within each of the focus groups, was in regard to individual perceptions that trauma-informed practices were in place within the prison, and within their own practices. Each group had very different understandings and interpretations of their own trauma-informed practice and how it related to them on an individual level. According to the research provided earlier (see Chapter 2),

> a trauma-informed approach involves: (l) realising the prevalence of trauma; (2) recognising how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice" (SAMHSA, 2015, p. 12).

Drawing from their own experience and knowledge, some professionals in the focus groups suggested there should be more awareness of trauma and the need for a model to address it. It was noted that, *"most of the girls in here have gone through something*" (FG1) and that "*of course we are trauma-informed*" (FG3). However, from the opinions provided by some of the professionals in the focus groups, it appears that there are some key components of those perceived trauma-informed practices missing in their discussions about trauma. This is highlighted by some discussions whereby, the recognition of the prevalence of trauma is where the groups believed that being trauma informed, began and ended.

Some professions, particularly those in health and mental health positions, believed that they were trauma-informed already but applying those principles was the challenge. Although some of the participants who manage inmates, other than health and mental health professionals, believed that they are frequently faced with clients who did not 'fit' the trauma-

informed model. They argued that the model did not account for things which they described as, "*complicating characteristics such as: diagnosis, levels of aggression, complexities surrounding their presenting problem*" (FG3). Or when, "*the inmate's environment (the prison) was a significant contributor to their problem*" (FG1).

Some professionals in the focus group discussed their pride in being able to provide a successful continuum of service, across a large and diverse population for extended periods of time. A statement by one participant from this overall group said, *"We provide an end to end service, across health, mental health, education, vocational training, employment and so much more. I don't think people realise how much services are provided to the inmates; they wouldn't get this anywhere else"* (FG2). However, there was still absence of trauma from this practice. Interestingly, the belief in the 'excellent service provided', was also echoed by some of the community counselling professionals.

When the focus group members were asked how trauma fitted into their work practices, they could not provide overall consistent answers. Whilst they believed that, as a whole, the workforce operated cohesively and collaboratively, there were necessary occasions when this could not happen. Often operational issues mean that certain information is withheld to one professional group and not shared. As one participant from FG1 pointed out:

> We all have times when we restrict certain information to ourselves. I mean the health staff don't tell us if the inmates contract a disease, do they? No! Sometimes it's a need to know basis and that's just the reality of it …

Other groups also voiced the need for restricting work or communication to their own professional groups. A member in FG1stated, "*sometimes we have to work in silos and don't really have too much to do with each other*" [especially when it came to] "*that touchy feely stuff*" (FG1). This belief was not conducive to implementing trauma-informed practices in the workplace.

It would appear that there was an understanding of the presence of trauma amongst the inmates, and a belief that this formed part of an organisational response, to meeting those inmates' needs. However, the participants had no cohesive singular understanding of how trauma fitted in with their own professional roles or responsibilities. It would therefore appear that the organisation (CSNSW) would need a whole of organisation approach, if they were to fully implement a trauma-informed model and capitalising on the outcome of the TSTP. Unfortunately, research indicates that being aware of trauma in the prison population is not enough and that the understanding of trauma is not sufficient to optimise outcomes for trauma survivors (Petrillo, Thomas, & Hanspal, 2019).

Subtheme 2b: Demand and Resources

The issue of job demands and access to resources were raised as a consistent theme across professional groups. Job demands were obviously occupational-specific centred around the maintenance of law and order within the prison. Members of all the focus groups mentioned that the prison itself, along with the routines and procedures within it, were clearly and specifically designed to maintain order and strict control over the inmates and the professionals working there. Often the policies and procedures that were in place meant that any trauma-informed response could and would be limited. One professional felt that, "*there are always issues with the demands on* [our] *jobs*" (FG3), citing administrative responsibilities across all of the professional groups had increased meaning less time spent doing work they believed was not their core responsibility. A member from FG3 stated that, "*general lack of resourcing for programs as a whole*" had an impact on how much they could involve themselves in a trauma-informed model. Another member from FG3 went on to clarify:

> We are all committed to doing the best we can and most of us, no matter what the position, go above and beyond, but realistically this is just one more thing for us to try and do that we simply don't have time for …

The comment from the FG3 member is a general consensus of all of the focus groups and it is interesting that they saw being trauma informed as increasing their workload rather than contributing to how they do their job. The groups saw the TSTP as, *"just another external program but it's not part of [our] core business"* (FG1). Even when discussing planning for inmates, the focus groups considered the logistics of operating programs, as someone in FG3 said: "*programming for inmates is a huge task and has to encompass so many factors, case management, health, mental health, education, behaviour and recreational activities*".

Time constraints as well as competing demands for resources, including people, meant that the focus groups believed that there is little time left for understanding and responding to trauma as well as all of the other programs run within the prison. As a professional in FG3 explains, "… *even if we were to consider it as a major component of any program, there aren't enough counsellors to see everyone or enough rooms to see them in or enough officers to escort and supervise them*".

The groups were consistent in stating that adding trauma counselling to a general program or developing a trauma-informed model would simply replicate the model they already believed that they had and, "*are struggling to resource and staff what is already in place"* (FG2). These are issues that they, as a group face daily and is a simple fact of working in a government department where *"money, or the lack of it, determines priorities"* (FG1). Based on the understanding that trauma is a matter that relates to individuals as are the responses, the issues around job demands and resources could be summed up in the following question provided as part of that discussion, "*How would people be prioritised; how do you determine who has greater trauma needs than another?"* (FG3).

Subtheme 2c: Outcomes and Measures

The statement below by one of the professionals in the focus groups gives insights into their concern about meeting outcomes or KPI's in relationship to the TSTP.

> We have measures for everything, standards, KPI's data, goals and everything in between. How then do we measure trauma, the impact of the TSTP and importantly, the effect it has on recidivism, because that's really what matters and how we determine success (FG3).

CSNSW is a government department and as such is accountable to the NSW Government as well as the NSW public. This fact means that there is a high level of accountability, not only in expenditure, but also in the outcomes for recidivism. These principles, ideals or drivers are documented in the CSNSW Annual Report, which records performance against key standards and indicators. These accountabilities also raised conversations in the focus groups around the need to have a clear measure of how well trauma-focussed counselling actually works.

Members of the focus groups discussed that the lack of an endorsed specific outcome measure for the TSTP was an issue for them. One of the participants from FG1 commented, "*How do we know it really works?", which* summed up the groups concerns. They rightly surmised that the work undertaken within correctional facilities was evidenced based and provided feedback on the outcomes of all programs, through the use of specific measures. When it was suggested that the implementation of the TSTP would provide evidence for the impact that the program had on inmates, all of the focus groups generally agreed that it should have been in place before the TSTP started. A concern raised by a FG3 member was: "*We get it. It's important and timely, but there should have been clear measures in place before the program started and we should have been consulted on the measures used*".

The focus group repeated the need to have clear linkages to other programs (see Subtheme 1a), in terms of the effects that the TSTP could have had, both positive and negative. For example, in FG1 someone asked, *"how do we know what impact it has on things like self-harm?"*.

A member of FG3 stated, "*that trauma is specific to individuals and that recovery varies from person to person*". This concept is well known, and generally accepted by the participants

in the focus groups. However, the focus groups discussed the need to ensure that the correctional centres were aware of how change is recorded, measured, and reported. Members of the focus groups were of the opinion that as the TSTP is a new program, there are no clear linkages to existing programs, measures or reports and, presents a limited opportunity for them, to understand the TSTP. This was not a reflection on whether the TSTP did or did not work, rather it was a reflection on the absence of obvious links to correctional priorities and organisational measures, meaning that again either the TSTP or the professional participants, were not clear in their intentions. Members of the focus groups opined that inmates participating in the TSTP did not make them less of a criminal, so questioned what relevance it had to their roles as professionals. Consequently, they were then less likely to appreciate or understand the importance of the TSTSP. For example, a member of FG1 stated, "*Ok, some people seem to improve, but they are still who they have always been*". Members of the focus groups suggested that because of a lack of transparency, reporting, and overall connections to existing CSNSW programs, the behavioural changes of the inmates, was not necessarily linked to their participation in the TSTP. This comment was typical of discussions or opinions in the focus groups, where members reflected that whilst they were aware of the TSTP, they were unable to attribute any changes, to inmates' behaviour to the TSTP because of a lack of collaboration or information. This strengthened the need for some form of measure of the effectiveness of the TSTP, and its reporting, to be developed. This was specifically so that professional groups would be more aware of the outcomes of the TSTP and provide some form of validation.

Subtheme 2d: Prison Environment

The research presented in Chapter 2 (Literature Review) provided clear indicators that prisons could not be used as a therapeutic milieu (Baldry, 2008). In fact, there were discussions that would suggest that factors such as: lights, noise, space, loss of liberty, restrictions, manual

handling, sparse cells, overcrowding, and violence, would actually trigger the inmates and re-traumatise them making any trauma work ineffectual. After all, the members of the focus groups have previously stated that the design of correctional facilities is intended to maintain safety and security, as opposed to providing a therapeutic environment to manage individual trauma histories.

Group members first discussed the prison in terms of its appropriateness for the delivery of trauma counselling. Members of the focus groups discussed prison as: "*coercive at best, re-traumatising at worst*" (FG3). All groups expressed an opinion that it was not the ideal location for undertaking this form of therapy. When pressed for reasons, the violent nature of prisons was discussed. The groups, as a whole, were reluctant to vocalise the internal violence which occurred within the prison but indicated that, "*some level of violence is just normal, and the inmates adapt accordingly" (FG1)*.

Except for a few professional participants, there was little recognition that this normalisation of violence was an example of re-traumatisation and along with, "*exposure to fights and that sort of stuff*" (FG2). It just added to their beliefs and, "*reasons why trauma counselling isn't a good idea*" (FG1). There was however, an acknowledgement that certain practices such as, "*strip searching, room searches, being locked in a room and being forced to live with [other]offenders*" (FG3) were also not, "*conducive to recovering from trauma and would tend to re-victimize people*" (FG3). They highlighted this by stating, "[we] *may not be trauma experts, but being told what to wear; what to eat; when to eat; how to behave*" (FG3) will definitely have an impact on inmates who have experienced trauma. They also stated that certain practices within the prison may have negative consequences. For example, if inmates are non-compliant and had to be restrained, this "*would also replicate abuse histories"* (FG3).

Members of the focus groups acknowledged that rules and regulations within a prison environment are necessary for safety and security but may have an unintended consequence

when it comes to recovering from trauma. As one member of FG1 put it, "*when all's said and done, people are locked in cages. Of course, it's traumatic*".

It was clear that participants were focused on the practical implications of trauma, as they related to operational needs. However, this did not include the safe space, both physically and psychologically, where inmates could develop positive relationships, feel more empowered to change and choose where to spend their time and focus. The need for a degree of safety and control in the prison environment is necessary for change to begin. However, as the professional groups focussed only on safety and security at an operational level, they did not consider alternatives for exploring trauma in the prison environment and the opportunities it presented for inmates. However, on a positive note, as a participant in FG3 noted, in regard to inmates' participation in the program, "*if nothing else, they have the time and opportunity to actually do something, maybe for the first time?"*

Conclusion

In this theme, professional participants discussed the absence of a trauma-informed model within the prison. They also reflected on their own practices, which they saw as being trauma-informed, despite not indicating that they implemented those practices in their day to day work. The discussions moved to how the demands of their roles prevented successful implementation of trauma-informed practices, and that often policies and procedures prevented them from responding in a trauma-informed way. Resourcing, for both staff and programs was discussed as being scarce and linked to the need to have specific measurable outcomes for all programs which contributed to CSNSW core business. This led to discussions about how the TSTP had no such measures in place, which made it challenging for professional participants to see the benefits of implementing such a program. The group went on to discuss that perhaps the prison environment itself was not conducive to implementing a TSTP and would actively

work against any successes that may occur. Overall, the groups provided a number of key factors that could be overcome in order to continue to successfully implement the program.

Theme 3: Professional Issues

The fact that there are differing occupational groups with a prison, which have role-specific requirements and key deliverables specific to each position, raised a number of discussions as to how the TSTP related to those professional roles. This provided professional participants an opportunity to discuss how they believed that the TSTP fitted within their role, and what they believed that the expectations were for them and well they were prepared to implement the TSTP.

Subtheme 3a: Role Clarity

A constant theme which arose within the focus groups was in relation to their professional roles and, whether or not being trauma-informed or managing potential negative outcomes of trauma therapy (e.g., self-harm, resentment) was actually part of their role. With the implementation of the TSTP, with its emphasis on trauma, focus group participants assumed that they would need to become trauma-informed. Members of all the groups expressed frustration regarding the need to be trauma informed given that it would add to their roles and workloads. When asked if it added to the role or changed how they did their roles, the response was consistent across both FG2 and FG3 and was encapsulated in this comment from a member of (FG2), "*my job is [security, health, programming, education, management], not therapy*".

The lack of clarity in how participants may have to deal with inmates who present with trauma, presents an understanding of why participants were frustrated with the program and why they may not appear to support it. One participant, in particular, referred to their own

occupational role and stated, *"How are we supposed to do our jobs [AND][1] have to be a social worker managing trauma*" (FG1).

Addressing trauma in any capacity, raised a fundamental issue in regard to the individual in the focus group expectations of what they thought they were expected to do as opposed to what they had been told they should be doing. It was acknowledged that some training had occurred as one participant in FG2 recalled, "*Victims Services came out and did a quick half day training*". However, members of the focus groups believed that beyond the initial introduction to being trauma informed and, "*having trauma counselling explained to us*" (FG1), they were of the opinion that working with trauma was still not part of their role. Again, there appeared to be a disconnect between the intention of the program and how participants saw their own participation as professionals within their occupational groups. The apparent disconnect between the concept of trauma-informed practice, the TSTP and the roles undertaken within the prison, seemed to at the centre of misunderstandings across the group and was clear that the concept had not been appropriately explained to them, in the context of their role.

The misunderstanding of what the TSTP set out to achieve and what they believed their role was led to discussions whereby the focus groups believed that a trauma-informed practice approach meant that they just let, "*inmates get away with things*" (FG1). When discussing what had prompted this belief, some members of the focus groups felt that this was the message conveyed in the media and general discussions with people outside of the prison environment. Many felt very strongly about this and stated that being trauma-informed was effectively letting inmates do what they wanted without consequence. Typical of the comments provided, a member of FG1 stated that "*bad behaviour cannot be permitted just because they had*

[1] Emphasis added by researcher to reflect tone of participant

something bad happen years ago, otherwise there would be anarchy. Safety is our number one priority".

When I attempted to challenge their beliefs on what trauma-informed practice actually was, some members of the focus groups persisted in their original beliefs and suggested that they would require significant training if they were to change those beliefs. A few participants were confident that they understood and employed a trauma-informed practice but did not, "*see trauma matters as part of their role, rather it's something we just do as good practice*" (FG3). These comments, whilst in the minority, did indicate that some occupational group members were considering trauma-informed practice in their roles, which in turn would support the TSTP.

Subtheme 3b: Diagnosing Trauma

A further key theme that presented itself within group discussions related to the ability to confidently determine if trauma symptoms were present within inmates. The establishment of the program meant that every occupational group was responsible for making referrals to the TSTP. However, identifying and referring inmates presented as somewhat of a problem. This was highlighted by one person in FG3 who stated: "*The program is all well and good, we know a lot of people in here have been affected by violence, but how do you actually identify that? We don't screen for it here …".* The lack of formal screening meant that different occupational groups used their own ad hoc methods to identify inmates with what they believed was trauma. One group participant stated, "we *sometimes just get a vibe of who has trauma and who we think would respond well"* (FG3).

However, there were very specific organisational policies and procedures which the professional participants utilised and for differing reasons, according to their occupation roles. An example was provided by a group member in FG3 who summed up the groups' concern as a whole:

> In gaol, there is no overarching consideration of behaviours that may result from trauma. In here inmates are diagnosed with a range of disorders that can be; depression, anxiety, personality disorders, psychosis, self-harm and so on.

Professional participants discussed the possible presence of complex trauma, which, as discussed in Chapter 2 (Literature Review), is often mistaken for other psychological disorders. It is in these situations the professional groups have to decide which symptoms are presenting by the inmates, and then decide on the order in which to address those symptoms. As another participant from FG3 said: "*What do we address first? Drug and alcohol; the symptoms, the psychosis, the personality disorders? That's easy when you are looking in, but with the volume we get, it's a lot harder*".

The differing health conditions by which inmates present, all impact on health planning, treatment and subsequent diagnosis, which places the professionals in somewhat of a quandary. Unless the inmate presents with visible trauma symptoms that are not better explained by a differential diagnosis, there can be little intervention, despite best endeavours to do so. One participant stated, "*We can't diagnose complex trauma or just trauma, we need an actual diagnosis, a treatment plan and a planned intervention*" (FG3).

Within prisons, trauma or complex trauma, is not seen as a priority due to the myriad of mental and physical health priorities that exist. As a participant in FG3 explains, it is seen as "*really just another mental health issue that we try and resolve along with the other health issues*". The issues and challenges in relation to diagnosing, or even identifying trauma and its long-term effects is summed up best by the following quote: "*Many of our high-end clients receive multiple diagnoses: psychosis, drug-induced psychosis … etc., and when they get out, they become a constant client of local health and mental health*" (FG3). The conclusion being, that specific treatment for trauma, is not a high priority and normally managed when they are released.

Subtheme 3c: Interventions

Successful trauma-informed practices and programing, support survivors in coping with trauma symptoms and remove treatment access barriers. However, trauma-informed care in prisons requires interventions which use practices (such as strip searching or physical restraint), that may re-traumatise or trigger traumatic memories in inmates. In addition, the interventions used are approved and based on considerable wealth of clinical research. Accordingly, a member of FG3 stated, *"We use evidence-based programs here, supported by relevant statistics to show what interventions work and what don't. With respect, trauma counselling (TSTP) here doesn't offer that"*.

Focus group members believed that because the TSTP was a not a pre-existing CSNSW program; nor was it linked to existing programs; and nor did it have an evidence base on which to support it; it presented multiple barriers to its implementation. The perceived absence of current evidence affects the ability to, "*plan or consider trauma from any other perspective other than referring people to counselling*" (FG2). The FG3 group agreed and elaborated further, with one participant explaining, "*We are sure that the counsellors do a great job and the girls speak very highly of them, but how do we know what the effects of counselling are*?".

In regard to the effectiveness of the TSTP, several focus group members were concerned that the intervention used was unlikely to yield the results that were hoped for, or that any apparent results could be identified as being a direct result of the TSTP. Accordingly, a member of FG2 asked, "*How do we know the changes are due to the counselling and not something else*?".

In sum, based on focus groups discussions, there appeared a need for professionals to gain a better sense of what was going on with regard to the TSTP, and a need for more linked evidence of therapeutic change as a result of inmates participating in the TSTP. Focus group members also agreed there was an inequality of power within the prison system that impacted

on their ability to work effectively, specifically not getting information from external providers such as approved counsellors.

