Mad and/or Bad? Structural violence and the experiences of forensic mental health patients in NSW

Karen Louise Daniels
c3166533

Thesis submitted in partial fulfilment of the requirements for the Degree of Social Science (Honours) to the School of Humanities and Social Science, Faculty of Education and Arts University of Newcastle, Australia.

June, 2015

STATEMENT OF ORIGINALITY

Student Declaration

I Karen Louise Daniels declare that this thesis entitled 'Mad and/or Bad? Structural violence and the experiences of forensic mental health patients in NSW' contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the School of Humanities and Social Science Thesis Library being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

Signed:

Dated: 11th June, 2015

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

ACKNOWLEDGEMENTS

Firstly, I want to thank my incredible supervisor, Dr Ann Taylor. Thankyou firstly for your undergraduate lectures which inspired me, then, for supervising this project and providing the ultimate academic support. I thank you for your time, knowledge, understanding, strength, and more importantly keeping me motivated with your incredible tolerance throughout the past year.

Secondly, thank you Dr Terry Leahy for your direction with honours coursework. Thank you for the extra time, effort, and interest in my research project.

To the amazing tutors/teachers, Debbi Long (thank you for amazing references and theorists, you nailed it), Tania Searle, Nicky Thompson and Aqua Hastings, you have all made my university journey richer, and allowing me at times to test your patience. Each and every one of you have taught me something different. I thank you for sharing your knowledge and teaching me some amazing skills that will last a lifetime; I show my gratitude to you all.

To my lifelong friends, Tracey Souvleris, Sandi Smith, Lyssa-Maree Taylor, Big Kev and Kim, thank you, your support has been vital I could not have done this without your support. I also need to thank Tracey Scaysbrook, Lisa Daley, Skye Hogan and Rae Brock for making an agreement whilst at TAFE to support each other throughout our university journey; you all kept your end of the deal, but more importantly, your word. Kylie Furey my university friend, what would I do without you? Thank you, for being you.

I thank my mob for standing beside me, your patience and the space needed to commit to this journey; I could not have done this without you.

To Mike's family thank you for loyalty, integrity and most of all for believing in me by sharing your story, which fuelled my path to *re*-education. I will be forever grateful for where your story has already taken me, and where else this journey may take me. More importantly, I will never lose sight of what Mike has endured. As Nelson Mandela (1995: 187) stated:

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

To my four case studies Mike, Farsad, Tarni, may Scott R.I.P and your families, I analysed your stories by way of data, you will not be muted, you will be heard with my voice. I hope that I have done your traumatic experiences justice, and by sharing your stories it brings change for your futures and for all forensic mental health patients.

I would also like to thank the Wollotuka Institute for your support, firstly, the Dean Professor Peter Radoll, Leanne Holt for her mobile number (awaiting for home address), and Robyn and Renee (Gosford getup). Thank you, your support it has not gone unnoticed.

Lastly, I dedicate this thesis to [*my twinny*] Ms Kelly Browne. You begged me not to stop researching for those suffering with a serious mental illness. Then we lost you in May 2014, “That’s the problem with corruption and maladministration- you don’t know how deep it goes” (Singh 2011: 1), on the other hand we do. We use to joke about ‘Have I reminded you lately?’ I just wish you could be here with all of us, your five amazing children, your daughters, Samantha, Brooke, Kate-Lyn, Candace, and son Scott. Now we need to stop these systematic administration and structural failures as they are failing beautiful people, their families and their extended kinship networks. “In the end, we will remember not the words of our enemies, but the silence of our friends”- Martin Luther King Jr.

TABLE OF CONTENTS

ABSTRACT

Forensic mental health patients detained within the New South Wales, Australia prison system are a marginalised sector of society. Issues of disempowerment increase as they progress through the criminal justice and medical systems. People in these prison systems are excluded, ignored and largely voiceless, and the dearth of research in this field is evidence of this. People who are cast into the criminal justice and medical systems and who have a serious mental illness form a unique sociological group. The experiences of forensic patients are hidden from the public gaze and the prison experience has been found to exacerbate mental illness. This exploratory study analyses four case studies to show how system failures impact forensic patients. Policy and legislation are found to have gaps and contradictions between what is written and how it is implemented. These were found to have significant implications for forensic patients' wellbeing. Documents from court cases, coronial inquests, parliamentary investigations, personal correspondence with state departments and official reports were analysed. Analysis uncovered how structures within the system violate forensic patients. Power is held and used within the systems that surround forensic patients in ways that further punish them. It is crucial to understand how these violations are affecting those within the prison systems if violations are to be addressed. This study examines the experiences of people held within the criminal justice and medical systems and how structural and symbolic violations are occurring. This is important for improving services towards reform.