Subtheme 3d: Training and Preparation

Introducing any new program requires a change in policy, practice, and even cultural change, particularly in the context of a prison whereby there is a need to view the inmate as a victim rather than offender, for the purposes of managing their trauma histories. Standards for trauma-informed practices highlight the need to educate staff about the nature of trauma and to reframe behaviours in the context of trauma.

The focus groups have previously highlighted that the absence of trauma-informed policies, procedures or education was an issue. This is despite some training being provided prior to the TSTP commencing. Focus group members thought that the training provided was no-more than, "*just an explanation of trauma*" (FG2). Members from the professional groups explained that they required training in how to identify what trauma behaviours were, for example real symptoms and trauma experiences, as opposed to fake histories. This statement from a member of FG3 summed up their concerns about their lack of training, saying:

> We need to tell the difference between certain behaviours. Are they manipulative, are they being avoidant, are they lying are they isolating themselves from others? We just need to know if the behaviours are trauma-related which people have used to cope with trauma or protect themselves or are they doing it to get something?

Focus group members went on to explain that more effective training would be required to learn and understand trauma-informed practices. They suggested de-escalation techniques for responding to emotional dysregulation occurrences during normal routines. Their concern was voiced by a participant of FG1 who enquired, "*How do we know if they are just being oppositional or if it's really a trauma response?"*. However, this was in contrast to their previous statements where they clearly pointed out that responding to trauma was not their role,

or could not be completed as part of their job (see Subtheme 3a). Focus group members further suggested that in order for the TSTP to be successful, there would need to be involvement from middle and senior management in the prison. They also suggested trauma-specific practices should be developed across the prison to provide understanding an understanding of trauma as it related to differing occupational roles. Training would then be necessary across all levels, senior management, management, operations groups and programs teams, in order for them to be adopted at each organisational level. This is illustrated in a quote by a member of FG2, *"If you are going to have this in place, you really need to have the people at the top supporting it and not just paying lip service"*.

However, focus group members were confident that trauma services were not a priority and would dissipate when the political push ceased. For that reason, they did not believe that management would be interested in doing training or committing to its implementation. Overall, they believed that training is potentially valuable but only if senior management buy-in.

Subtheme 3e: Disconnect Between Services

The focus groups discussed the idea that, in relation to trauma, there was a disconnect between individual service providers within the prison. They suggested that this was normal when an external program was introduced into the prison, as the facilitators often did not understand the nuances of prison life, and agreed that information was not a two-way process inside the prison system. This meant that whilst, as mentioned earlier (Subtheme 1c), prison staff were not provided details of the TSTP, the trauma counsellors were also not provided information about inmates' participation in the TSTP by prison staff. For example, as a participant of FG3 explained, *"We could have a critical incident here and manage it as per policies, but unless it poses a risk to the counsellor, we wouldn't tell them"*. As outlined by Substance Abuse and Mental Health Services Administration (SAMHSA, 2015, p. 22),

"working collaboratively to facilitate the individual's sense of control and to maximize their autonomy and choices throughout the engagement process is crucial in trauma-informed services". However, there was a clear disconnect between internal and external services where competing agendas may mean that the service does not reach its full potential. Another member of FG2 elucidated, *"We focus on our priorities and you focus on yours, sometimes they just don't match up, that's just how it is"*.

As mentioned previously (see Subtheme 3a), the groups consistently reaffirmed the idea that, "*Trauma is not my job, we refer and that's it*" (FG1) and consistently deferred to other occupational groups stating, "*That's the psych's job*" (FG1) or "*SAPOs* [Services and Programs Officer's.] *do that and are damned good at it too*" (FG2) and, "*Why do you think we have psychiatrists here*?" (FG2). It appears that each service seems to have a predetermined arrangement as to how they work and have clear demarcations between roles and responsibilities. However, when it comes to trauma, they all see it as someone else's role. It was suggested by a person in one group member that in order to improve this relationship between services and see the broader picture, they would need, *"A clear integration between services so that they all contribute to the one plan and there are not so many stand-alone external services in place*" (FG3).

It seems that the focus group members were thinking from a solution-focussed perspective but were not provided the opportunity or had the motivation to enact the change. They also indicated that they were very much client-centred from a strengths-based perspective. A member from FG2 justified, "*Trauma counselling is only one small part of a bigger plan in place for staff to work within so that we can get the best outcomes for our girls*". Research tells us (see Chapter 2) that any organisation that is seeking to be trauma-informed has to realise the widespread impact of trauma and understand potential paths for recovery.

However, for this to occur, CSNSW as an organisation, would have to commit to integrating the services provided to actively address trauma.

Subtheme 3f: Non-Corrective Services Professionals

There is a range of service providers within any correctional facility. Members of the focus groups identified some key challenges in working with external providers when they commenced with the prison. Particularly, the focus groups mentioned a lack of communication between the service providers and correctional staff, and the fact that external people often lost sight of the fact that they were dealing with inmates. With the introduction of external people into a correctional centre, there is always a risk that they will be groomed or taken advantage of by inmates. In fact, Corrective Services NSW provides training as part of their Induction Program for precisely this reason. As one participant in FG1 put it, "*External people come in here with the best of intentions, but they only see one part of the inmate, they don't see the whole person or what they are really like*". Members of the focus groups went on to discuss the fact that external providers do not see the broader context of who the inmates actually were, and that inmates had often committed serious crimes to end up in prison. The focus groups believed that they external people forget who they are dealing with and that the inmates can be quite manipulative. As one participant explains, they felt that when an independent person arrives at the prison to provide a service, specifically a victims-focused service (TSTP) the inmates just, "*put on a show and play the victim, they don't tell people what they are in for, they just want the sympathy or a chance to be someone else*" (FG2). The focus group acknowledged that inmates were more than just their crimes, but that often "*outsiders forget or choose to forget that some people in here are really bad people*" (FG1). This led to a discussion about the perception that some counsellors coming into the prison were, as one participant from G1 stated, "*naïve or just plain being conned*" by the inmates because they only saw one side of them. In contrast, it was suggested by one of the approved counsellors,

who delivered the TSTP, that perhaps they just get "*a different perspective of who the person is and get a chance to see someone for more than why they were locked up*" (FG2), but the scepticism remained.

The discussion also led to participants expressing their opinions around, what had happened to the inmate (victimisation) as opposed to what they had done (offending). One participant from FG3 reflected that it is important to note here that most participants noted that it was important to have, "*someone validate what the girls went through*", "*because it must have horrific*" (FG2). Focus group members discussed and stated that this should be an external person as they, as professionals within the system, had a belief, that "*trauma has no real visibility*" (FG3) in prison as dealing with trauma was not a primary function of their roles, or perhaps trauma was so normalised within the inmate population that it became invisible. The focus groups further discussed the fact that issues like, "*safety, shame and the like are seen as vulnerabilities to be exploited by everyone*" (FG3) and as such are hidden by inmates. This raises a contradictional tension between the professional groups and the inmates, as they are both opposed in this view. The inmates are not ashamed of their experiences within the prison population, as they are aware the majority of that population has experienced some form of victimisation. The professional groups, however, are of the opinion that the inmates are ashamed and hide their experiences of victimisation from other inmates. Overall, focus group members agreed that maybe external people were best to take the lead in addressing trauma but that there had to be a way for those external people to work more closely with correctional staff.

Conclusion

This theme was a reflection of the professional participants' view on how they saw the management of trauma in a prison, as it applied to their roles. The lack of understanding on what it meant for their own practices and what the expectation was for them, was raised as a

concern. The belief that it was not evidence-based and was not linked in with any other programs was seen as a problem. This may be linked to the limited training which was provided to CSNSW staff, which professional participants saw as an introduction to what trauma was, not training in how they should be implementing trauma-responsiveness into their own practices. Adding to this was the beliefs that trauma was invariably someone else's job and that overcoming it would require significant commitment by CSNSW and clear integration into specific roles. They assumed that the TSTP would be better implemented if the facilitator for the TSTP was a CSNSW staff member, so that information could be shared and so forth. However, they did not consider this independence of the TSTP facilitator to be one of the strengths of the program that would lead to its success. Overall, the professional groups had quite strong opinions about the TSTP which was not grounded in practice or research.

Theme 4: Clients

Focus group members discussed the clients/inmates participating in the program at some length. Most of these inmates were known to the professionals in one capacity or another and whilst they spoke from personal experience about individuals, the discussions centred around the prison population as a whole.

Subtheme 4a: Victims or Offenders?

Under the earlier theme of Clients, a prominent subtheme identified was the need to define the participants in the program as either victims or offenders. Focus group members pointed out that irrespective of their trauma or past experiences, it had to be acknowledged upfront, that they were first and foremost offenders to them. This sentiment is illustrated in the comment by one of the professionals from FG3 who said, *"The reality is that the women here are offenders, first and foremost. If they weren't, the they wouldn't be here, and we wouldn't be having this conversation*".

There was a further acknowledgement from all groups that they were only too aware that the inmates were not solely defined by their criminal behaviour and could be seen through other lenses. As professionals, they recognised that the inmates were also, as one FG1 participant put it: "*Sisters, mothers, aunts, daughters and much, much more but that's not why they are here*". The need to categorise or classify people appears to be a workplace culture issue prevalent in prisons and appears to be necessary. Inmates are classified according to their offending/sentences, the jobs they do, the units they are in, even the cultural groups that they belong to. There was a general opinion of who would benefit from the TSTP, but again, those inmates were often referred to as their category, as opposed to being categorised by their trauma history, as said by a FG2 participant, *"Category One's don't stay very long, they'd be best suited for programs like this".*

With the propensity for the prison (both people and systems) to categorise inmates, the focus groups struggled to discuss the female inmates in the TSTP as a single entity, rather switching between terms (specifically, victim and offender) to describe specific individuals. One participant from FG1 clarified this, when he stated, "*Inmate classification system which uses seven categories starting from category 5 – the highest security classification, down to category 1."* This switching back and forwards of terms between terms, was recognised by the focus groups as concerning, as there are no specific categories for female offenders, just inmates within the correctional system. Occasionally, in the focus group discussions pertaining to the inmates, professional participants referred to the inmates' crimes, based on the type of offence rather than the crime itself, but this again appeared to be a way of "*categorising inmates rather than judging them*" (FG2). Focus group participants spoke of inmates that had committed murder or serious offences as a single group, irrespective of circumstances and, compared them to others that may have been habitual offenders but committed lower level crimes, such as drug possession and theft. There was some discussion by focus groups, that

any investment in therapy would be more appropriate for lower level offenders rather than more serious offenders, was based purely on the nature of the offence, not the offender or their trauma histories.

Sadly, the comment from a participant in FG2 highlights the reality and repetitive nature of low level crime or drug affected female inmates and some of the focus groups members' opinion of those inmates, *"Half of them are druggies, the minute they're out, they'll be on the creep, pump a few breaks, then be back in again and all of the work will have been for nothing"*. What this discussion from focus groups did highlight, was it is difficult to personalise inmates' situations unless the professionals working with them had an established relationship, and even then, it was the nature of the relationship which dictated people's opinions of whether they would benefit from trauma counselling.

While discussing the theme of categorising, the focus group members also discussed or referred to inmates in terms of "ownership". For example, inmates were recognised as being in the care of a psychiatrist or psychologist, being medicated, having specific needs, attending specific programs, or being in protective custody. This again reflected the relationships that inmates and the professionals had, and a possible hierarchy in terms of who had greater influence over the inmates' participation. It could be assumed that keeping the inmates at a distance in terms of hierarchy presented a professional almost business-like structure when referring to inmates in this way, with no derogatory or desultory references. For example, one participant from FG3, commented on inmates were referred to by stating, *"There's one of mine. Dr [X] prescribed Seroquel (antipsychotic medication). Though how people like her function in counselling when taking that is beyond me"*.

Regardless of the method of classification used during the focus groups, there were seldom occasions when inmates were referred to by name during the focus group discussions. This may have been a professional reflex given the custodial context and the fact that they were

talking with an external researcher, but it was not elaborated on by participants in the focus groups. Of interest, the participants frequently referred to inmates as an absent third party, with no name or personality, which appeared to keep the inmates as an abstract rather than an individual. Rarely were they considered in a victim context, despite acknowledging they may have experienced degrees of victimisation.

Subtheme 4b: Trauma Histories

The discussions around inmates' trauma histories were challenging as many participants felt that this was personal information that they did not necessarily need to know. This was of interest as the individuals in the professional groups previously (in Subthemes 2a and 3f) suggested that they needed more information about the TSTP experiences. After further discussion, I asked professional participants for more information, they then stated that they meant reports that could be reviewed in light of the inmates' negative behaviours rather than as inmates' experiences of actual trauma. As one participant from FG1 went on to confirm, *"We just need to know if they disclosed something or that would affect their behaviours. We don't need to know the gory details"*.

The focus groups acknowledge the inmates' trauma histories, however the groups were reasonably consistent in that, that knowledge needs to be considered with a caveat of some sort. For example, a participant in FG3 stated "*Yes we know some of what happened to them, BUT*[2] *they still committed a crime*". The discussion around trauma histories of inmates, was normally linked back to the offending behaviour and seen as something separate and distinct. As one member from FG2 expressed, a lot of, "*compassion for the trauma they [inmates] went through*", but although some the professional participants showed empathy towards the inmates, it came with frequent reorientation back to the inmates' choice of committing a crime.

[2] Emphasis added by researcher to reflect tone of researcher

A member from FG1 expressed it this way, *"Yes, some of them have gone through trauma, but lots of people do and don't commit crimes*". That participant went on to acknowledge that "*bad things have happened to them, they'll tell anyone, you don't have to be a counsellor to get them taking about it, still no excuse for what they did though*".

It was challenging to get the groups to focus on the trauma not the offending. This may have been because the participants believed, at least to some extent, the trauma was being used as an excuse for the offending. An example was provided by a participant of FG2, who questioned, *"So because someone was abused as a child, they get a free pass to commit crimes? Is that it?"*. Interestingly, this is in contrast to the female inmate participants' perspectives in the previous section of this Chapter 7 (Results Qualitative Study 3), who quite strongly declined to use the trauma they experienced to justify or excuse their offending.

For the professionals in the focus groups there was a role-related emphasis when discussing the topic of trauma, as they felt there were specific roles or which had specific responsibilities to be considered. For example, the following comments illuminate the focus group participants' feelings, "[we are] *paid to make sure that people are safe, and instructions are followed, not to talk about bad relationships"* (FG2) and again by a member of FG3 who stated, *"we need to make sure they are healthy first, if they aren't then they're in no position to work on anything else".* Finally, as a member from FG3 explained:

> We have to deal with what we are presented with, depression, anxiety, sleeplessness, self-harm … and so on. Rarely do they tell us that it relates to trauma, nor do we have the time to explore issues beyond that.

This focus on roles was important as it formed the basis for core responsibilities for the professional and was linked to key performance indicators (KPI) which were reviewed by their appropriate supervisors or line managers. Members of the focus groups believed this to be crucial in fulfilling their employment contract.

Members of the focus groups recognised that often the women's pathways to offending were in some way linked to their experiences of trauma. However, focus group members also saw this as something very separate and distinct to their roles in working with the inmate. This was reflected in a comment from a member of FG1 which reflects,

> Let's be clear, that is NOT why they are here, it's not why they did whatever they did … We should be concentrating on that before we send them back" (FG1). A member from FG3 went on to say, "[After all, staff] only see the bad things, we only hear about what they did and who they did it to, when we hear the other stuff, it really takes second place.

It is important to be aware that the conversations by focus group participants around inmates' trauma histories related directly back to their roles and responsibilities as prison staff and indicated some degree of institutionalisation in the rigidness of responses. When the topic of rigidity was raised, the participants stated that it was not only in their best interests, but also in the best interests of the inmates. A participant from FG1 provided some context in regard to inmate trauma histories by stating, "*What happened to them is common knowledge or at least the fact that something happened is*" (FG2). However, it was further discussed by the focus groups, that this history was not shared between professional groups in case, "*it's used against them by other professionals*" (FG1).

These discussions by the professionals, specifically in relation to sharing knowledge about people's trauma histories, were in contrast to the inmates' perspectives. In Chapter 7, inmates discussed during interviews that sharing knowledge about trauma histories was not an issue. Rather, because most of the other inmates had experienced trauma, it placed them all on common ground, meaning that it was not something that was exploited, and actually made managing the trauma easier because of the shared knowledge.

Subtheme 4c: Why Do Trauma Counselling?

This quote, *"You can't open that can of worms"* by a member of FG1 was a common sentiment when referring to the provision of trauma-specific counselling. This sentiment is also an important consideration as it represented the participant's general opinion that trauma counselling would lead to further declines in mental health and higher levels of dysregulation, both emotional and physical. As emphasised by a member from FG3, *"You simply can't do that here, it'll just make them* [*inmates*] *worse"*. A concern raised by some focus group participants, when discussing the groups dealing with trauma treatment, was that not all of the various occupational groups in the correctional centre were capable of dealing with potential negative outcomes of trauma counselling. For example, if an inmate self-harms or should become highly dysregulated, each professional role manages a single part of any response to that inmate, but not necessarily the outcomes of the behaviour. The need for clarity in managing trauma by a specialist was highlighted by the focus groups and was reflected in a comment by a participant in FG3 who stated, "*dealing with in depth trauma memories and the immediate need for a more specialist response for when things don't go well*".

Building on the need to have specialist staff to manage trauma, the focus group discussions led into specific concerns that prison was not the place to address those trauma histories. Participants admitted their concerns with addressing trauma in prisons, as highlighted by these comments: *"still not convinced it's the right thing to do, what happens when they lose it and then we are left picking up the pieces"* (FG3) and *"*[*After all*] *you can't tell me that gaol is the best place to do counselling? It's full of crims and likely to cause more trauma that it fixes"* (FG1). The concerns that prison may not provide the most appropriate environment to address trauma histories, may be underpinned by the focus groups general lack of understanding of trauma (Subtheme 2a) as well as a lack of awareness of the impact that it has across services, settings, and the prison population. Perhaps the underpinning lack of

knowledge about trauma led to the concern that the TSTP would not be appropriate for custody and formed strong opinions within the focus groups, as stated by a member of (FG2),

> Some of these women are violent mentally ill train wrecks. What happens when you go through all of the past abuse? They'll be worse, then we have to contain them … It's not fair to them or us.

The previous comment from a member of FG2 again raised the issue of prisons not being a place of safety and stability, particularly if other issues were present as noted by a member of FG3, "*In all honesty, we expect them to be unwell. It's gaol. They're going to be depressed, anxious, moody … it's what we expect. How do you deal with trauma in a place like this?*".

Overall, across the focus groups, there is recognition that trauma has occurred, and counselling is necessary, but without evidence and a transparent approach, it was generally thought that prison is not the best place to do this. Again, the link between victimisation and offending was questioned by members across all groups. This was highlighted by a member of FG3 who asks, "*Will going through counselling affect how they behave on the outside? Will they all magically stop offending? Probably not".*

Subtheme 4d: A Sense of Self

The female inmate's perception of her own sense of self was raised and discussed in terms of how the various occupational groups, believed how the inmates' felt about themselves or how the inmates' saw their own levels of self-esteem and self-confidence. When considering the effects of the TSTP, the concept of self was discussed with particular reference to the focus group participants' observations (or lack thereof), of any changes that could be attributed to the TSTP. The participants suggested that there were, as noted by an individual in FG1, "*some noticeable changes in self-esteem, or at least self-awareness*". However, participants raised the concerns, or rather raised questions, as to whether those changes were, as a member of FG2 put it, "*a result of resolving trauma or just giving them some time and strategies?"* (FG2).

The focus groups did agree that trauma, particularly complex trauma, *"would damage anyone's perception of who they are and the world that they live in*" (FG2). The groups also believed that trauma counselling "*provides an opportunity to regain a part of themselves and we can see that in some people but not others"* (FG1). However, some participants in the groups wondered if they considered those changes simply because they, "*were looking for that type of change and just believed it had occurred as opposed to it actually having happened*" (FG3).

Although focus group members agreed that in relation to the TSTP, "*the girls were noticeably more self-aware"* (FG1) and that their overall levels of self-perception had "*improved and carried over into other areas, which the girls themselves attribute to counselling*" (FG3). Focus group members also identified, as highlighted by a remark from a member of FG2, that "*the girls did learn some coping skills"* and that, as one participant from FG2 stated, they "*noticed that they were actually able to use those skills in everyday life".* One participant from FG1 in particular, noted that one specific inmate had learned to manage herself stating:

> She would call her family, argue with them, become violent and we would have to restrain her. What we noticed after she had been doing victims counselling, was take the call, then instead of stressing out, she approached us and told us to get her to her room now. We can't quantify it, but we know if happened and why it happened.

The groups' recognition that trauma symptoms can, as highlighted by a member of FG3, "*overwhelm inmates and affect how they are able to function in daily life*" was apparent and considered the primary strength of counselling. This was an interesting discussion point to consider, particularly in light of previous issues discussed in other themes, that they were unsure if trauma counselling could work in prisons.

There was a belief by focus group members, that whilst in prison, there may be, as noted by a FG1 participant, a general degree of "*avoidance by inmates, in acknowledging their individual trauma histories"*, which kept their behaviours in check. This is clear contrast to the perspectives of the inmates themselves, who were happy to acknowledge those trauma histories (see Chapter 7 and Subtheme 3f). This assumption held by focus group members, that participants avoid acknowledging their trauma, would further lead them to avoid any stressors in prison that may trigger a trauma response (a negative behavioural response). It would further keep the inmates calm and consistent in their behaviours. However, a general concern amongst focus group participants was, that by providing trauma-specific counselling and allowing the inmates to review (relive) that trauma history, they may then become highly dysregulated or even aggressive as a result of the stressors discussed in counselling. For professionals, particularly corrective services officers, these behaviours are viewed in the context of safety and security and the negative consequences that may ensue. In that context, trauma-specific counselling would be seen as negatively impacting on the prison environment. For others, the TSTP was considered in terms of the inmates' rehabilitation and the concerns that addressing the trauma histories in counselling may result in negative behaviours by the inmates, which may have unintended consequences for the inmates' rehabilitation.

Conclusion

This theme commenced with the professional participant's inability to consider the inmate as both offender and victim or personalise them in that context. The discussion led on to how much professional staff knew about the inmates' trauma histories. Despite an acknowledgement that some of them were extensive, there was the belief that as professional staff, they did not need to know that information as it had little bearings on their professional roles. There was a general belief that even though the inmate shad experienced trauma, prison was not a safe place to address it. When considering the possible positive outcomes for inmates

in undertaking the TSTP, the focus group members suggested that the outcomes were not visible, nor could they be attributed to an inmates' participation in the TSTP. What was suggested however, was that an inmates' participation in the TSTP may lead to high dysregulation and that as a result they may exhibit more challenging behaviours as a result.

Chapter Summary

This chapter presented the voices of the key stakeholders (professional groups) who work with the female inmates participating in the TSTP. It considered their experiences of the programs as well as their opinions on the process and their roles. There was tacit agreement among focus group participants that the TSTP was needed and was likely clinically effective, despite any occupational differences that existed within the prison. However, the pervading opinion remained that the TSTP is perceived as a stand-alone program, with no evidence of integration into existing programs, plans or measures and would likely be unsuccessful as a result. This is a significant point given the necessary rigidity of providing any services with a prison facility and linking them to core CSNSW outcomes, such recidivism. The findings of this study provide a different perspective of the program from those of the inmates. The emerging themes from this data presented in this chapter will be correlated with the inmate responses of Chapter 7 and will be considered in greater depth in Chapter 9 (Discussion).

CHAPTER 9

Discussion

"People do not change, they are merely revealed."

Danielle Bernock

Introduction

This thesis was based on one simple question: can trauma be effectively treated in a correctional facility? To address this research question three overarching aims, there were three interrelated studies, with a series of research questions and hypotheses specific to each study were analysed and presented. Each of the previous three chapters provides details of the results of the studies undertaken. While brief mention of those results will be made, the focus of this chapter is to provide a context for discussing those results in more detail, providing an interpretation for the results.

Each of the three studies are discussed in their own section which includes an interpretation of the results, and the strengths and limitations of the study are identified. However, given the interdependence of the three studies, there is some crossover, in that, when focussing on one study, references may be made to either one or both of the other studies. The implications for theory, research, and practice, are discussed as they relate to each individual study, and all three studies as a whole.

Study 1: Comparison of Trauma Histories Between Custody and Community Samples

Overview

The initial objective of Study 1 was to consider the major similarities and differences between the trauma histories of two groups, a female inmate population, and a female community population. More specifically, Study 1 was developed to elucidate the extent to

which the two groups differed in terms of: the prevalence of victimisation they experienced, the points within the lifespan that the victimisation occurred, and the differences in the diagnosis that they received. The reason this study was undertaken was that we know that trauma can be treated successfully in community settings, however, if we are to determine if trauma can be effectively treated in a correctional facility, we first need to know how the trauma experienced by the inmate sample compared to that of a non-correctional population. The results of Study 1 are provided in greater detail in Chapter 5.

Discussion of Findings for Study 1

Overview

There is an increasing body of evidence which suggests that an overwhelming majority of incarcerated women have suffered trauma as a result of violent victimisation. The findings of this study are consistent with the literature (see Chapter 2); the inmate population presented with an extensive history of victimisation. The study also showed differences existed between the custodial and the community group in the type of trauma, its prevalence, the presence of polyvictimisation, when, in the lifespan, the trauma was experienced, and the resulting diagnosis.

Complex Trauma

Study 1showed that members of the custodial sample were more likely to have a typology of complex trauma. This trauma stems from cumulative, interpersonally generated victimisation, which are pervasive, and can impact both the inmate participants' mental and physical health for years after the abuse. In this study, 100% of the custodial sample were deemed to be have a typology of complex trauma as a result of victimisation, whilst only 11.34% of the community cohort presented with this typology. This was the first indicator which suggested that the two groups in the study demonstrated marked differences in regard to trauma.

Prevalence of Victimisation

As discussed in Chapter 2, current research suggests that incarcerated women experience a higher prevalence of victimisation. Study 1 showed that when the two sample populations were compared, the duration of the reported act of violence (AOV) spanned between 1 and 22 years. What was evident from the data analysis was that the two samples reported very different experiences of victimisation. A majority (82%) of the community sample reported victimisation occurring within a 0-4 year period, whilst the custodial sample reported much more enduring experiences, some lasting up to 11-12 years. Consistent with the findings in Chapter 2, women in custody experience trauma which has more longevity, more likely to have commenced in childhood, and persists across a significantly longer timeframe than non-incarcerated women.

Polyvictimisation

An investigation into polyvictimisation, or the extent to which women experienced numerous different forms of violent victimisation was undertaken. Consistent with the literature, a significant number of female inmates in the custody sample had reportedly experienced polyvictimisation. In fact, 100% (n = 141) of the women in custody reported high levels of polyvictimisation compared with only 5.2% of the community-based sample. With regard to additional reported acts of violence, the results indicated that whilst all members of the incarcerated population reported three or more additional AOV's, only 6.38% of non-incarcerated participants reported one additional act of violence.

When considering the number of offenders and who the offender were, the two groups again differed significantly. With regard to the number of offenders, 100% of the custodial population reported having more than one offender perpetrate an AOV against them, contrasted with only 5.2% of the non-incarcerated sample. In relation to who the perpetrator of the AOV was for the two populations, 41.8% of incarcerated women stated that the offender was a family

member, whilst only 10.4% of non-incarcerated women reported a familial connection with the offender. Overall, the results indicate that female inmates experience significantly high levels of violent victimisation than women in the community sample, across a number of key variables, primarily experiencing significantly more polyvictimisation from familial offenders. Given the research suggests that trauma is central to a women's offending, it was unsurprising to see that not only did inmates report a higher prevalence of victimisation, but also suffered greater experiences of polyvictimisation.

Victimisation Across the Lifespan

Findings for victimisation across the lifespan are consistent with those findings presented in the literature (Chapter 2). Specifically, female inmates are more likely to report higher rates of violent victimisation across all stages of the lifespan, that is, childhood, adolescence, and adulthood (Chesney-Lind & Pasko, 2012; DeHart, 2008). For example, for both childhood and adolescence, more than 80% of the inmate sample reported experiencing violence compared to less than 3% for the community sample. When analysing the AOV that occurred in adulthood, the results showed that 98.58% of the custodial group reported an occurrence of AOV, whilst only 46.80% of the non-incarcerated sample who did not report a similar occurrence. These findings also suggest that victims of early childhood or even late childhood (adolescence) victimisation stand to be at risk of more complex trauma than those who didn't experience some form of trauma during the same period (Peters, 2019; Salisbury & Van Voorhis, 2009; Stathopolous & Quadara, 2014). This then leads to the consideration as to whether or not, these differences in experiences of victimisation translate into different diagnoses between the two groups.

Differences in Diagnosis

It was hypothesised that the profile of diagnoses for the custodial group would be markedly different from that of a matched community sample. The results highlighted that the

custodial group were more likely to receive a diagnosis of Post-Traumatic Stress Disorder (PTSD) (67.37%) compared with 5.20% for the community sample. The higher rates of a trauma-based diagnosis (i.e., PTSD), is consistent with more sustained durations of a reported AOV. These findings mirror the previously discussed research, highlighting that female inmates would more likely be diagnosed with PTSD (Beck & Johnson, 2008; Clark, 2002; NCTSN, 2019; Pinna & Johnson, 2014). This is significant, given that in Australia, an estimated 5% and 10% of the population will be diagnosed with PTSD (Phoenix Australia, 2013). When compared with the approximate figure of 67.37% for the custody sample who are diagnosed with PTSD, this is a significant over representation in a relatively small sample.

The other major difference between the two groups was that the community sample were more likely to receive a diagnosis of generalised anxiety disorder (GAD) (84.39%), compared with no reported diagnosis of GAD for the inmate sample.

Implications

The high rate of victimisation reported in childhood for the inmate sample is most concerning. The literature suggests that trauma experienced in childhood and early adolescence impacts on the brain's ability to develop, impedes psychological development, and leaves the victim vulnerable to a range of multiple risk factors for health and wellness well into their adult lives, which includes offending (Felitti V. J., et al., 1998). Specifically, Andrews et al. (2013, p. 153), have stated:

> Children exposed to traumatic life experiences develop an increase sensitization of those parts of the nervous system related to stress and emotion, and in consequence may develop an increased vulnerability to later stress due to hyper-reactivity of corticotrophin-realising factor, as well as other neurotransmitter systems.

The lack of an intervention to resolve the presence of trauma (particularly in the early stages of life) can lead to substantial costs to the public in the future, including health, education, and welfare amongst others (Norman, Byambaa, Scott, & Vos, 2012). These costs are not limited to the survivor of the trauma, but also to their children. For example, research indicates that when previous trauma is left unresolved, it can impact on a women's ability to provide appropriate parenting to a child. This can be seen in the type of attachment which is reflected between the mother and the child (Iyergar, Rajhans, Fonagy, Strathearn, & Kim, 2019; Van Ee, Kleber, & Jongmans, 2015). There is also the economic cost of unresolved trauma to the Australian public. This has been estimated to be in the region of $9.1 billion per year (Kezelman, Hossack, Stavropoulos, & Burley, 2015). This further adds to the argument for delivering a TSTP in correctional facilities.

Strengths of Study 1

A plethora of research clearly shows that incarcerated women often present with high levels of victimisation, when compared to non-offending women (AIHW, 2009; Clark & Fileborn, 2011; Forsythe & Adams, 2009). The results of Chapter 5 highlight these findings, particularly that there are significant overrepresentations of victimisation and trauma in a custodial sample of women.

Prior to the research being undertaken the use of exact matching for incarcerated and non-incarcerated participants to ensure there was a moderate degree of homogeneity and comparability between groups (in regard to demographic details, e.g., age and place of usual residence). Although there is a dearth of Australian research in measuring the prevalence of victimisation of female inmates, the results of Study 1, are consistent with the findings of previous research (e.g., Kilroy, 2001; Richters, et al., 2008; Wolff, Shi, & Siegel, 2009). This is an important finding, as the prevalence of trauma histories of women in custody, particularly those with history of child sexual abuse, can be considered as indicators that they will

experience other forms of victimisation across their lifespan (Reeve & Van Gool, 2013).

Limitations of Study 1

A review of Study 1 highlighted different limitations, namely, research bias, under-reporting of victimisation, issues with standardisation, perceived benefits of participation, and discrepancies in diagnoses. Each one is presented below as it relates to this study.

Recall Bias

Research shows that certain subsections of populations, (e.g., victims of childhood sexual assault), may make more errors when attempting to recall details or incidences of crimes perpetrated against them (Felson & Palmore, 2018; Paunovic, Lundh, & Ost, 2002; Vrijheid, et al., 2009). However, memory is further affected by the volume of subsequent traumas experienced as a result of violent victimisation (Schneider, 1981). Wheelan (2013) believed that memory is not always a good source of data. Specifically, it can be easy to 'recall' a history that assists one in making sense of present circumstances. For instance, Wheelan described a study where women diagnosed with breast cancer were more likely to report having high fat diets when compared to women who did not have breast cancer. What was unexpected however, was that all the women had recorded a food diary year earlier before any of them received a diagnosis of breast cancer. The sample who had been diagnosed with cancer had recalled a higher fat diet than they actually ate; whereas the other group, that is those with no cancer, did not, indicating that memory is partially constructed. Applied here, some women in prison may be more likely to recall traumatic events that did not happen or were exaggerated, as a means to explain their current circumstances of being in prison. This is not to suggest that the inmate sample do not have greater trauma histories, but only that a recall bias could partly explain why the difference between the inmate and community samples is so great.

Under Reporting of Victimisation

Another limitation which could be considered here, can be attributed to under-reporting in the community sample (Felson & Palmore, 2018). Barriers to reporting certain acts of violence, particularly sexual assault, include shame, self-blame, guilt, fears of confidentiality, and a fear of not being believed (Sable, Danis, Mauzy Denise, & Gallagher, 2006). Additonal factors, particularly where familial offenders of sexual assault are concerned, have further constraints on reporting. They include family denial of the AOV, a reluctance to report a partner or family member, a fear of ostracisation from the family; and a fear of bringing shame on the family (Eklit & Christiansen, 2013; Taylor & Caroline, 2013). These factors have been considered as a primary reason for women in the general population not reporting acts of violence towards them, and may be a reason as to why participants in the community sample could have declined to report other acts of violence during the TSTP.

A Lack of Standardisation

The histories for each group, both community and custodial, are taken by an approved counsellor with Victims Services. However, as part of a mandatory report provided to Victims Services, however, there are no specific guidelines for documenting trauma histories. This lack of standardisation means that there is an unsystematic methodology in which histories are taken and recorded by counsellors. Future studies therefore, could benefit by adopting a research design which specifically gathers prior histories of victimisation in a standardised format.

Perceived Benefits of Participation

According to Christopher et al. (2016), prisoners would be more likely to engage in programs (such as TSTP) if they believed that it may benefit them in the future, for events such as parole hearings. Yet while it was consistently reinforced to inmates that participation in the TSTP could not be used for that purpose, some may still believe that their participation, and any subsequent improved behaviour that could be attributed to the program, could be influential

at parole hearings. This could possibly lead to inmate participants decreasing their scores on their final Depression Anxiety Stress Scale (DASS) administration.

Diagnostic Differences

One additional point, though small, is in regard to the diagnosis provided for inmate participants and why there may be a disparity between groups as they relate to trauma-specific disorders. Approved counsellors who provide a diagnosis for the community trauma victims (according to Victims Services) are mostly community therapists who are in private practice, and may be sole practitioners. Without the support of a multi-disciplinary team behind them, they may be more reluctant to provide a more clinically appropriate diagnosis (Emerson & Markos, 1996; Paris, 2007;). In a custodial setting however, the inmates may already present with diagnosis from the psychology team or the psychiatrist in the prison. The multi-disciplinary setting in place within custody provides additional source of information that contribute to the diagnosis of the inmate. This collaborative approach may result in better assessment of inmates, leading the TSTP counsellors for inmates more confident in making a diagnosis.

Summary of Study 1

Based on the investigation undertaken, women in custody present with a more extensive trauma history than their community counterparts. Given the research available in regard to women's experiences of trauma and victimisation, how they interface with their offending behaviours, and their mental health whilst in custody, it can be seen that there is a complex relationship between: the trauma experience and type, polyvictimisation, multiple perpetrators (abusers), trauma experienced in childhood, and mental health outcomes in general. The resulting analyses demonstrated that there was a marked difference between the two groups across each of the variables of polyvictimisation, lifespan occurrences, and diagnoses received. Female inmates presented with more incidences of victimisation, such as domestic and family

violence and sexual assault; suffered significantly elevated rates of victimisation across the lifespan, particularly in childhood; and presented with a higher incidence of PTSD related symptoms and subsequent PTSD diagnoses.

These differences also show, that whilst trauma arising from victimisation is common amongst the community sample, it is significantly more prevalent among the custodial sample. Research shows us that the impacts of complex trauma are cumulative "pervasive, and if unresolved, negatively impact mental and physical health across the lifespan" (ASCA, 2013, p. xxviii). The research presented in Chapter 2 (Literature Review) shows that child abuse is one of the key antecedents of complex trauma, and causes ongoing and pervasive symptoms. The cumulative and repetitive nature of the trauma sustained, that is complex trauma, supported the need to provide a TSTP for this group to address their trauma and the need to provide a TSTP to treat any unresolved trauma is essential.