Chapter 1: INTRODUCTION TO THE RESEARCH

Introduction

This thesis is an exploratory study of four individuals diagnosed with varying forms of schizophrenia, who are referred to in this paper as suffering a Serious Mental Illness (SMI). These offenders are called forensic patients and all have been detained within the prison system in New South Wales (NSW) Australia. The NSW prison system is administered by the Department of Corrective Services. Three of the four case studies have been given pseudonyms to protect their identity, the fourth case study has passed away and therefore does not have reviews by the Mental Health Review Tribunal (MHRT); hence his name can be published.

This chapter introduces the study in the broader context of critical sociological research on people in prison who have a SMI. It describes the background to the project and the prolonged circumstances that led to this study being conducted. This thesis represents the end result of a request from a family member which asked for the actual experience of a forensic patient to be heard. Statistics are used to illustrate the prevalence of SMI in NSW prisoners. The relevant literature in the area of this study is outlined and then the term 'forensic patient' is explained.

Background

The researcher was approached in mid-2004 by Mike's family and kinship networks. They asked that she listen to the story of his circumstances, and to delve for further information in the hope that the family may gain some resolution regarding this specific tragedy. A Google search with key terms such as Mike's name, the court cases and the coronial inquests he was involved in revealed the details of his case which are on the

public record. Following this, a search was made under topics including ‘deaths in custody’ and ‘forensic patients’. From there further searches were conducted amongst parliamentary reports and the court documents of other inmates. This formed the initial search. The deeper into the search, the more engrossed the researcher became: the search was physically taking over her living room.

The first major piece of information unearthed was the copy of the parliamentary enquiry called the General Purpose Standing Committee (2005: 16). It was found submerged in the portfolio area ‘Juvenile Justice’ although the two subjects were aged 25 and 27 at the time of the events. The finding was timely as it was taken to Mike’s trial in 2006 for his Supreme Court case. Mike’s kinship network provided it to the victim’s family. This act showed the compassion of Mike’s wider family and kinship networks. The question remains as to why this report, which admitted failure in duty of care on the grounds of negligence, was not taken into account in Mike’s sentencing. Furthermore, why has an external inquiry not been carried out, as Justice Whelan suggested in his sentencing in 2006?

Between 2007 and 2012 much material was collected and collated. No contact was made with Mike’s next of kin and kinship network because the researcher wanted to avoid causing false hope. The researcher enrolled in Technical and Further Education (TAFE) courses, which ultimately led to the university experience which taught the necessary skills for conducting academic research. The intention was to research Mike’s case and also to explore the experiences of forensic patients.

In February 2012, a phone call was made to Mike's next of kin. The researcher was able to inform them that after five years the search was complete. A vast amount of collated data was explained in that call, and then sent to Mike's uncle to be taken to the family barrister. In May 2012, the family's barrister called. He said that the collected data was secure in his office, and that it was a 'winning case'. On the grounds of false imprisonment he would run the case. The next stage was for Mike's next of kin to obtain a Legal Aid solicitor to do the necessary ground work that would not be covered by the barrister. However, Mike was denied a grant of Legal Aid funding (noted in chapter 6).

One search lead to another. Information about the other three case studies surfaced when researching legal documents, and coroners' reports. The information that was being uncovered was unexpected and surprising. Excavating through data of all four case studies unearthed the fact that a leaden silence covered much of the experience of forensic patients. The prison experience is unknown to the majority of citizens and indeed, the vast majority prove myopic to their plight. This research aims to contribute to critical sociological studies of structural and symbolic violence in the actual lived experiences of forensic patients. Structural and symbolic violations harm forensic patients but there seems to be little accountability nor repercussions for the perpetrators of the violence. Speaking from a global platform, Farmer (2003: 28) exclaims that this violence and is taking its toll on all those within the systems affected by these violations.

Statistics

The four case studies examined in this thesis highlight an issue which is of broader concern. Australian Institute of Health and Welfare (2013: ix) state that in excess of

21% of prisoners have been told prior to incarceration they have a mental health disorder, 46% had been diagnosed with a mental health disorder on discharge from prison and 20% of inmates take mental health medications. The 2003 Justice Health report on SMI amongst prisoners within NSW, and a survey in 2001 by Baldry, state that the occurrence of psychiatric disorder in prisoners is 74%, in comparison to 22% of those within the community (Baldry 2009: 7- 8; NSW Community News Network Archive 2005b: 1). When alcohol and other drug disorders were removed from those statistics, 50% of inmates entering prisons, and 30% of sentenced inmates had a SMI (Baldry 2009: 8).

Forensic patients: background and definition

Forensic patients are a marginalised sector of society. Forensic patients are labelled and stereotyped, and because of this they experience stigmatisation, and thus become voiceless. In this thesis I argue that forensic patients' welfare is given limited regard by the policies and legislation formulated around them. Current policy tends to be aimed at keeping forensic patients within the complexities of both the criminal justice and the medical systems. Additionally, policy keeps forensic patients out of sight from society and is geared towards protecting society from what is seen as forensic patients' anti-social behaviour but not treating their psychiatric illnesses. These issues are common in many countries around the world.

In Australia before the 1970s mentally ill individuals were placed into psychiatric hospitals (Ibell 2004: iv). Then in the 1970s, deinstitutionalisation introduced a community focus placing mentally ill individuals within a community setting (Jansman-Hart, Seto, Crocker, Nicholls, and Cote 2011: 326; Ibell 2004: 181). Although, this was done for economic reasons as a cost cutting measure by the Australian Government, it

was said that this community focus was better for those with a SMI (Jansman-Hart et al. 2011: 327). Carroll, Scott, Green, Dalton, Brett, and McVie (2009: 36); Huxter (2013: 739); and Jansman-Hart et al. (2011: 326) discuss how closing psychiatric hospitals within the community resulted in further reinstitutionalisation of the mentally ill because those mentally ill individuals who committed crimes then became subject to the complex criminal justice and medical systems. Notably, the majority of the literature (Huxter 2013: 739; Carroll et al. 2009: 36; Jansman-Hart et al. 2011: 326) shows how, when hospital deinstitutionalisation was implemented, it was envisioned that a community focus for forensic patients would result, however, it did not. In fact, deinstitutionalisation resulted in *re*institutionalisation of forensic patients into prisons.

Literature review: Research into mental health and forensic patients

Literature in the broader field of forensic mental health is diverse. Jansman-Hart et al. (2011) research article focuses on international trends in demands for forensic mental health service and emphasises the lack of research in forensic mental health. In the area of behavioural sciences and law, Olley, Nicholls, and Brink (2009) used a case study to demonstrate challenges that prevent effectual mental health care within the prison system. They spotlight failures and gaps in service delivery. This article has a humanistic underpinning which shows ethical injustices experienced by people with a SMI in prisons. Olley et al. (2009: 811) showed this was because the prison culture is guiding the doctor, not medical ethics. Findings showed there are complications in caring for forensic mental health patients in prisons: for example; incapabilities of staff, legislation affecting prisoners, long waiting lists, as well as the requirement of regular reviews of forensic mental health patient needs. In addition, Olley et al. (2009) further

concentrated on the lack of support services, human rights concerns, and the impacts on prisoners.

Human rights concerns emerge in Huxter's (2013) article which shows human rights concerns and the extent of negative impacts on individuals within corrective services. There are limitations around medical systems and the care of forensic mental health patients and Huxter (2013: 738) shows the need for reform. Psychiatric literature argues that forensic mental health patients should not be in confined settings, yet psychiatrists are subject to system constraints that prevent this. Because a humanistic approach is used, neglect, inhumane treatment and overcrowding emerged in the findings as problems. The highlight in Huxter's article was the variance between those diagnosed in prison with a SMI, and those entering the prison system that have a SMI. Huxter compares Australia to the rest of the world as "an international embarrassment" (2013: 737) because of the criminalisation of mental illness and also the placement of those with a SMI in prisons.

Methods used in the literature vary. Galanek (2013) used ethnographic fieldwork in a United States of America (USA) prison to engage with staff narratives to collect constructivist data. The proposed research will use document analysis because interviews with forensic mental health patients are obstructed by system restraints that relate to ethics and access. The result of this is that forensic mental health patients voices remain muted.

Galanek (2013) used interpretivist and constructivist perspectives to explain how psychiatric knowledge is shaped. Interviews with staff showed that prisoners may

present with symptoms of psychiatric illness in the prison context, but leave prison and not have symptoms of psychiatric illness (Galanek 2013).