Study 2: Quantitative Analysis of the Therapeutic Intervention

Overview

Study 2 set out to determine if prisons indeed could be a therapeutic milieu, particularly for female inmates whose trauma occurred as a result of violent victimisation. Having determined (in Study 1) that the incarcerated and non-incarcerated populations markedly differed in their trauma histories, the next question which arose was, whether a TSTP offered in prison could be effective in resolving that trauma.

Discussion of Findings for Study 2

The study looked at three main effects of administering a TSTP in a correctional facility: Did it work? Did the effects last? And how did they compare to a community sample? Using the scores from a DASS as an outcome measure, the inmate and community samples were administered the DASS prior to commencing the TSTP, again at the mid-point and

conclusion of the intervention, and then again after a period of ten weeks following the completion of the TSTP.

Prior to discussing the actual interactions of the TSTP across groups, it is important to note a key observation from the pre-test DASS scores gathered, specifically that respondents from the inmate population scored higher in terms of severity than the community participants did. For pre-test scores, the mean inmate ratings for depression, anxiety, and stress were all categorised as extremely severe according to the DASS scoring procedures (Lovibond & Lovibond, 1995). By comparison, the mean ratings for the community sample scored as moderate for depression, extremely severe for anxiety, and moderate for stress. These scores are consistent with the findings of Study 1. Essentially, before the intervention commenced, the inmate sample had a starting point (M = 38.12) which was significantly higher than that of the matched community population (M = 20.85).

Reducing Symptoms

First the study looked at whether or not a TSTP would reduce DASS scores across both groups. The results from the analysis highlighted the statistically significant reductions in each of the DASS domains (i.e., depression, anxiety, stress) for participants across two time points (10 weeks into the TSTP and at the completion).

These results provide a solid foundation for the premise that trauma-specific therapy can be undertaken, with successful outcomes in a correctional facility. This is despite concerns from researchers that prisons may re-traumatise inmates or may simply not be possible given the challenges that inmates may face by virtue of the view that prison cannot serve both therapeutic and punishment purposes (Baldry, McComish, & Clarence, 2009; Pollack & Brezina, 2006).

Whilst no comparative testing was undertaken between the inmate and community populations, it was of interest to note that the inmate mean scores were actually lower than

those of the community population. This is important as the inmates' pre-treatment scores were considerably higher than the community groups on commencement, but on completion were at least comparable, if not lower than that of the community groups' scores.

Lasting Results of the TSTP

The next question sought to determine if benefits of the TSTP continued past the point of completion. Specifically, what were the post treatment effects? Again, the data were analysed for all three groups (ITG, WCG, and the community group), from the completion of the TSTP to a predetermined (ten week) point. As discussed in Study 2 (Chapter 6), the results suggest that the positive treatment effects were maintained, beyond the TSTP. Again, this provides further support that the resolution of the trauma and the effects of the TSTP are long lasting with a degree of permanence, which is consistent with previous research (e.g., Brom, Kleber, & Defares, 1989; Cort, et al., 2014; Graham-Bermann & Miller, 2015; Johnson, Zlotnick, & Perez, 2011; Vickerman & Margolin, 2009)**.**

The reduced DASS scores are likely to be partly due to prison providing a stable environment for female inmates who were experiencing high levels of dysregulation in the community. The completion of trauma-specific treatment then provides a previously unrealised opportunity for inmates to address their trauma histories. That is not to say that prison is better at addressing trauma histories; rather that it creates a stable environment for inmate participants who previously may have lacked a stable and safe environment to access to services and focus on their self. Study 3 will elucidate these ideas more broadly from the perspectives of the inmate participants undertaking the TSTP.

Links to Criminogenic Needs

The final hypothesis of Study 2, posited that at the conclusion of the TSTP, inmates will be more likely to be ready to address criminogenic needs as a result of addressing prior trauma histories. Unfortunately, there was an assumption at the outset of the investigation, that

inmates would likely not be considered ready to address their offending behaviours, prior to engaging in the TSTP. The results of the Treatment Readiness Questionnaire (TRQ), which assessed an inmate's readiness to address offending behaviour, indicated that the inmate participants were already at that phase. This was a positive outcome of inmates but meant that the proposed hypotheses could not be tested, and a broader link between trauma and women's pathways to offending. Although a causal link between a history of violent victimisation and offending can be suggested, "such a history and its effects appear to be central features of women's pathways into offending, their experiences of custody, and their capacity to engage in rehabilitation programs" (Stathopolous & Quadara, 2014, p. 17).

Strengths of Study 2

There are several noted strengths of the current study. First, this is either the first, or only one of remarkably few, randomised controlled trials to evaluate the effects of a trauma-specific treatment intervention program for female inmates with prior histories of violent victimisation. It should provide a significant contribution to research and has broader implications for practice in the field. Secondly, the WCG provides a comparison for the ITG to isolate the independent variable (i.e., the TSTP) and determine its impact in an ethical way. By ethical, I mean that the inmate participants were not denied an opportunity to receive treatment (i.e., participate in the TSTP). Additionally, measures were collected across four individual time points (40 weeks in total), which include a baseline and follow-up measure (post intervention), to further enhance the conclusions drawn regarding the effectiveness of the TSTP.

Causality

Shadish, Campbell, and Cook (2002) summarise philosopher John Stuart Mill's criteria for establishing causality: cause preceding effect, covariation of cause and effect, and discounting all other plausible explanations. For the cause preceding effect criterion, all groups

showed a significant reduction in DASS scores 10 weeks after commencing the TSTP. However, to rule out the possibility of a pre-existing downward trend before the commencement of the TSTP, the WCG completed the DASS, 10 weeks before commencing the program, and then again at the commencement of the program, thus yielding two sets of DASS scores during a non-treatment period. There was no statistical difference between the scores obtained at the two time periods, thereby providing strong support that any effect followed the intervention. In meeting the covariation of cause and effect criterion, there was no variation in participant's experience, they were either participating in the TSTP or they were not (as was the case for the WCG during the 10-week baseline phase) and they participated in the program only once for a total continual period of 20 weeks. The relationship between participation in the program and a reduction in DASS scores provides strong support that the TSTP had some measurable effect. Finally, in relation to the third criterion, discounting all other plausible explanations, Corrective Services NSW (CSNSW) was able to confirm that inmate participants were not engaged in other programs that would account for the changes in DASS scores.

Limitations of Study 2

Three limitations were acknowledged for Study 2, which are: effect sizes of the inmate sample; the use of a trauma-specific psychometric tool; and the lack of a screening tool.

Limitation of the DASS

Future research could benefit from the use of a more specific trauma scale, (e.g., Trauma Symptom Inventory (TSI) or the Trauma Symptom Checklist (TSC-40)), which are specifically designed to evaluate PTSD and other psychological consequences of experiencing trauma. The decision to use the DASS predated the current study and was taken by both Corrective Services NSW and Victims Services. The decision was made by these agencies for a number of reasons, the first being that there was no specific screening in place at the time

that the TSTP was implemented. This would address some of the limitations of the current research, provide confirmation of the effects of the TSTP on inmates' trauma and extend Study 2. A further limitation of the DASS, like many self-report measures, is that participants (inmates and community) may attempt to respond in a way that they believe the researcher would want them too. Chan (2009) believes that social desirability is perhaps the leading criticism of self-report data This social desirability response bias, may account for the drop in conclusion scores (i.e., less severe DASS scores) for the inmate sample in Study 2, but is unlikely.

Effect Sizes

An important consideration of this study is the use of the DASS to assess symptoms associated with trauma. The reliability and validity of the DASS are well known (Basha & Kaya, 2016; Le, et al., 2017; Szabo, 2010). Research has also shown that the DASS is suitable for use in some clinical environments as an effective measure of the evaluation of wellbeing, including the association with PTSD symptoms (Allen & Annells, 2009; Berle, et al., 2018; Guest, Tran, Gopinath, Cameron, & Craig, 2018). However, it was noted in this study, the effect sizes were quite large for the prison sample (see Chapter 6). While some research does sometimes yield large values for Cohen's *d* (e.g., Moeenizadeh & Zarif, 2017), the large effect sizes for Study 2 requires some consideration. In a highly regulated environment, such as a prison, there can be an 'all or nothing' phenomenon happening where inmates are either in an unhappy/depressed mood or they are happy. For example, simply receiving a phone call or visit form a family member, can elevate a prisoners' mood for a few hours. Applied here, in the presence of a supportive counsellor (which is when they completed the DASS) they are likely to have an elevated mood. One day before or one day after their session they could be back to their normal mood. In speaking with the counsellor about these scores, she stated: "The severity and complexity of the women's trauma, it [high scores] was only to be expected … Many of

the women presented with untreated PTSD symptoms which were unaddressed by the prison system" (personal communication, 30/04/2020).

A Lack of Trauma Screening

There are no specific trauma screening processes currently in prison. This means that without a screening process, it is not necessarily easy to identify inmates who have experienced trauma. Instead, service providers must rely on self-reports about the occurrence of traumatic events. More importantly, any trauma-specific service requires self-referral to the TSTP by the inmate as it cannot be, by definition, an enforced program.

The main barriers to the evaluation of trauma and the diagnosis of mental health issues in prison settings, are inmates not reporting trauma and professionals not identifying the presence of trauma. To provide effective treatment and planning, comprehensive screening must occur, and a TSTP offered which complements existing prison programs. Some aspects of the study design may be limiting, such as the relatively short (10-week) follow-up period. Whilst that period may have indicated successful maintenance of severity scores, a longer period would better determine the extent of the TSTP's ability to provide enduring results.

Summary of Study 2

The study showed that there was a clear association between participation in the TSTP and a reduction in DASS scores, thereby providing support for the research. These results have implications for behaviour management in a custodial environment and broader applications to other programs with a correctional facility. The need for a TSTP in a correctional environment was highlighted in Study 1, then Study 2 provided support that the TSTP was successful in reducing DASS symptoms as evidenced by reduced DASS subscale scores. The question now is, why, from a participant's perspective, how did the TSTP work? Study 3 then sought to provide some degree of insight into that question.

Study 3: Qualitative Analysis of Inmate and Community Participants; and Professional Focus Groups

Overview

Study 3 was conducted as two studies. Study 3a considered the experiences of the TSTP participants (both inmate and community), whilst Study 3b considered the TSTP from the perspective of the professionals (i.e., prison staff) who work with the TSTP participants. This section aims were to make sense of the data by building on the results presented in Chapters 7 and 8. The discussion focuses on the most significant and relevant points raised. Sometimes the discussion points are presented from the perspective of the inmates, sometimes from the professionals, and other times they are presented together.

The Aftermath of Trauma

In study 3, the actual experience of trauma was not investigated, nor did it form any part of the interview questions. However, TSTP participants shared the aftereffects of experiencing that trauma during the interviews. Violent victimisation is traumatic. It is evident from Study 1, that for many of the inmate participants there are high levels of polyvictimisation occurring in childhood, adolescence, adulthood or all three, prior to or between incarceration. However, what was not obvious from these findings, was the individual experiences of the trauma, such as shame, that resulted from that experience, which TSTP participants carried with them.

Addressing the Elephant in the Room

Having someone acknowledge their experiences of trauma, validate it, and provide a safe and secure environment to process the associated shame, formed core discussion points with both inmate and community participants. A frequent comment from TSTP participants was that they were finally in a place where they could "tell their stories" and begin to resolve the past trauma. Given the extensive nature of the trauma histories of inmate participants, it is likely that those feelings of shame had been experienced by the participant for years, without

resolution. It is also likely that those experiences led to a range of negative behaviours, such as cognitive distortions, emotional dysregulation, dissociation, and poor attachment (Kezelman & Stavropoulos, 2012). With this in mind, it would seem logical to treat this trauma in prison, improve specific behaviours, and potentially remove barriers to criminal rehabilitation.

However, when the same issues pertaining to managing trauma-related behaviours were discussed in the professionals' focus group, there was a very different view to that presented by inmate participants. Whilst there was acknowledgement of the fact that trauma was present, the professionals did not focus on the trauma, or on the need to respond to that trauma. Rather, the professional group focused instead on how inmates' experiences of trauma affected them as professionals, effectively depersonalising trauma histories of their client groups. Discussions centred around whose role it was to manage trauma should the need arise, why current roles were unsuited or why more policies and procedures were required in order to be more responsive to inmates affected by trauma. The group suggested that, even if trauma was part of their role, how could they be expected to identify the trauma and respond appropriately.

Despite professional participants acknowledging that trauma has occurred within the inmate population, they do not seem to be aware of the details of the trauma, or how it impacts on the individual. Inmates report needing someone to listen to them, to validate their experiences. These contrasting views between the inmates and the professionals indicate a disconnect between the two perspectives. Perhaps, by not formally acknowledging that responding to inmate trauma histories was important, it provided an opportunity for professionals to avoid the problem of how to manage trauma? This may be linked to the inability for professionals to see the inmates as more than the offence they have been convicted for. There are reportedly, clear policies and procedures in place to ensure professional boundaries, which may account for why trauma is ignored, but whether it is purposeful or not remains unclear.

Can Prisons Be Trauma-Informed?

Throughout the discussions, there was an emphasis on organisational responses, which are typically rigid, rather than on understanding inmate behaviours in the context of their trauma. Rigid organisational directives often do not permit a more humanistic response by the professionals, to be able to take trauma into consideration. This demonstrated an absence of trauma-informed principles being practices within the prison. As highlighted by Hopper, Bassuk, and Olivet (2010, p. 82): trauma-informed principles are based on a strengths-based delivery approach that is:

> grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

When professional participants discussed trauma, there was a general consensus that they saw prison as being in direct opposition to those principles. Specifically, whilst CSNSW and its employees insist that their role is safety and security, the professional participants raised the question, as to whether inmates could be kept safe in a prison? There were often ambiguous discussions which occurred, in which professional participants suggested that they were trauma-informed, but provided little evidence to support this claim. Additionally, in spite of claiming that they were already trauma-informed, the group suggested that they would require additional specialised training to become trauma-informed. This tension and ambiguity carried across into many of the discussions around being trauma-informed and created some degree of confusion.

Some members of the professional focus groups believed that there were risks to the inmates' safety by undertaking trauma-specific counselling. For example, the inmates may engage in self-harm behaviour after attending the TSTP, which professionals were not prepared

for. Despite these concerns, no reports of this type of behaviour occurred after participation in the TSTP. Inmate participants countered professional participants' concerns. However, stressing that the TSTP counsellor provided the safe space to address their trauma and provide strategies to manage trauma-responses outside of the in the prison environment.

Beyond their immediate roles and job descriptions, members of the professional groups also stressed the lack of an organisational response to trauma, citing a lack of relevant policies and procedures which would support the prison becoming a trauma-informed organisation. The group also suggested that even if the prison did become a trauma-informed environment, trauma-responsiveness does not form part of their core responsibilities, which they believed to be safety and security. As a whole, the group espoused that even though they believed their core duties centred on safety, they believed they were trauma-informed and believed that they acted in their professional roles accordingly. However, few professional participants, were able to articulate how they were trauma-informed and how this played out in their roles. If a part of being trauma-informed is to understand their symptoms, and do so in the context of their trauma histories, professional prison staff need to see inmates as more than just offenders.

Communication and Decision Making

A discussion point arose in the context of two-way communication processes between the TSTP facilitator and correctional staff. Professional staff stated that "improved communication with the TSTP facilitator is necessary for them to perform their roles". Specifically, they felt that this lack of communication affects their decision-making capacity on a day-to-day basis as they were left unaware of issues that may arise during therapy. The group reinforced that without all of the necessary information at hand, they would be making decisions which may in turn have unintended consequences for the inmates. Whilst on the surface this request for information may seem reasonable and in line with their roles, it would in fact go against trauma-informed principles and may compromise the therapeutic alliance

between the counsellor and inmate. This is because trauma-specific services have to comply with trauma-informed principles in how counsellors share information (Machtinger, et al., 2018). There are clear boundaries, legally, clinically and professionally, which restrict what information is shared, with whom that information is shared, and how that information is shared. Any communication requests from correctional staff to the TSTP facilitator would have to meet statutory and regulatory requirements before information could be shared.

Barriers to Implementation

Professional participants thought that there were some practices that have the potential to re-traumatise inmates, such as strip searches, that served as barriers to adopting trauma-informed approaches in prisons. However, even though these practices are necessary for safety and security, some practical alternatives could be developed to minimise these practices. Professional participants were unable to foresee the possibility of pre-empting trauma-inducing incidents through the use of trauma-informed practices to minimise behavioural triggers for inmates and reduce critical incidents (Kubiakk, Covington, & Hillier, 2018). Perhaps if they were to view inmates' trauma histories as a set of defining and organising experiences which contribute to identity and behaviour, they could shift their focus to what has happened to the inmates, rather than focusing on what they believe is wrong with them. This is a strong argument to suggest why being more trauma-informed would be beneficial as it would assist with seeing things through a trauma-informed lens.

Another barrier to implementing programs like the TSTP was the belief by professionals that such a program would be forced onto the prison and as a consequence, they would have to be involved with the program. The problem of losing control relates to the fundamental needs for autonomy. Deci and Ryan (2012) discuss this need for autonomy at great length in their self-determination theory. Specifically, based on extensive research, they assert that unless people believe they have a degree of autonomy over their work, that is, they

endorse the activities they engage in, they are likely to feel disconnected and disengage. Applied here, prison workers, unless they feel a sense of autonomy, they will feel disconnected to the TSTP. To overcome feelings such as 'lack of autonomy', prison staff, for whom a program like the TSTP is relevant, should engage in a trauma-informed conversation. Doing so could give these staff some degree of insight into how and why trauma-based services are being be introduced, and how it might impact on them. It is also likely to result in the perception that their autonomy is maintained through integrating their opinions into any implementation. Without that cultural change, which values and promotes professional participants' engagement, the program may not be fully accepted by correctional staff, even if a whole of organisation (CSNSW) review required it.

Other challenges identified by professional participants in implementing the TSTP include the difficulty in attributing change in participating inmates' behaviour and wellbeing to the TSTP, measuring that change, and the sustainability of clinical improvements in a prison. This research in particular, provides evidence of that change, however more reporting of results may assist with addressing issues regarding measurement of the change. Additionally, there is a need for cross-program linkages, between the TSTP and other relevant programs, to effectively report against core CSNSW values and key performance indicators, such as reductions in self-harm, reductions in suicidal ideations, reductions in conflict among others. Unless these issues are addressed, programs like the TSTP may not reach their full effectiveness or be well integrated within the prison.

Trauma-Specific Programs

This research commenced with the question as to whether a TSTP would work in a prison. It seems only appropriate that this be raised as a key discussion point. In the previous section, the focus was on trauma-informed care, primarily from the perspective of the professional participants, which focused on organisational issues, rather than individual issues.

The sections that follow, now focuses on the TSTP participants' perspective and the implications it has for the inmate population.

Treating the Trauma

Whilst female inmates are in prison, they report being provided with an opportunity to focus on themselves, without the issues which arise in day to day community life (e.g., work, school, health, childcare and other daily routines). This degree of stability allows women in prison to access a range of services that they normally could not or would not, such as trauma-specific services. Removing the need to attend work, look after children, study and other daily routines, provides an opportunity for female inmates to focus on themselves without distraction. Importantly, being in prison provides a degree of safety where they are removed from perpetrators or potential perpetrators. That is not to say that the best place for women recovering from trauma is prison, merely that being removed from everyday situations allows them to focus on themselves and their recovery.

As shown in Chapter 2 the extended exposure to trauma experienced by the inmate population can lead to PTSD symptoms. It is likely that the levels of repeated exposure to trauma in childhood and adolescence will have resulted in negative belief systems, changes to the perception of the self, and impacted inter-personal relationships. From a simple perspective, this means that the inmates may see themselves as bad and unworthy, others as emotionally unavailable, relationships as dangerous, and the outlook for the future as bleak (Briere & Rickards, 2007). For inmates, the TSTP provided an option to begin to address these beliefs and begin to treat their trauma. In the focus group discussions, professional participants acknowledged that they were aware that the inmates in their care had experienced trauma. However, whilst being trauma-informed is necessary to effectively work with the clients, on its own it does not provide recovery, only a trauma-specific response would achieve this.

When discussing the TSTP, the inmate participants reflected on the trauma-specific symptoms that they experienced in custody, and how the TSTP provided an opportunity for those symptoms to be discussed. They reflected on key aspects of a trauma-specific approach, including the ability to establish psychological safety within the therapeutic relationship. This appeared to be key in addressing core aspects of recovery that led towards the resolution of the TSTP participants' trauma. Research suggests that the outcomes for people suffering with trauma, depend upon the provision of support to resolve that trauma (Kezelman & Stavropoulos, 2012). For victims of trauma who do not receive appropriate and timely intervention, they may instead engage in self-destructive behaviours, self-injurious behaviours, and self-medication (Scott, Coleman-Crowger, & Funk, 2014). The TSTP provided an alternative to these behaviours, by providing strategies and tools to manage those behaviours.

TSTP participants reported that disclosure of their trauma, was one of the more beneficial components of the TSTP. This was framed by the belief that counselling provided an opportunity for them to tell their story. They believed that this was more than just telling someone the details of the victimisation which occurred, it was talking about the emotional impact of the trauma. This inability to disclose the abuse is important as often the nature of the trauma, especially if the abuse was by a family member. The inmate participants felt that they had not previously been able to talk about the abuse, due to a sense of betrayal, shame, a fear of not being believed or even being concerned that they have brought shame on the family (Marriot, Lewis, & Gobin, 2016).

For many of the inmate participants, they reflected that participating in the TSTP was the first time that they had spoken about what had occurred. Talking about their experiences (in a supportive environment) raises inmates' awareness, which according to Ryan and Deci (2017), facilitates "the possibility for clients to examine their inner lives in the kind of interested way that will give them greater capacity for regulating themselves effectively,

experiencing satisfaction of their basic needs, and feeling a sense of personal satisfaction" (p. 451).

During the interviews, TSTP participants provided clear accounts of betrayal and the feeling of being discredited by others. Inmates reported that they needed to be provided with an understanding of betrayal-trauma, which is present for victims of familial victimisation, and is necessary in order to address betrayal in therapy. The inmates reported, an understanding of betrayal and trauma provided an environment in which they were accepted and provided an opportunity to address faulty assumptions about the offender, which may have occurred following the trauma. The ability of the counsellor to assist the inmate to redefine the trauma narrative and apportion self-blame from the inmate participant back to the offender, provided a significant step in recovery from trauma.

The Client-Counsellor Relationship

Study 1 reflected the extensive nature of trauma histories of inmate participants, particularly in comparison to community participants. It is likely that those experiences of trauma, may develop into a fearful-avoidant or disorganised-disoriented attachment style (Nelleke, 2017; Ringel, 2019). As many of the inmate participants reported suffering trauma by a familial offender in childhood or adolescence, they would likely have experienced inconsistent emotional support (as well as abuse) from an attachment figure (e.g., a parent). However, engaging in therapy that provides a safe and trusting environment, and provides opportunities to identify and develop skills, assists in overcoming these attachment issues.

Using a counsellor independent to the prison, to facilitate the TSTP, provided the inmate participants with an opportunity to develop a more secure attachment, and thereby creating a more interpersonal connection with the participant/counsellor. This independence from the institution helped to overcome attachment issues, associated with betrayal, and created safety, and further developed trust between the inmate and the counsellor.

In contrast, professionals thought that they need to have more information about inmates' participation in the TSTP. Professionals stated that they need to have more information about inmates' participation in the TSTP. However, inmate participants stated that the reason why they believe that the relationship with the counsellor was successful, was precisely because information was not shared. In essence, the independence of the TSTP counsellor was a significant factor in the ability of the inmate to establish trust in the counsellor and the TSTP. These opposing views highlight some of the tensions that exist between the correctional professionals and inmate participants. In this instance however, the needs of the inmate would have to outweigh the requests of the professionals (limited confidentiality notwithstanding), as the priority to address current trauma would be more important than providing unspecified information to the professional correctional participants.

Establishing Safety

Inmate participants reported that the TSTP provided a forum where they could first have a safe place to disclose the trauma and secondly have those experiences validated. Some inmates suggested that whilst they often disclose the details of the traumatic event, they rarely, if ever, provide the details of the impact that the trauma had on them. For example, inmates who experienced domestic violence as a child may also report: psychological symptoms (sleeplessness, anxiety, depression), physical symptoms, inability to establish intimate relationships, and having a damaged sense of self. The failure to understand the complexity of trauma puts earlier discussions of prison staff into context, where they believed that they were already aware of the trauma, but on a much more simplistic basis.

In regard to processing the trauma, TSTP participants also reported that the TSTP reinforced the importance of understanding what their trauma was and how it may have affected them. The psychoeducation provided in the TSTP appeared to be crucial in underpinning how the inmates understood and accepted their traumatic pasts as well as

providing a basis for processing the trauma safely. This can be seen in the inmates' interview responses, when they reflected on the coping skills they gained as a result of their participation in the TSTP and how they were able to apply them outside of a trauma-specific context. After moving through the first phase of treating the trauma, namely stabilising the inmate and then completing the second phase of treatment, which is assisting them with processing the trauma, the counsellor would move onto, integration, as the third phase of trauma treatment. This third phase, refers to how the inmate participants integrate self-regulation or emotional regulation into their day to day lives (Kezelman & Stavropoulos, 2012). Inmate participants confirmed that the TSTP helped with the reintegration of regulation, through practical strategies, in the prison environment.

Developing Skills

Once feeling like they were in a safe environment of therapy, TSTP participants (inmate and community) reported that they gained positive practical outcomes by engaging in the TSTP. Based on inmate participants' responses it appeared that talking therapy was not the only approach taken by the TSTP counsellor. Inmate participants reported that they gained practical skills and strategies that they could use in daily life. Importantly, these skills and strategies were specific to prison life and were applicable to a correctional setting. Given that research indicates that inmates with significant histories present with high levels of dysfunction and dysregulation, this was effective as traditional approaches alone may not be as effective in treating complex trauma (Dass-Brailsford, 2007; Kezelman & Stavropoulos, 2012; Schnyder & Cloitre, 2015; Walker, 2019;).

According to inmate participants, these strategies and skills carried across into some key areas, such as improving their ability to self-regulate emotionally. It further provided inmates with alternatives to self-injurious or even suicidal behaviours. The acquisition of skills and strategies is supported by self-determination theory (Ryan & Deci, 2017), which proposes

competence (i.e., the ability to effect change in one's environment) as a fundamental psychological nutrient for optimal wellbeing. Acquiring skills that allows one to be competent "enables individuals to adapt to complex and changing environments, while lacking in competence is likely to result in helplessness and demotivation" (Deci & Ryan, 2000).

Additionally, TSTP participants focused on issues of choice and collaboration as an effective component of counselling. Victimisation often takes away the choice of the victim, making them an unwilling participant in the act of violence and taking away their sense of control in what was occurring. Moreover, being in prison can further add to the lack of choice. This was important as the inmates perceived the success of the TSTP as providing them with a personal experience, in which they could move at their own pace, with no fixed agenda and reveal what they wanted to, when they wanted to. Such ownership means that what is learned is more likely to be valued, retained, and acted on. This is particularly important, for as Combs and Gonzalez (1994) have noted: "People do not sabotage their own projects" (p. 141)

Developing new skills was not only a discussion point raised by inmate participants. Professional participants also rightly suggested that they could benefit from more education and training. This certainly would be helpful as education and training would help staff in distinguishing between inmate behaviours that were related to the trauma, or simply a display of poor behaviour. Again, the discussions around being trauma-informed were contradictory and filled with ambiguity. Despite putting forward the argument that they were trauma informed and wanting more training, the professional groups suggested that they did not see it as a key part of their role or responsibilities. It also appeared from the discussions, that members of the professional groups believed being trauma-informed was not applicable in many operational aspects of their roles, despite admitting acknowledging that they would need training in trauma-informed practice.

Rediscovery of the Self

Research suggests that during the period of victimisation, many victims see themselves as powerless, out of control and vulnerable (Chung, Jalal, & Khan, 2017; Tanaka, 2001). This is especially true for victims of child sexual assault (CSA), of which the research showed that a significant proportion of female inmates in this study reported experiencing. During the interviews, TSTP participants also provided clear links to feelings of betrayal, not being believed, and a sense of being discredited by others. For inmates, shame takes the form of identity and affects their overall sense of self. The resolution of shame is critical in treating/resolving the trauma and recreating the inmate-victims' sense of self. In completing the TSTP, inmates believed that TSTP helped them realise that there was a possibility of recovery, as well helping them regain their lost identity and sense of self.

Research also indicates (Alexander, 2011; Allnock, 2010; Cashmore & Shackle, 2013; Manigilio, 2009) that victims of CSA display a variety of long-term trauma symptoms across the lifespan into adulthood, affecting their sense of self and manifest as a never ending list of guilt, shame, confusion, and self-destructive behaviour. What this means is that inmate participants may not remember who they were before the various traumas and have to re-establish what their sense of self is. This highlights the need for the TSTP to be more than just a traditional form of counselling or rehabilitative type of therapy. The purpose of those traditional approaches is to restore what was lost to the client. However, with high levels of polyvictimisation across the lifespan, there may be no actual point that the victim can easily return to. Instead, the TSTP allows the victim to decide what their sense of self is, and the counsellor can guide them accordingly. This was an important concept for inmates given that they reported taking a great deal of responsibility for the victimisation that they experienced, which changed who they believed they were.

Like the professional participants, inmate participants also need a degree of autonomy in order to obtain optimal wellbeing (Ryan & Deci, 2017). Having control of the direction of the therapy and having a choice in what to discuss is something inmate participants would not usually find in prison. Prisons are an environment that is heavily authoritarian, where inmates are told what to do, how to do it, and when to do it. The TSTP provides a freedom for inmates to stop, and offers opportunities for a new way to think about issues which are personally meaningful and important to them. By working through the issues they were able to work on re-establishing any sense of self that may have been lost in the victimisation and resulting trauma.

Strengths of Study 3

The richness of data obtained through the use of both interviews and focus groups, provided alternative and complementary insights into the TSTP. Sixty interviews were conducted, 30 with community participants and 30 with inmate participants. The ability to compare and contrast inmate and community participants' experiences, allowed a better understanding of what worked for inmates in prisons and what was important and what worked in terms of recovery. Undertaking three focus groups with 27 professional participants across a variety of occupational groups (correctional officers, justice health staff, programs staff and psychologists) meant that a diverse set of views and perspectives was obtained to enhance and illuminate the findings of Study 1 and Study 2.

While the concept of validity is routinely discussed in quantitative research designs, it is less discussed for qualitative research designs. However, it is still just as important for qualitative studies (although this is considered a controversial issue by some; see Cypress, 2017). For qualitative studies, validity is conceptualised somewhat differently from when it is used in the quantitative context. In qualitative research, validity relates to trustworthiness of findings (Gubba & Lincoln, 1994; Noble & Smith, 2015). Cypress (2017) states that

trustworthiness "refers to quality, authenticity, and truthfulness of findings of qualitative research" (p. 254). To enhance the validity and trustworthiness of the findings in this study, several different, but complementary approaches were employed. First, consideration was given to ensure that the most appropriate method of data collection was used to ensure the credibility of content analysis (Polit & Beck, 2012), namely interviews and focus groups using semi-structured questions. Self-awareness of the researcher also adds to the credibility and trustworthiness of the findings. Throughout the initial research planning stage, through to the analysis stage of the research, I ensured that I constantly reflected on whether or not I was leading or manipulating the responses of the participants. My supervision team were crucial in assisting with self-reflection, providing objectivity and guidance throughout this process, which contributed to the trustworthiness of the results. Finally, using a second researcher to assist in preparing and coding the data for analysis, provided further assurance of the data credibility (Moretti, et al., 2011).

Limitations of Study 3

One of the possible limitations of Study 3 was the potential influence of the Hawthorne effect, whereby some participants may alter their behaviour or responses as they are aware that those responses are being observed which may lead to inaccuracies (Gachabayov, Dyatlov, & Bergamaschi, 2019). However, this was mitigated by developing a rapport with the participants and continually reassuring them that the purpose of the process was to improve the TSTP, not judge the process, or the people working within it, including correctional staff. Additionally, inmate participants were not forced or coerced to participate in the TSTP. It was made clear to them that their participation in the TSTP would not contribute to early release (parole) or contribute to upcoming court matters. However, despite providing advice to inmates about this, it does not mean that they believed it or did not assume that their participation may indeed contribute to court or parole in some way.

One limitation with the use of focus groups, is that participants may be prone to bias, such as observer dependency or social desirability (Mansell, Bennet, Northway, Mead, & Moseley, 2004). Specifically, in this research there is always the fear for professional participants, that there may be the possibility of repercussions from the prison because of their expressed opinions. Assurances of confidentiality were made to all participants and they had complete control if they wished to attend the focus group or not, and could withdraw without prejudice, by me as I was independent from the prison.

The use of the self as an instrument, carries with it the possibility that some distortion would occur in the data being gathered, that is, some degree of researcher bias could occur (Combes & Gonzalez, 1994). As a PhD student, there is a degree of investment in pursuing the research, obtaining an outcome, and making inferences about the information (data) being presented. Shaughnessy and Zechmeister (1997) suggest that while such bias can never be eliminated, the researcher can minimise it by being aware of its existence. As a researcher, I was aware of the potential for bias and attempted to keep it in check throughout the study, mitigating the observer bias through digitally recording interviews and focus groups. I also ensured that my supervision team were also aware of this and checked on it throughout the investigation.

Summary of Study 3

Study 3 was conducted in two separate but related parts: interviews with inmate and community participants receiving trauma-specific treatment; and focus groups comprising correctional professionals who work with female inmates. What was clear from Study 3, was that whilst professionals in prison consider themselves to be trauma-informed, there were gaps in their knowledge and practices. To address these gaps, a whole-of -organisational cultural shift would have to occur to implement a trauma-informed approach into policies and procedures, followed by the provision of occupational-specific trauma-training to correctional

professionals. To be trauma-informed, an organisation, needs to recognise the impact of trauma on inmates, avoid re-traumatising practices, and integrate trauma into policies and procedures. More importantly, the prisons need to provide options for recovery, specifically trauma-specific interventions. Doing so may empower prison staff, resulting in a reduction of trauma-driven behaviours, such as restraint, which require a necessary operational response from the prison. Based on discussions with female inmates, in order to facilitate recovery, this response would have to go beyond trauma-informed care, that is the prison and its staff would have to realise the impact of trauma, understand its signs and symptoms, provide an appropriate response and integrate trauma into the prisons policies and procedures. This must extend to evidence-based trauma specific interventions which would address the trauma, as well as any other co-concurring disorders as a result of that trauma. The findings suggest that female inmates want trauma-specific services, which are independent of the prison, and importantly, believe they want to know that those services work. In considering the barriers that prevent inmate participants attending the TSTP, it was evident that custody does provide a stable environment, in which women can access services and focus on recovery, without the encumbrances of everyday life in the community. On a personal level, female inmates reported that they saw positive changes within themselves, and were able to apply intervention strategies and techniques into non-trauma based situations that they experienced within custody. Overall, Study 3 provided a unique opportunity to learn what female inmates believe they need to manage their own experiences of trauma from victimisation, and what prison staff need in order to do their jobs effectively. Most importantly, its findings are consistent with, and provide further support for, the positive outcomes of the TSTP reported in Study 2.

Implications for Research, Theory, and Practice

Overview

The three studies undertaken as part of this research provide a number of important

findings which contribute to answering the main question of whether or not trauma can be effectively treated in a correctional facility. The answer that was determined, based on the combination all three studies, was yes, trauma can be treated effectively in prison. Based on the findings, a number of implications for theory, research, and practice are apparent and presented in this section. Theory, research, and practice are inextricably linked and by presenting them separately, is in no way meant to suggest that they are separate. To separate them is to weaken them, given their interdependent nature. Presenting them in the following three sections is purely for convenience.

Implications for Theory

The findings of this research contributed to current theory and understanding about the possibilities of recovery from trauma in a correctional setting. There has been significant emphasis on developing the concept of trauma-informed corrections (Kubiak, Covington, & Hillier, 2017) as it relates to Pathways Theory (Belknap & Holsinger, The gendered nature of risk factors for delinquency, 2006), yet there remains a paucity of research in regard to developing of trauma-specific treatments for female inmates and progressing trauma theory (Stathopolous & Quadara, 2014). The challenges presented by the very nature of prisons (e.g., authoritarian, removal of some rights, seclusion, segregation, and strip-searching), have led to some researchers believing that the provision of such services in a prison is virtually impossible (Baldry, 2008; Pollack & Brezina, 2006). The findings of this research, confirm the high levels of polvictimistion occuring across the lifespan in female inmates, particularly when compared to a community based sample. Further, the findings show that processing the trauma event(s), significantly contribute to recovery, which has already been confirmed in trauma theory (Moloney, Van den Bergh, & Moller, 2009) and this research contributes to that theory.

As the inmate participants stated in Study 3a, self-regulatory and self-determination processes were key to their perception of recovery from trauma. In this way, the research also

contributes to self-regulation shift theory (Benight, Shoji, & Delahanty, 2017). Self regulation shift theory builds on Bandura's (1997) social cognitive theory and provides an explaination for survivors' self-regulation where they experience a loss of self-determination. The development of self-determination, within self-regulation shift theory, is a significant indicator of recovery outcomes including, childhood trauma (Cieslak, Benight, & Lehman, 2008). The lack of empirical evidence to support trauma-specific services to inmates suggests that current research has not sufficiently addressed the full scope of women's offending. Given that a history of victimisation and subsequent trauma histories are considered to be risk factors in offending, the current research findings make a valuable contribution to advancing theory and understandings about trauma recovery in inmates. It does so by suggesting that an integration of female inmates' trauma into organisational programs is key to understanding what women need; and provides a basis for understanding how addressing that need can fit into rehabilitation programs.