Ethnographic research is recommended by Wacquant (2002) who focused specifically on prison ethnographies that seek to uncover the social and cultural processes within the institution, rather than examining institutions. A document analysis was used by Olley et al. (2009) whose research revealed flaws within systems that forensic mental health patients are exposed to. Olley et al. (2009: 815) exposed that the mental health condition of forensic mental health patients is exacerbated whilst detained in a correctional environment. Huxter's (2013: 736) article applied discourse analysis to examine concerns regarding human rights and the amount of adverse impacts on forensic mental health patients in prisons.

A number of different theories are applied through the literature. According to Galanek (2013: 203), illnesses are constructed through social and cultural processes. He uses a number of works by different theorists to support his critical exploration. Theories that Galanek (2013) relied on are: Foucault's (1977) theory about the construction of illness, Foucault's (1989) critique of social control, Goffman's (1961) theory on prison institutions enforcing inmates into social relationships with other inmates, and Wacquant's (2002) theory on how prison ethnographies are the most effective way to examine the social and cultural processes within prison institutions. Comparing Galanek's (2013) research approaches to this research project, a number of differences are evident. This project addresses the topic of marginalisation of forensic mental health patients, comparative to Galanek's topic which addresses the construction of psychiatric disorder by prison medical clinicians. This project uses theories of symbolic and

structural violence to explore how power is used within social structures such as mental health and criminal justice.

There is no literature which directly addresses the area addressed by the proposed project; the possible contradictions between policy and legislation in forensic mental health. Galanek (2013: 211) suggests that forensic mental health patients are treated in a way that sees them go from “mad to bad”. The argument here is that psychiatric diagnoses of prison inmates are not clearly defined, but are contested and influenced by interactions with prison staff. This is supported by Galanek (2013: 201) when he shows that appropriate assessment of whether an inmate has SMI may be linked to maintaining safety and security of the prison, rather than solely to treat a SMI.

Much of the literature covers arguments about gaps in both services and in research. More research is seen to be necessary of forensic mental health and non- forensic mental health systems and ideal organisations when responding to needs of mentally ill offenders who encounter the law (Jansman-Hart et al. 2011: 333). Further lack of services is documented by Olley et al. (2009: 819) but also variances between health systems and prisons systems due to funding budgets. Likewise, Olley et al. (2009: 815) identified that prisons lack therapeutic interventions for forensic mental health patients. Subsequently, researchers and authors have stated that large numbers of patients from the old psychiatric hospital bed system have made trans-migrations to prisons (Huxter 2013: 736). These large old hospitals were the subject of reports that found “rampant squalor, scandals, and frequent inhumane treatment” (Huxter 2013: 736).

Problems associated with deinstitutionalisation form some major arguments put forward by the literature. These include issues which touch on human rights. A 2008 United Nations report mentioned "Australia was not complying with its signatory obligations under the 'Convention against Torture' on many accounts" (Huxter 2013: 736). Disturbingly, this report from the High Commissioner for Human Rights cited that the Australian corrections system "lacked access to adequate primary health care, overcrowding, lack of community supports, poor cultural integration, over-representation of the mentally ill and their subsequent inhumane treatment as inmates within Australian jails and prisons" (Huxter 2013: 736). Human rights are an important issue argued in the literature and this justifies why the proposed research will investigate it further.

Olley et al.'s. (2009: 811) systematic review contributes to the debates around prison reform and ethical and humanitarian injustices in forensic mental health. Olley et al.'s. (2009: 818- 819) article addresses many of the key debates addressed here. These are the lack of mental health services in correctional settings, lack of competency in correctional officers, and the limited amount of confidential interview space and more importantly that correctional settings are not legislated mental health facilities.

Huxter's research is recent and shows that Australian prisoners are "grossly over-represented" (2013: 737) and have turned into "psychiatric institution of last resort" (Huxter 2013: 735). Huxter (2013: 737) added that there are number of individuals who are diagnosed with a SMI prior to incarceration, and those already incarcerated who are deemed to be suffering with a SMI. One possible reason for this may be found in

Galanek's (2013: 211) work which identified that prison staff assist in making assessments of prisoners' behaviours which psychiatrists rely on in their diagnoses.