Implications for Research

Developing a Standard Measure for Polyvictimisation

Consistent with research in this area (i.e., prisons, trauma, and counselling), the current research highlights the differences in early experiences of trauma between a matched pair sample of community and custodial TSTP participants. The findings provide support for the hypothesis that the prevalence of victimisation, specifically polyvictimisation, presents as a significant risk factor for women entering the criminal justice system. The findings from this research have important implications for the recovery of trauma in correctional settings, as they provide strong support that trauma-specific treatments can be effective in prison. However, future research would benefit from strengthening components of this research. For example, while the findings from Study 1 relating to polyvictimisation have shown that inmates have extensive trauma histories, the development of a more standardised measure of

polyvictimisation would allow future research to produce more specific details on what polyvictimisation is. Understanding polyvictimisation will provide greater insight into trauma, as well as any co-occurring disorders which may occur. The current research looked at additional occurrences of violence against TSTP participants, multiple offenders, and if the offender was a family member. The definition of polyvictimisation could also be broadened to include other characteristics, such as differentiating between victimisation and re-victimisation at differing points across the lifespan. This differentiation would assist in determining some of the predictors of victimisation and could be used to provide early intervention and prevention programs for the inmate participants.

Trauma-Specific Treatment as Prevention

Given the encouraging results of this research, there is value in future research that investigates whether or not the TSTP would be effective in providing a preventive aspect to future acts of violence, for example, through improved choices, more secure relationships. This is in no way to downplay the responsibilities of perpetrators, but the improved sense of self and new skills acquired in counselling, may provide additional strengths, particularly given that the trauma experiences of women in custody are repetitive, enduring, and persistent across the lifespan.

Autonomy Supported Environments

In the current research, the TSTP was provided by an independent counsellor, that is, a counsellor not employed by CSNSW. From discussions with the inmate participants, the independent nature of the service created a degree, of safety, trust, control, collaboration, and empowerment, which promoted inmates' active involvement in the program. This then enabled recovery to take place by utilising trauma-informed principles (SAMHSA, 2015). In this way, the research contributed to self-determination theory (Deci & Ryan, 2012), as the inmate participants' success with the TSTP, was linked to the high degree of control or autonomy

regarding their participation. That is, their decision to participate was theirs alone, and not linked to any extrinsic reward (e.g., consideration for early release). They could choose to attend the TSTP or not without penalty, and while attending, they reported having control over the sessions, not being pushed into discussion, and being encouraged to talk about what they wanted to talk about.

The independence of the counsellor was crucial in allowing TSTP participants to more freely express themselves in therapy. This expression of self-determination, provides inmate participants with autonomy during counselling sessions, giving them a degree of control over aspects of their lives that they would not normally have, due to imprisonment. The value of inmate participants' experiencing autonomy in the TSTP is clear, as in prison, there are strict rules and regulations, which can undermine opportunities for autonomy (vaan der Kaap-Deeder, et al., 2017). However, the need to experience autonomy is a fundamental human need, among others, that must be catered for in order to promote and maintain inmates' wellbeing. With this need identified, future research could explore if autonomy-supportive environments (Deci & Ryan, 2012) could be created in other areas of prison life (e.g., education and learning, sports, recreation).

Also discussed in this chapter was the need for prison staff to experience autonomy in their duties. There is an abundance of research on the importance of autonomy in the workplace (Gagne, 2014). However, there is little in the literature that addresses the fundamental need of autonomy for prison staff. The focus of this study has been on the TSTP's effectiveness in dealing with trauma-effected inmates, and not on prisons as such. However, it is clear that any counselling program to address inmates' trauma-related needs, can only benefit when prison staff are working effectively and experience job satisfaction. Therefore, an investment in research into prisons and employee wellbeing is a wise investment. A paper by Australian Industry Standards (2018), reported that a leading cause of skill shortages among prison staff,

was due to high employee turnover. This underscores the need for more research to investigate the conditions that produce job-satisfaction and employee wellbeing within the prison system.

Replication of the Current Research

The often large effect sizes achieved for some of the statistical analyses in this research (see Chapter 6) are impressive. However, Kline (2009) cautions that large effect sizes are no substitute for replication. Replicating is important as it provides greater assurance that results are valid and reliable; it also provides further information as to how much the results can be generalised, and it considers the applications of the results to the broader prison populations. Replication should occur in different prisons throughout the country, and with different counsellors.

In addition to replicating the research in order to gather more support for the findings presented in this dissertation, new research questions and hypotheses are needed. Good research should not only provide support for the original hypotheses for which it was employed to investigate, but it should generate new research questions and hypotheses. Future research could focus on questions that require more advanced statistical analyses and investigate new hypothesis about potential moderators (e.g., prison workplace culture) and mediators (e.g., counsellor's effectiveness).

We know that for the non-prison population, some people respond differently to different modes of therapy. This is no less true for prison populations. Future research could try to identify what components of the counselling used brought about change. Potential research questions for future research include: Would different modes of therapy (e.g., schema therapy, acceptance and commitment therapy) work in the prison setting? Would some clients benefit from a group session approach? Do some clients benefit from assigned homework between sessions?

Implications for Practice

Treating the Trauma

The growth in research regarding trauma in prisoner populations focuses on the organisations staff becoming trauma-informed. If trauma-specific services refer to those evidence-based treatments which directly address that traumatic history, then this means that the context in which trauma is addressed, should be within the confines of a trauma-informed framework, and include staff culture, as well as organisational practice. However, according to research (e.g., Stathopolous & Quadara, 2014), correctional organisations should be trauma-informed, before the introduction of the trauma-specific service, in order for it to be successful. Yet, as this research explains, whilst the prisons did not demonstrate many examples of being trauma-informed, there were still reductions in DASS scores after inmates participated in the TSTP. Additionally, responses from interviews and focus groups provide evidence that the TSTP did produce positive changes in the behaviour of the inmate participants. Importantly, the inmates attributed these positive behaviour changes to their participation in the TSTP. The current research demonstrates that trauma-specific services can be effective in addressing trauma in a correctional setting, whilst the organisation moves towards trauma-informed goals. Further research would identify the extent of any changes by comparing and contrasting trauma-specific services in both trauma-informed and trauma-uninformed environments.

Towards a Model of Trauma-Informed Corrections

Trauma is an established factor in the lives of many female inmates (AIHW, 2009; Covington & Bloom, 2006). In order to facilitate the best environment for managing trauma in an inmate population, correctional organisations seeking to provide trauma-specific services should work towards becoming trauma-informed first, in order to create an environment where survivors of trauma can work through the impacts of their own trauma. Ideally, the introduction of programs like the TSTP should be seen to reflect or align with the organisation's goals and

values. If such an alignment is not observed or intuited, by inmates and the staff responsible for their care, then the wellbeing of staff and inmate is compromised.

The results of this research provide strong support that the TSTP is effective in addressing the needs of the individual, however it is still a single intervention. The research suggests that in order for inmate participants to benefit from a TICC model, it has to consider the widespread trauma needs of the entire inmate population, not just a select number of inmates. This would include a cultural shift of correctional staff, supported by trauma-informed amendments to policies and procedure.

Screening for Trauma

The current research highlights the extent of trauma histories in the participating inmates. As Study 1 showed, this history is repetitive and sustained over a significant period of time. However, in this study, only inmates that self-referred or were referred by a prison staff member, participated. There was no specific trauma screening in place to identify which inmates would benefit from the TSTP. As such, the overall CSNSW response in identifying and planning for treatment for inmates' trauma histories, could be improved by having an ongoing screening program.

Currently, there is no screening program in place, which specifically screens for trauma. While this remains the case, trauma-specific symptoms and trauma-specific disorders will likely remain unaddressed. A more comprehensive screening program would then impede any successful programming and planning for inmate rehabilitation, mental health interventions or trauma treatment. A comprehensive screening process would provide a better system for treatment planning, intervention and additionally provide a rich source of data to provide a basis for further research.

Links to Rehabilitation

Whilst this research attempted to determine if inmates were more willing to engage in rehabilitation programs after completing the TSTP, the results from pre and post TRQ scores showed that inmate participants were already in a 'program ready' state, that is, they were already in a state in which they were prepared to engage in treatment to address offending behaviours. If the TRQ was included in a standard battery of tests for all inmates, it would assist in determining if the TSTP could be a contributing factor in preparing them for rehabilitation or forming part of that rehabilitation program.

Whilst the implications of this study inform the need to develop more effective trauma-informed programs for female inmates, it also likely to inform the current practice of assessments and case planning in a correctional environment. The value for inmates participating in the TSTP should be realised in their participation in any subsequent rehabilitation program for offending behaviours. Specifically, future research should focus on whether or not improved rehabilitation outcomes could be achieved following completion of the TSTP. As one of the main theories regarding the rehabilitation for female offenders is that of (Belknap & Holsinger, 2006) pathways theory, (i.e., that the early onset of trauma contributes to the trajectory of offending behaviour), extending the current research would be of value if the outcomes of the TSTP were evaluated in line with rehabilitation outcomes for inmates.

Inmates with Disabilities

In NSW, an inmate with a disability is defined under the *Disability Inclusion Act 2014* as "a long-term physical, psychiatric, intellectual or sensory impairment that, in interaction with various barriers, may hinder the person's full and effective participation (in the community) on an equal basis with others" (p. 9). CSNSW work with Statewide Disability Services to work with these inmates in line with the relevant state and federal legislation. Much

of the existing research on female inmates and trauma, neglects the impact of trauma from violent victimisation. Some information and self-reports suggest that it is reasonable to assume that most individuals with disabilities have experienced a great deal of polyvictimisation (Cuomo, Sarchiapone, Di Giannantonio, Mancini, & Roy, 2008; Fleishman, 2013). Future research that includes inmates with disabilities, who have experienced trauma, would be a valuable area of research.

Chapter Summary

There is little doubt that violent victimisation and its resulting psychological trauma are enduring factors in the lives of many female inmates. This research answered the question of whether or not that trauma can be effectively treated in a correctional facility. The three studies which comprised the current body of research addressed that question, albeit within the inmate samples used. Results confirmed that the inmate population differed in the extent of their trauma histories when compared to a matched community sample. Results then confirmed that the TSTP was successful in reducing depression, anxiety, and stress subscale scores in both the inmate and community samples. The qualitative component then provided insights into the reasons why the TSTP was successful. Most notably, an independent counsellor (external to CSNSW) was used to facilitate the program. The counsellors were able to implement basic trauma-informed principles to establish a therapeutic alliance, and facilitate safety, trust, control, collaboration, and empowerment for inmates to help recovery from trauma (Kezelman & Stavropoulos, 2012). In short, the answer to the question was, yes, trauma can be effectively treated in a correctional facility.

CHAPTER 10

Conclusion

"It is quite amazing how two people can read the same book and yet reach different conclusions".

Nitya Prakash

The Problem

Trauma is a part of the fabric of life. It is destructive, costly, and has no boundaries in regard to race, colour or creed. However, given the rates of under-reporting in female victims of crime, particularly sexual assault, trauma still remains largely unrecognised, unaddressed, and unidentified (Kezelman & Stavropoulos, 2012; Messina & Grella, 2006). The need to address trauma is viewed as an important part of health care. However, some sections of the population are overlooked and forgotten (Machtinger, et al., 2018). One population which appears to be neglected, is that of women in custody. The number of women entering into the NSW Correctional system has dramatically risen across the past couple of decades, with women's rates of incarceration increasing (BOCSAR, 2018). However, despite these numbers and the extensive trauma histories of women entering custody, no standard program exists to address trauma in custody. Programs exist for addressing criminogenic needs, alcohol and other drug use, gambling, etc., but not for pre-existing trauma.

Relatively little research has been undertaken within the female inmate population in regard to their prevalence of violent victimisation (Stathopoulos, 2012). However, the research that has been conducted (e.g., AIHW, 2019), suggests that female inmates report elevated levels of mental health issues, more social disadvantage, and importantly, higher levels of prior histories of violent victimisation than women in the community. Whilst under-reporting of victimisation remains a consistent issue for women in all settings, research suggests that a

significant percentage of the female inmate population have experienced trauma in their lives (Richters, et al., 2008; Teague, Mazerolle, Legosz, & Sanderson, 2008).

Throughout this thesis, I have reiterated the connection between women in custody and the extent of the trauma which they have sustained. The overarching aim of this research was simple, it asked the question as to whether trauma counselling could be undertaken within a correctional environment? Some researchers (e.g., Baldry, 2008) believe that it is virtually impossible to undertake trauma-specific counselling in a prison. Specifically, critics such as Baldry believe that the ability to provide physical and psychological safety is crucial if the therapy is to enable recovery from trauma, something that prisons cannot guarantee. Despite the concerns raised by critics, it does not take away from the fact that female inmates are deserving of a program to specifically address trauma. A literature review (Chapter 2) was undertaken to provide a foundational understanding of what trauma is and its relation to violent victimisation. The impact and implications of trauma were then considered for the female inmate population.

This Research

To answer the overarching research question of this research, three interrelated studies were undertaken as part of a mixed-methods research design. Study 1, a quantitative study, sought to examine the participants' trauma backgrounds, first to determine the extent of the trauma, and secondly to compare their experiences with a matched community sample. Study 2 utilised a quantitative approach to consider the outcomes of the Trauma Specific Treatment Program (TSTP) using the Depression Anxiety and Stress Scale (DASS) as the dependent variable. A sample of inmates from two prisons were allocated to one of two groups: a waitlist control group and an immediate treatment group. A matched community sample was also used to provide a comparison of treatment effects in the community during the same time period. Finally, Study 3 was divided into two sections. Section 1 of Study 3 adopted a qualitative

approach to explore female inmates' experiences of trauma-specific counselling and compare and contrast the findings with the experiences of the community-based non-offending counterparts. The second section of Study 3 was also a qualitative study where focus groups were conducted with professionals who worked with inmates. This second section of the study was done to understand how correctional services professionals viewed the TSTP and to provide a different perspective in understanding the experiences of inmates who participated in the TSTP. The combined studies provided a rich source of information about the lived experiences of the people involved in the TSTP.

The Findings

Study 1 results provided confirmatory supporting that women in custody experience far greater prevalence of victimisation in their trauma histories, than women in the community (Topp, 2011). The research showed that the inmate sample presented with significantly more reported acts of violence than the community sample, which spanned across a 20-year period. The custodial group also reported higher levels of polyvictimisation than the community sample, which include more occurrences of victimisation, more offenders, and a higher rate of familial offenders. The findings also showed that the custodial sample disclosed a higher rate of victimisation across all phases the lifespan when compared to a community sample. Over 80% of the custodial sample reported incidences of victimisation in childhood and adolescence, compared to less than 3% of the samples in the community groups.

Having established the differences in the trauma histories between the two samples, the research set out to determine if the TSTP would be effective in reducing trauma symptoms in an inmate population. The findings of Study 2 provided strong support for the TSTP overall in improving wellbeing as indicated by a reduction of scores on the DASS. The results demonstrated that there were statistically significant differences between DASS scores at the commencement and completion of TSTP. The design of the study also demonstrated that for a

10-week pre-treatment period, there was no significant effect on DASS scores for participants in the waitlist control group, providing support for the hypothesis that any reduction in DASS score, was due to participation in the TSTP. The results further provided evidence that the TSTP provided lasting effects for the inmate sample. The DASS was administered at a 10-week follow-up period, in which no treatment was provided. The results of the post-treatment DASS showed that the scores on each of the subscales remained consistently in the reduced range, with no statistically significant differences in DASS scores between ending the TSTP and the post-treatment period, for both the inmate sample and community sample.

Results from Study 3 further validated and extended the results of Study 2, but also offered an insight into why the TSTP worked. The results highlighted that a trauma-specific intervention can be effective at overcoming a range of symptoms associated with a history of trauma. More importantly, what it also demonstrated was that it can be effective in a prison setting. Study 3 findings demonstrated that one of the main reasons why the TSTP worked, was that the three phases of addressing trauma, specifically safety/stabilisation, processing, and integration were facilitated in a prison, through the use of experienced, independent trauma-counsellors. Another main reason why the TSTP worked, was that the participants saw improvements in their overall sense of self, through the reduction of self-blame and improved emotional regulation. The participants were confident that the outcomes achieved, could be attributed to the TSTP and the success of the TSTP. Of note was the suggestion that whilst community participants had to contend with conflicting priorities in their lives, the custodial sample were able to access services to meet a range of needs without the encumbrances of daily responsibilities.

Even though research exists by (e.g., SAMHSA, 2015) which suggests that the trauma-specific services would be greatly enhanced by the adoption of a trauma-informed approach, particularly within correctional organisations, more research is needed for specific populations, such as prisons. The findings provided evidence that inmates could gain significant and lasting benefits by engaging in trauma-specific services delivered in a prison. The findings also suggested

that at an organisational level, Corrective Services NSW should work towards implementing a trauma-informed model of correctional care. Such a trauma-informed model would assist in increasing female offenders' responsivity to recidivism-based programs. Based on discussions with professionals, cultural change at the organisational level would have to occur in order to fully implement trauma-informed principles.

Reflections

Female offenders often encounter unique challenges when compared to their male counterparts, poverty, homelessness and the subject of this thesis, trauma. It was a challenging experience to meet with those women and hear their stories and experiences. It changed the emphasis from a theoretical perspective to one of more personal nature, having borne witness to their stories. The degree of adversity that they have faced, and the impact that trauma has had on their lives, highlights the way that their trauma and offending are linked. This made undertaking the current research much more personal, as the impacts that the TSTP could have on individual people was made all the more real. In completing the thesis, I began visualising them more and more as people in need of help, rather than participants or inmates. What was also apparent, was the commitment of the staff who work with this cohort of women, despite the silos that their beliefs and opinions come from. Each person I spoke with were committed to their role and the women that were entrusted into their care, and each person presented as only wanting the best outcomes for those women. The challenge lay in the different ways that could be achieved.

From my experiences in undertaking this research, it would appear that a trauma informed correctional environment could work, however changes would be required to accomplish this. This would have to start with a mandate from a Ministerial perspective, have a shared set of goals in place, and a clearly articulated trauma informed plan, in line with core correctional practices, in order to be implemented. I believe that by acknowledging the

presence of trauma and seeking to address it will have long-term benefits for not only the individuals, but also the community in terms of women's recidivism. There appears to be a point in which the congruence and divergence between desistence and trauma meet, and by restoring a sense of self to the person, improving relationships, seeking responsibility, we can progress to recovery from trauma, and desistence from crime.

Recommendations

Whilst the aim of this current investigation was to determine if trauma can be effectively treated in a correctional facility, future research could expand on this and explore female inmate experiences pre and post incarceration, to better understand trauma and the impact that it may have on their desistence. This may include an exploration of the offending lives of the women in line with their experiences of trauma. It would also be useful to explore whether resolving women's trauma through participation in a TSTP, impacted the ability for these women to desist from offending post release, and if the resolution of trauma assisted in community reintegration.

Looking Ahead

The results of this study are important when considering both the short-term and long-term wellbeing of female inmates. The findings provide strong evidence that provision of a trauma-specific intervention can make a positive difference in improving the wellbeing of female inmates who have experienced a significant history of trauma. Unless trauma is effectively dealt with, prisoners are at risk of re-entering the justice system after they have been released. Trauma-specific interventions can be extended into pre-release programs, in order to provide some preventative strategies to change possible life course trajectories of female inmates experiencing further traumas. The current research also contributes to existing theories related to psychology, trauma, and wellbeing. For example, trauma theory suggests that trauma and its outcomes are linked to women's offending behaviours, which, in turn, are linked to

unresolved trauma. Resolving this trauma may circumvent future re-victimisation and from part of the rehabilitation process. Findings from this research provide support for one of self-determination theory's (Deci & Ryan, 2012) tenets, namely that the provision of an autonomy-supportive environment is just as applicable to inmates as it is to the general population in promoting psychological wellbeing.

In conclusion, the findings of this comprehensive research provide strong support, that a trauma-specific intervention service can work in a correctional setting to effectively improve the wellbeing of female inmates and contribute to their recovery from trauma. The findings also provide a basis for further research, not only for the purpose of replication to increase confidence in the findings of the current research, but to improve generalisability, explore new applications, and extend existing related theories. The findings also support the proposition that the TSTP not only improves the quality of life for trauma-affected inmates, but also has the possibility to add to their quality of life once they leave prison. It is recommended that based on the findings of this research, that trauma-specific services be implemented into prisons. Findings also suggest that the value of the TSTP is further enhanced when prisons adopt a model of trauma-informed correctional care. This not only improves the outcomes for women participating in the TSTP, but also improves the confidence, capability, and capacity of those professionals who work with these women.

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Appendix A: The Victims Support Package - Approved Counselling Scheme

'Victims support' describes the package of counselling services, financial support and recognition payment available to victims of violent crime in New South Wales through the *Victims Rights and Support Act 2013* ('the Act').

The complete victims support package consists of:

Counselling

- 22 hours of free counselling and more if needed.

Financial Support

- Financial assistance for immediate needs (up to $5000) for expenses incurred urgently to secure the victim's safety, health and well-being.
- Financial assistance for economic losses, including out of pocket expenses, loss of actual earnings, medical and dental expenses, justice-related expenses, and assistance relating to the loss of or damage to personal effects such as clothing.

Recognition payment

- Fixed payments of $1,500 to $15,000 to recognise the trauma caused to the victim and the offence or offences committed against them.

Who can apply for victims support?

The package of counselling, financial support and recognition payment that makes up victims support is available to victims of violent crime in New South Wales. The types of victims that are eligible for victims support are:

- Primary victims
- Secondary victims
- Family victims
- A parent, step-parent or guardian of a child primary victim

- A third party (in relation to a primary homicide victim only)

Time limits

The general time limit for financial support and recognition payment eligibility is **two years after the act of violence.** However, there are exceptions and extensions, depending on the time between the occurrence of the act of violence and lodgement of the application; the type of victim; the age of victim at the time of lodgement, or at the time the act of violence occurred; and the type of offence committed against the victim.

Factors that may affect eligibility for victims support

Eligibility for victims support is affected by criteria specifically addressed in the legislation. This includes:

- The person has been paid, or is entitled to be paid compensation awarded by a court, in respect of the act of violence.
- If that act took the form of, or the injury arose as a consequence of, a motor vehicle accident within the meaning of the *Motor Accidents Compensation Act 1999* (NSW).
- The act occurred while the person was engaged in behaviour constituting an offence.
- The act of violence occurred while the person was imprisoned as a convicted inmate within the meaning of the *Crimes (Administration of Sentences) Act 1999* (NSW). Some exceptions apply.
- Other circumstances in which approval of victims support to an otherwise eligible applicant can be adversely affected relate to matters under section 44 of the Act.

What documents are needed to receive victims support?

To request victims support, a completed application form must be lodged with Victims Services. Certain documentary evidence is also required for financial support and recognition payment to be approved.

How to apply for victims support

To request victims support, a completed application form must be lodged with Victims Services.

The Approved Counselling Service (ACS)

The Approved Counselling Service (ACS) provides free individual counselling to people who have become victims of violent crime that occurred in NSW and aims to assist victims recover from the psychological and emotional impacts the crime has had on them. The ACS is available to people of all ages and backgrounds.

Counselling is provided on a short-term basis of up to 22 hours, with a clear focus on rehabilitation. While recovery responses are generally positive for victims who access counselling soon after the incident has occurred, people who have been victims of events many years earlier can find several benefits through counselling. This includes those people who have been too afraid to open up about the incident before, or who feel they were not understood by others when they previously tried to.

Approved Counsellors under the ACS are social workers, psychologists, clinical psychologists or psychiatrists in private practice who have proven experience in working with victims of crime. They are paid by Victims Services and are available in the metropolitan and most rural and regional areas in NSW. While the service is a state-wide service, Victims Services has approved counsellors in other states and territories and also overseas.

Clients may ask counsellors to support them through their justice journey. This support could be in many forms, for example providing counselling in preparation for reporting a crime to police, support to attend court, and assistance with preparing a victims impact statement. A victim does not need to report the violence to another person or agency to access counselling.

For information on how to choose an Approved Counsellor, and the professional requirements and standards Approved Counsellors must meet, please review the How to find an Approved Counsellor page.

Who can apply for counselling?

You are eligible to receive free counselling from an Approved Counsellor if you are psychologically, emotionally and/or have been physically injured:

- as a result of an act of violence (assault) in NSW; or
- as a result of witnessing an act of violence; or
- as a result of learning of the act of violence and you are the parent or guardian of a primary victim who was under the age of 18 years at the time of the act of violence; or
- preventing someone from committing an act of violence in NSW, or
- arresting someone who is committing, or has just committed an act of violence, or
- helping or rescuing someone against whom an act of violence is being committed, or has just been committed.

Family members of homicide victims where the offence occurred in NSW. A family member is:

- the victim's spouse
- the victim's defacto spouse, or same sex partner who has lived with the victim for at least two years
- a parent, step-parent or guardian of the victim
- a child or step-child of the victim, or other child of whom the victim was the guardian
- a brother, sister, half-brother, half-sister, step-brother or step-sister of the victim.

Counselling for the family of a person killed by a motor vehicle

The immediate family of a person who is killed by a motor vehicle can apply for counselling only if the death occurred in the commission of murder or manslaughter. Contact us for more information.

Appendix B: Australian Catholic University Human Research Ethics Committee

From: Kylie Pashley <Kylie.Pashley@acu.edu.au> on behalf of Res Ethics <Res.Ethics@acu.edu.au>
Sent: Tuesday, 25 August 2015 9:30 AM
To: Anthony Dillon; Thomas_Dornan@agd.nsw.gov.au
Cc: Res Ethics
Subject: 2015-147HI Ethics application approved!

Dear Applicant,

Principal Investigator: Dr Anthony Dillon
Co-Investigator: Prof Lazar Stankov
Student Researcher: Thomas Dornan (HDR student)
Ethics Register Number: 2015-147HI
Project Title: Responding to female inmates' prior history of violent victimisation
Risk Level: Low Risk
Date Approved: 25/08/2015
Ethics Clearance End Date: 31/08/2016

This email is to advise that your application has been reviewed by the Australian Catholic University's Human Research Ethics Committee and confirmed as meeting the requirements of the National Statement on Ethical Conduct in Human Research.

The data collection of your project has received ethical clearance but the decision and authority to commence may be dependent on factors beyond the remit of the ethics review process and approval is subject to ratification at the next available Committee meeting. The Chief Investigator is responsible for ensuring that outstanding permission letters are obtained, interview/survey questions, if relevant, and a copy forwarded to ACU HREC before any data collection can occur. Failure to provide outstanding documents to the ACU HREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research. Further, this approval is only valid as long as approved procedures are followed.

If your project is a Clinical Trial, you are required to register it in a publicly accessible trials registry prior to enrolment of the first participant (e.g. Australian New Zealand Clinical Trials Registry http://www.anzctr.org.au/) as a condition of ethics approval.

If you require a formal approval certificate, please respond via reply email and one will be issued.

Researchers who fail to submit a progress report may have their ethical clearance revoked and/or the ethical clearances of other projects suspended. When your project has been completed a progress/final report form must be submitted. The information researchers provide on the security of records, compliance with approval consent procedures and documentation and responses to special conditions is reported to the NHMRC on an annual basis. In accordance with NHMRC the ACU HREC may undertake annual audits of any projects considered to be of more than low risk.

It is the Principal Investigators / Supervisors responsibility to ensure that:

1. All serious and unexpected adverse events should be reported to the HREC with 72 hours.
2. Any changes to the protocol must be reviewed by the HREC by submitting a Modification/Change to Protocol Form prior to the research commencing or continuing. http://research.acu.edu.au/researcher-support/integrity-and-ethics/\
3. Progress reports are to be submitted on an annual basis. http://research.acu.edu.au/researcher-support/integrity-and-ethics/
4. All research participants are to be provided with a Participant Information Letter and consent form, unless otherwise agreed by the Committee.
5. Protocols can be extended for a maximum of five (5) years after which a new application must be submitted. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

Researchers must immediately report to HREC any matter that might affect the ethical acceptability of the protocol eg: changes to protocols or unforeseen circumstances or adverse effects on participants.

Please do not hesitate to contact the office if you have any queries.

Kind regards,

Kylie Pashley
on behalf of ACU HREC Chair, Dr Nadia Crittenden

Ethics Officer | Research Services
Office of the Deputy Vice Chancellor (Research)
Australian Catholic University

Appendix C: Corrective Services NSW Ethics Approval

Corrective Services NSW
Attorney General & Justice

20 Lee Street
SYDNEY NSW 2000
GPO Box 31 SYDNEY NSW 2001 | DX 22
Tel 02 8346 1333 | Fax 8346 1010
www.correctiveservices.nsw.gov.au

D13/509865

9 August 2013

Mr Thomas Dornan
Manager Policy and Service Delivery
Victims Services
NSW Department of Attorney General & Justice
160 Marsden Street
PARRAMATTA NSW 2124

Dear Mr Dornan

I refer to your research application entitled *"Evaluation of the counselling in prison trial"*. The project will seek to evaluate the effectiveness of the pilot program in providing therapeutic services to address the trauma experienced by inmates who may also have suffered as a victim of violent crime. The pilot program has been a joint undertaking by both Corrective Services NSW and the Crime Prevention Division in Department of Attorney General & Justice.

I am pleased to inform you that conditional approval has been given for your research project. The conditions of approval are that you comply with the 'Terms and Conditions of Research Approval' [Attachment A]

I wish you every success in your endeavours.

Yours sincerely

[redacted]

PETER SEVERIN
COMMISSIONER

Appendix D: Approval from Victims Services

NSW GOVERNMENT Justice Victims Services

Parramatta Justice Precinct
160 Marsden Street, Parramatta
Locked Bag 5118, Parramatta NSW 2124
Tel 02 8688 5511 | Fax 02 8688 9632
vs@agd.nsw.gov.au | www.lawlink.nsw.gov.au/vs

Dr Anthony Dillon
Institute of Positive Psychology and Education
Australian Catholic University
25A Barker Road
STRATHFIELD NSW 2135

Dear Dr Dillon,

I write in regards to a request by Thomas Dornan in support of an ethics application as part of his current PhD proposal.

I can confirm that Thomas Dornan is the current Manager Strategic Policy and Programs at Victims Services. As such he has specific approval to conduct research in relation to his remit. In particular he is responsible for managing the counselling in prisons trial as well as associated clinical programs under the Approved Counselling Service.

I am aware that Mr Dornan's area of interest, as part of his proposed research, is in regards to responding to female offenders past histories of victimisation and resulting trauma. I can advise that Mr Dornan is undertaking this research with my approval..

Victims Services operate under strict privacy and confidentiality legislation. During the proposed research period, Mr Dornan must ensure that he adheres to all relevant legislative obligations and to ensure that the requirements for Victims Services are met and maintained throughout the proposed period of research.

It must be noted that all client information requested by Mr Dornan will be retained on individual client files and that only de-identified data and information will be available to him. However full de-identified data sets will be made available and are accessible to him.

As a current NSW Government employee, Mr Dornan has a current National Criminal Record Check clearance and a current Working with Children Check. He is also an authorised visitor for NSW Correctional Centres and has approval to enter those prisons. Further, I can confirm that Mr Dornan has approval from the Commissioner, Corrective Services NSW to obtain the requested data and information as appropriate.

If you would like to discuss this request further or require further information, I can be contacted on 8688 8181 or at Mahashini_Krishna@agd.nsw.gov.au. I look forward to your kind assistance in this matter.

Yours faithfully

[redacted]

Mahashini Krishna
A/Commissioner of Victims Rights

Appendix E: Interview Questions

Introduction

INTERVIEWER: Thank you for agreeing to talk with me today.

INTERVIEWER: I would like to hear about your experience of the Victims Services counselling service. The information you give will be used in an evaluation of the service. This will help us understand the good things about the service and about the things that need to be improved. It will also help us determine if the program should be expanded to other prisons.

INTERVIEWER: What you say will be treated as confidential and your name will not appear on any research findings. There are no right or wrong answers to the questions.

INTERVIEWER: If you do not wish to answer any questions please just say so and if you want to stop the interview at anytime, that is fine as well.

INTERVIEWER: The interview will last approximately 40 minutes. I would like to record the interview, is that okay with you?

INTERVIEWER: I'm not going to ask you about the things you talked about in counselling sessions or why you went to see [the counsellor] in the first place. But if this does come up and you want to talk about it, that's OK too. What I'd like to hear about is what it was like to go and if seeing a counsellor has made a difference to you.

INTERVIEWER: The Counsellor is available today, both now and after the interview in case you

think that you need to talk about anything as a result of the interview. If you need to talk with her just let me know and we can stop the interview. OK?

Background

INTERVIEWER: Have you ever spoke to anyone else about [your history of victimization]?

INTERVIEWER: If yes, Who? For how long? How did you find them?

INTERVIEWER: If No, then why not?

First heard about the counselling

INTERVIEWER: Can you tell me how you first heard about the counselling service?

INTERVIEWER: When you first heard about it, what did you think?

INTERVIEWER: What helped you make up your mind to go?

INTERVIEWER: When you thought about it, what put you off going?

INTERVIEWER: What, if any, information did you get beforehand?

INTERVIEWER: What did you think about the information?

INTERVIEWER: Did anyone help you get to see the counsellor, like put your name forward? If so, who?

INTERVIEWER: What did this feel like?

INTERVIEWER: Did you have to wait before seeing [the counsellor]? If so, how long?

INTERVIEWER: What did it feel like waiting?

When you first went to see the counsellor

INTERVIEWER: Can you remember how you felt before your first counselling session with [the counsellor]? (explore reluctance, fears, anxieties etc)

INTERVIEWER: Do you remember what you expected before you first went to see [the counsellor]?

INTERVIEWER: Is there anything you would like to have known about the service before you used it?

INTERVIEWER: What did you hope to get out of the counselling?

INTERVIEWER: What did you think would happen in the counselling?

INTERVIEWER: Have you found that it turned out the same or differently from what you expected?

Evidence of therapeutic change and effectiveness

Helpfulness

INTERVIEWER: Overall, do you think going to see [the counsellor] was helpful?

INTERVIEWER: In what ways was it helpful [as related to nature of victimisation]?

INTERVIEWER: In what ways was it not helpful [as related to nature of victimisation]?

INTERVIEWER: Can you remember anything that happened that made a difference to you?

INTERVIEWER: Can you think of anything about [the counsellor] that you found helpful? – anything about [the counsellor] as a person?

INTERVIEWER: Can you think of anything that [the counsellor] said or did that you found helpful?

INTERVIEWER: Can you give me an example of something that worked well about the counselling? And an example of something that didn't work so well?

INTERVIEWER: Looking back over all your sessions, which one is the one that stands out the most for you? And what was it that made that session the most memorable?

INTERVIEWER: Are there other moments that stand out for you? Why?

Personal Change

INTERVIEWER: Overall, do you feel that you have changed in any way since you went to see [the counsellor]?

INTERVIEWER: Explore further: if change, what do you think may have led to that change?

INTERVIEWER: Can you give me an example of how you have changed?

INTERVIEWER: How might the counselling have made a difference?

INTERVIEWER: If no change, why do you think that is?

INTERVIEWER: Explore how the counselling may have been helpful, but the person or their

situation stays stuck.

INTERVIEWER: And what do you think people who know you very well would say if I asked them, do you think you have changed since going to see the counsellor?

INTERVIEWER: If you think back to how you felt before you started counselling, and tried to give a mark out of 10 to how you felt where 10 is the best you've ever felt and 0 is the worst, what number would you give that feeling?

INTERVIEWER: And what number would you give to how you feel today?

Strengths and weaknesses

INTERVIEWER: What would you say is the best thing about going to counselling?

INTERVIEWER: And what is the worst or hardest thing about it?

INTERVIEWER: If you could start the counselling all over again, what is anything would you do differently?

INTERVIEWER: If you felt you had worries you needed help with, would you go to see a counsellor again? Why

Referrals

INTERVIEWER: What do you think of the way inmates are referred to the service?

INTERVIEWER: Would you change anything about the way referrals happen?

INTERVIEWER: What do you think of the timing when you went to see [the counsellor]? Was it the right time for you?

INTERVIEWER: What helped/did not help with this?

Location

INTERVIEWER: What do you think of the location of the counselling service?

INTERVIEWER: Do you think it was a good/bad location, why?

INTERVIEWER: Was it easy for you to get to and to find?

INTERVIEWER: Would you change anything about the location? If yes, what?

INTERVIEWER: Explore: in visits area, unit or off site as well as where in prison

Room

INTERVIEWER: What do you think of the counselling room?

INTERVIEWER: Is it the right size, is it comfortable, is it private enough?

INTERVIEWER: Is there anything you would change about the room?

Trust

INTERVIEWER: Inmates who have not used the service, have said they would be worried about trusting a counsellor. Do you think they should be?

INTERVIEWER: Do you feel that you could trust [the counsellor] when you talk with her?

INTERVIEWER: Can you say what helps/does not help with this?

INTERVIEWER: Can you think of any ways the service could help to convince others that they can trust a counsellor?

INTERVIEWER: Can I ask if anyone else knew/knows that you are seeing/have seen [the counsellor]? If so, who?

INTERVIEWER: How does it feel to you that they know about this?

Recommendation

INTERVIEWER: Would you recommend the counselling service to another inmate? Why would you/Why would you not?

INTERVIEWER: What would you tell them about the service?

Satisfaction with the Service among the service users

INTERVIEWER: Think of a mark between 0 and 10 for satisfaction with the counselling service, where 0 means totally unhappy with the service and 10 means totally pleased and happy with everything about the service.

INTERVIEWER: What number would you give to the counselling service?

INTERVIEWER: If you could summarise your experience of counselling in one sentence, what would that be?

INTERVIEWER: What would be the best single word, only one word, to describe how you feel about the counselling?

INTERVIEWER: If you were in charge of the counselling service, what would you change about it? Why would you do that?

INTERVIEWER: What would you like to see the counselling service doing more of? Why would you like that?

INTERVIEWER: Do you have any ideas how the service might do what you suggest?

Impact of the Service within the Prison and the Wider Community

INTERVIEWER: Do you think the prison has changed in anyway since the counselling service was available?

INTERVIEWER: If so, how do you think it has changed?

INTERVIEWER: Do you think the prison staff are more aware that sometimes inmates have a prior history of victimisation that they need help with?

INTERVIEWER: Would you mention the victims counselling service to other inmates? Why/Why not?

INTERVIEWER: Do you feel you could explain to someone else what a counsellor does?

INTERVIEWER: What would you say?

INTERVIEWER: How would you describe counselling now?

INTERVIEWER: What would you say it's all about?

INTERVIEWER: What would you say is the counsellor's job?

INTERVIEWER: What do you think counselling can help with? And what do you think it doesn't or can't help with?

Finish

INTERVIEWER: That is all of my questions, is there anything else you would like to say or to ask me about?

INTERVIEWER: Thanks a lot for speaking with me it was really helpful.

Appendix F: Focus Group Questions

1. **Knowledge of service**
   1.1. What do you believe led to the Program being established in the first place?
   1.2. Do you think there was a need for a scheme like this?
   1.3. Was the purpose of the VS Counselling Program clearly explained?
   1.4. How would the Corrective Services NSW describe the main objectives of the Program?
   1.5. Are there any difference between the CSNSW's objectives and what you see as the main objectives of the Program?

2. **Location**
   2.1. What do you think of the location of the counselling service?
   2.2. Do you think it was a good/bad location, why?
   2.3. Was it easy for you to get to and to find?
   2.4. Would you change anything about the location? If yes, what?
   2.5. Explore: in visits area, unit or off site as well as where in prison
   2.6. What do you think of the counselling room?
   2.7. Is it the right size, is it comfortable, is it private enough?
   2.8. Is there anything you would change about the room?

3. **Referrals**
   3.1. Who do you think refers inmates to the VSCP?
   3.2. What do you think are the key factors that encourage a referral?
   3.3. What do you think are the key factors that discourage a referral?
   3.4. Benefits and problems of referring through [professional] staff?
   3.5. Benefits and the problems of inmate self-referral?

4. **Theoretical Orientation**
   4.1. Describe the theoretical orientation your counselling practice under the Approved Counselling Scheme is based on
   4.2. Describe what you understand "victimisation" to be.
   4.3. Describe what you understand to be the cause(s) of "victimisation".
   4.4. Do you believe that inmates would benefit from therapeutic intervention for their history of victimisation? Why?

5. **Diagnosis and its Formulation**
   5.1. What information would you routinely try to obtain over the first few interviews with a new client?
      5.1.1. demographics:
      5.1.2. social history:
      5.1.3. history of abuse:
      5.1.4. general medical history:
      5.1.5. general psychiatric history:
      5.1.6. treatment or counselling received for problems other than victimisation:
      5.1.7. treatment or counselling received for problems other than offending;
      5.1.8. client's perception of problem:
      5.1.9. client's treatment goals:

5.2. What criteria do you apply when assessing the counselling needs of your client?
5.3. Describe the process you use for setting goals for your interventions with clients.
5.4. How do you decide which techniques and strategies you will use with clients?
5.5. How do you decide when and where to refer clients for additional support?
5.6. Where/who do refer clients for additional support?
5.7. If you were unsure about your treatment of a client what would you do?
5.8. Do you think that the Psychometric measures used were suitable?
    5.8.1. Depression Anxiety Stress Scales (DASS)
    5.8.2. Corrections Victoria Treatment Readiness Questionnaire (TRQ))
5.9. What other standardized measures do you think would have been appropriate? Why?

6. **Management of a case and related issues**
    6.1. Please provide specific examples of the techniques and strategies you use when counselling clients. (Examples: Reflective listening, imaginal desensitisation, free association, role playing.)
    6.2. Describe the techniques you understand to constitute Cognitive Behaviour Therapy.
    6.3. To what extent do you consider the counsellor- client relationship important in your counselling practice.
    6.4. Describe how you use the counsellor–client relationship in your counselling practice.
    6.5. Describe the techniques you use in ending counselling with a client.
    6.6. Describe how you go about reviewing the progress of your counselling with clients.
    6.7. In what ways does the work you do with inmates differ from that with clients in the community presenting with similar issues?
    6.8. Do you believe that the experiences of inmates' history of vicitmisation differs from that of your community clients?

7. **Counselling Outcomes**
    7.1. What do you consider to be a successful outcome in your counselling sessions?
    7.2. What factors do you consider contribute to achieving successful outcomes in counselling?
    7.3. What factors do you think hinder the achievement of successful outcomes?
    7.4. Have you noted any changes in the inmates who attended counselling (e.g. emotional, behavioural, interpersonal?)
    7.5. Can you give me an example of any specific changes/impacts you have observed?
    7.6. How would you describe the impact of counselling upon inmates emotional/psychological wellbeing/overall functioning?
    7.7. Did you feel that the counselling achieved purpose/goals?
    7.8. What, if anything, would you change about the VS Counselling Program?

8. **Program Outcomes**
    8.1. What are your Principal psychological concerns (if any) for inmates participating in VSCP?
        8.1.1. (Prompt: emotional, behavioural, self-harm/suicidal ideation, interpersonal/conflict with others?)
    8.2. Perception of inmates' principal motivations for attending counselling?
    8.3. Professional expectations of the counselling scheme?
    8.4. Expectations of inmates & professionals?
    8.5. Have expectations changed? If so, how?
    8.6. Success/effectiveness of the program?
    8.7. What were the barriers to successful implementation

9. **Behavioural Outcomes**
   - 9.1. Have you noted any changes in the inmates who attended counselling (e.g. emotional, behavioural, interpersonal?)
   - 9.2. Can you give me an example of any specific changes/impacts you have observed?
   - 9.3. How would you describe the impact of counselling upon inmates emotional/psychological wellbeing/overall functioning?
   - 9.4. Did you feel that the counselling achieved purpose/goals?
   - 9.5. What, if anything, would you change about the VS Counselling Program?

10. **Staff perspectives re: VSCP**
   - 10.1. What do you believe has been the impact, if any, of the VSCP on prison staff?
   - 10.2. What is your assessment of the efficacy of the VSCP in relation to addressing inmates' prior victimisation?
   - 10.3. In your view what would be the most effective way of addressing this history of victimisation?
   - 10.4. How would you describe the relationship of the VSCP with:
     - 10.4.1. correctional officers
     - 10.4.2. Program staff
     - 10.4.3. Psychology
     - 10.4.4. Justice Health
   - 10.5. How effective do you believe VSCP is in terms of support to inmates on a practical level?
   - 10.6. Do you believe that the service provided by VSCP is well known in the inmate community?
   - 10.7. How do you think VSCP is seen by inmates with a history of victimisation?
     - 10.7.1. Male inmates
     - 10.7.2. Female inmates
   - 10.8. How do you think the program would seen by the general public?
   - 10.9. Did you receive any feedback regarding the counselor?
     - 10.9.1. From Inmates
     - 10.9.2. From Corrections Officers
     - 10.9.3. From Programs staff
     - 10.9.4. From others

11. **Future implementation of VSCP**
   - 11.1. Would you make any changes to the VSCP?
   - 11.2. Are there agencies/services that the VSCP should be in contact with.
   - 11.3. Are there agencies/services that the VSCP should remain independent of.
   - 11.4. What do you believe that the limitations to what the VSCP can do for:
     - 11.4.1. Inmates
     - 11.4.2. Prisons in general
   - 11.5. What do you believe is the future of VSCP in prisons?

12. End
   - 12.1. Thank participants
   - 12.2. Ask if there are any if there are any questions for interviewer
   - 12.3. Advise that the resulting paper will be presented to victims services and corrective services respective commissioners who will decide on the nature of the release for the document.

1. **Theoretical Orientation** This section aims at understanding something of the relationship between theoretical frameworks and applied techniques in counselling practice.
2. **Diagnosis and its Formulation** In this section we would like to understand the diagnostic decision making process of counsellors. We are interested in what counsellors therapeutic decisions are based on and how these relate to the material clients present with.
3. **Management of a case and related issues** This section will provide an overview of the way counselling practice occurs within VSCP. We are interested in exploring the "minutiae" of a counsellor's daily practice and the techniques and strategies they employ in that practice.
4. **Counselling Outcomes** This section aims at developing a picture of counsellors' views regarding counselling outcomes; what they are and how they are achieved.

Appendix G: Participant Information Letter

PARTICIPANT INFORMATION LETTER

PROJECT TITLE: Evaluation of the Counselling in Prisons Trial

PRINCIPAL INVESTIGATOR: Dr Anthony DILLON

STUDENT RESEARCHER: Thomas DORNAN

STUDENT'S DEGREE: Doctor of Philosophy

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

You have been invited to participate because you currenlty work with a client who has participated in counselling with Victims Services NSW. However, you do need to be over 18 years of age to participate in this research.

We would like to interview you so that we can hear, in your own words, how effective you believe counselling to be for that client group. This is important so that we can get a better understanding of the counselling experience from your perspective.

Who is undertaking the project?

This project is being conducted by Thomas Dornan, from Victims Services and will form the basis for the degree of Doctor of Philosophy at Australian Catholic University under the supervision of Dr Anthony Dillon and Professor Lazar Stankov.

Are there any risks associated with participating in this project?

There are no foreseeable risks in participating in the project. A counsellor will be available immediately following the interview if you need to talk to someone about issues that may

come up in discussion. The interview will **not** ask who was in counselling or what may have been disclosed in counselling.

What will I be asked to do?

You will be asked to participate in a **30 minute** focus group with your peers which will be digitally recorded (voice only). The interview will take place at a mutually convenient location based on your availability.

The questions will look at what you know about counselling, how you felt it helped your clients and if there were any major barriers or supports in engaging them in counselling.

What are the benefits of the research project?

This study is intended to improve researchers', academics and practitioners' understanding of the counselling experiences of victims who have been affected by victimisation. We hope that this better understanding will improve counsellor's practices and responses to victims of crime. However, we cannot and do not guarantee or promise that you will receive any benefits from this study.

Can I withdraw from the study?

Participation in this study is completely voluntary. You are not under any obligation to participate. If you agree to participate, you can withdraw from the study at any time without adverse consequences

Will anyone else know the results of the project?

The results of the study will be published in the form of thesis or scientific journal articles. No-one will be identified as a participant in the study and your full rights to privacy and confidentiality will be maintained.

Will I be able to find out the results of the project?

A summary of the findings will be made available at the completion of the project. Please send us an email Thomas_Dornan@agd.nsw.gov.au if you would like to receive a summary of the findings.

Who do I contact if I have questions about the project?

If you have any questions about the study I can contact the Chief researcher or Researcher below

Dr Anthony Dillon Thomas Dornan,

Post Doctoral Fellow

Institute for Positive Psychology and Education,

Australian Catholic University

02 9701 4670 or Anthony.Dillon@acu.edu.au

Manager Strategic Policy and Programs,

Victims Services

(02) 8688 2518 or

thomas_dornan@agd.nsw.gov.au.

What if I have a complaint or any concerns?

The study has been reviewed by the Human Research Ethics Committee at Australian Catholic University Ethics Register Number: 2015-245H. If you have any complaints or concerns about the conduct of the project, you may write to the Manager of the Human Research Ethics Committee care of the Office of the Deputy Vice Chancellor (Research).

Manager, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
North Sydney Campus
PO Box 968
NORTH SYDNEY, NSW 2059
Ph.: 02 9739 2519
Fax: 02 9739 2870
Email: resethics.manager@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?

If you are interested in participating in this research, please let us know by email Thomas_Dornan@agd.nsw.gov.au. We will contact you to arrange a suitable time for the interview.Before we can proceed with an interview, please return the signed and witnessed consent form (see attached). You can return it as an attachment by email to Thomas_Dornan@agd.nsw.gov.au if or post it to:

Thomas Dornan
Victims Services
Locked Bag 5118 PARRAMATTA NSW 2124

Appendix H: Application Form

Application for initial counselling

Victims Services and CSNSW Counselling Trial

Victims Support and Rehabilitation Act 1996 (the Act)

NSW GOVERNMENT Attorney General & Justice

PART 1: Details of counselling applicant

1. Have you already applied for victim's compensation or counselling for this act of violence? No ☐ Yes ☐

2. Full name — Surname/Family _____ Given name _____

3. MIN _____

4. Date of birth — Date / /

5. Gender — Female ☐ Male ☐

6. Correctional Centre _____

7. Early Possible Release Date — Date / /

8. Unsentenced — No ☐ Yes ☐

9. Next court date — Date / /

10. Are you of Aboriginal or Torres Strait Islander origin? *(Optional - for statistical and planning purposes)*
No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐

PART 2: Details of the act(s) of violence for which you are applying for counselling

11. When did the act(s) of violence happen?

a. If a single incident, please indicate the date:

Date / /

b. If incidents were over a period of time, please indicate the start and end dates:

from / / to / /

12. Where did the act(s) of violence happen?

Suburb/town _____ State _____

13. What was the type of act of violence?

Assault ☐ Sexual Assault ☐ Robbery ☐ Home Invasion ☐

Domestic/Family Violence ☐ Other ☐ ▶ *Please specify* _____

14. Was the act of violence reported to the police? No ☐ Yes ☐

15. Describe what happened, clearly stating the nature of the act of violence.
For example *"I was sexually assaulted between 2002 and 2005."*

_____

_____

_____

_____

16. What was your connection to the act of violence? For example, *I was a victim of an act of violence; I was a witness of an act of violence; I am the parent of a deceased victim of an act of violence.)*

_____

_____

_____

17. Type of injury sustained — Physical ☐ Psychological ☐

PART 3: Referrer's details - Corrective Services staff

Staff member's name

Position

Correction Centre Phone No.

Date / /

Note: Corrective Services will be the applicant's representative within this counselling trial. All correspondence from Victims Services about the applicant's Approved Counselling will be sent to Corrective Services.

PART 4: Referrer's details - Legal representative

Name of legal firm/practitioner

Address

Postcode

Phone No. Email

Note: If you complete these details, a copy of all correspondence from us will be sent to your legal representative.

Does this client have an existing counselling claim?

No ☐ Yes ☐ ▶ *What is the claim number?*

PART 5: Applicant's declaration

I hereby apply for counselling provided by Victims Services within the Counselling Trial pursuant to section 21 of the *Victims Support and Rehabilitation Act 1996*.

I am aware that the contents of my counselling session may be used in preparation of a report to Victims Services for the purposes of my subsequent counselling and /or compensation applications.

I am aware that the contents of my counselling session will be confidential and will not be disclosed to staff within CSNSW unless the counsellor has concerns about my current safety including risk of harm to others or myself, or if required by any other laws of the state or commonwealth.

The counsellor may also need to make a report to Community Services Helpline if they become aware that a child is a significant risk of significant harm.

Applicant's signature Date / /

Where to send this form

Application may be emailed to: vscounsellingtrial@agd.nsw.gov.au

or faxed to: (02) 8688 9631

or posted to: The Director
Victims Services
Locked Bag 5118
PARRAMATTA NSW 2124

Appendix I: Mixed-Effect Output

Mixed-Effects REML Regression (Depression)

Depression	Coef[a]	Std.Err.[b]	z	p > z	95% Conf. Interval	
Group						
2	1.2632850	0.4748749	2.66	0	0.3325473	2.194023
3	-16.4929100	0.3593574	-45.9	0	-17.19724	-15.78858
Time						
2	1.2632850	0.4748749	-41.98	0	-20.425	-18.60278
3	-22.6250000	0.4648604	-48.67	0	-23.53611	-21.71389
4	-26.7361100	0.4648604	-57.51	0	-27.64722	-25.825
GroupXTime						
2 2	18.6443200	0.6645193	28.06	0	17.34189	19.94676
2 3	1.0452900	0.6645193	1.57	0.116	-0.257144	2.347724
2 4	1.1853860	0.6645193	1.78	0.074	-0.1170473	2.48782
3 2	16.0623500	0.5028691	31.94	0	15.07675	17.04796
3 3	18.1900100	0.5028691	36.17	0	17.20441	19.17562
3 4	19.7573900	0.5028691	39.29	0	18.77178	20.74299

a = Coefficient. b = Standard Error.

Mixed-Effects REML Regression (Anxiety)

Anxiety	Coef[a]	Std.Err.[b]	z	p > z	95% Conf. Interval	
Group						
2	1.244565	0.4613673	2.7	0.007	0.3403018	2.148829
3	-16.56353	0.3491357	-47.44	0	-17.24783	-15.87924
Time						
2	-20.34722	0.4504605	-47.44	0	-21.23011	-19.46434
3	-23.11111	0.4504605	-51.31	0	-23.994	-22.22822
4	-29.72222	0.4504605	-65.98	0	-30.60511	-28.83934
GroupXTime						
2 2	19.91244	0.6439345	30.92	0	18.65035	21.17453
2 3	0.8937198	0.6439345	1.39	0.165	-0.3683686	2.155808
2 4	4.113527	0.6439345	6.39	0	2.851438	5.375615
3 2	15.9406	0.4872918	32.71	0	14.98553	16.89568
3 3	18.12293	0.4872918	37.19	0	17.16786	19.07801
3 4	22.15012	0.4872918	45.46	0	21.19504	23.10519

a = coefficient. b = Standard Error.

Mixed-Effects REML Regression (Stress)

Stress	Coef[a]	Std.Err.[b]	z	p > z	95% Conf. Interval	
Group						
2	0.8864734	4804811	1.84	0.065	-0.0552522	1.828199
3	-17.12175	0.3635999	-47.09	0	-17.83439	-16.40911
Time						
2	-19.13889	0.4753421	-40.26	0	-20.07054	-18.20724
3	-21.94444	0.4753421	-46.17	0	-22.8761	-21.01279
4	-27.33333	0.4753421	-57.5	0	-28.26499	-26.40168
GroupXTime						
2 2	18.28382	0.6795029	26.91	0	16.95202	19.61562
2 3	1.002415	0.6795029	1.48	0.14	-0.3293857	2.334217
2 4	2.594203	0.6795029	3.82	0	1.262402	3.926004
3 2	16.26891	0.5142078	31.64	0	15.26108	17.27674
3 3	18.18322	0.5142078	35.36	0	17.17539	19.19104
3 4	20.83688	0.5142078	40.52	0	19.82905	21.84471

a = coefficient. b = Standard Error.