Literature speaks strongly to the need for reform. Huxter (2013: 736, 737, 739) states that in the last three decades even though the Australian Government funded the Richmond Report (1983) and the Burdekin Report (1993) which found that prison conditions were detrimental for, and exacerbated mental illness, the Australian Government have not acted on this, and have not improved the situation for forensic mental health patients. Literature repeatedly raises the issue of forensic mental health patients being overly medicated within corrective services with no therapeutic intervention. Huxter (2013: 737) cited the Burdekin Report (1993) highlighting "prisoners were frequently denied psychiatric treatment in jail and if they were given treatment it was drug therapy only." The existing research shows considerable evidence that forensic patients should not be held in prisons. None of the literature addresses whether there are contradictions between legislation and policy in the area of forensic mental health.

Galanek (2013) found that large numbers of inmates in the USA meet the criteria of the Diagnostic and Statistical Manual (DSM) for a severe psychiatric disorder, meaning that there is an over-representation of mentally ill in prison. Huxter's (2013: 737) main issue is supported by statistics that show that incarceration is detrimental and exacerbates mental illness. Social customs such as excessive alcohol and drug use are not pathologised and defined as a mental illness by the DSM, whereas they are by forensic psychiatric approaches. Huxter (2013) shows how there are negative legal implications for mentally ill offenders who consume drugs and alcohol at the time of committing a

criminal offence. Olley et al.'s (2009) foremost concern is that in the USA and Australia, policy makers' state that the fundamental well-being of inmates is of no concern to policy makers or citizens. The literature tends to speak from its area of specialisation, however there is no article that reviews any implications for forensic mental health patients regarding contradictions between policy and legislation and draws it altogether.

Forensic patients within prisons or forensic hospitals are faced with a new set of difficulties. They are treated differently to mentally unwell patients in community hospitals. Mentally unwell patients in community hospitals are released as soon as their symptoms have subsided. Mentally unwell inmates in prisons or in forensic hospitals are not released as soon as their symptoms have subsided, but are held indefinitely (Jansman-Hart et al. 2011: 333). Jansman-Hart et al. (2011: 333) went on to explain that once a mentally unwell individual who commits a crime becomes 'forensified' they are subjected to significantly more time either in a hospital or incarcerated than if they were a civil patient in a hospital or convicted of the crime as sentenced as a criminal.

Huxter (2013: 736, 737) describes the over-representation of prisoners with a mental illness, as experiencing inadequate care and inhumane treatment within the USA, United Kingdom and Australia. He further demonstrates that prisoners are regularly denied psychiatric treatment and the only treatment regime of prisons is drug therapy (Huxter 2013: 737).

Other articles use quantitative research to support the argument. Jansman-Hart et al. (2011: 328) claim that forensic mental health patients that face the MHRT had a

collective diagnosis of 53% suffering schizophrenia, trailed by 25% suffering affective disorders, 18% with a substance abuse disorder and 18% with a personality disorder.

The majority of the literature states that hospital deinstitutionalisation was intended to result in a community focus for forensic mental health patients, but actually it resulted in a large scale reinstitutionalisation of forensic mental health patients into prisons. Jansman-Hart et al. (2011: 334) see that forensication of the mental health system is a problem. They propose that moving forensic mental health patients from forensic mental health services to civil psychiatric services, where appropriate, will address the problem of forensication of the mental health system. In contrast to any of the other articles, Jansman-Hart et al. (2011) discussed two ways to reduce or even reverse the forensication of the mental health system. Firstly, reduction of individuals admitted into the forensic mental health system; and secondly, have more individuals discharged from the system (Jansman-Hart et al. 2011: 334).

A leading concern raised by Olley et al. (2009) and Felthous (2009) is that in the USA and Australia, policy highlights how the essential well-being of forensic mental health patients is not a concern to policy makers or citizens. Literature was found to be written from the perspective of its area of specialisation, yet there are no studies that review the experiences of, or the implications for, forensic mental health patients with regards to contradictions between policy and legislation. This study aims to address this issue based on the research question: What are the contradictions between legislation and policy implementation in Criminal Justice and Forensic Mental Health, and the implications of these for prisoners with mental health diagnoses?

This research project focuses specifically on forensic patients within NSW. It aims to contribute to core debates in the critical sociology of understanding mental illness. The project applies the theoretical framework of structural and symbolic violence (Bourgois and Schonberg 2009; Bourgois 2009; Farmer 1999a; Farmer 1999b; Farmer 2003; Farmer 2005; Farmer 2009; Farmer, Nizeye, Stulac and Keshavjee 2006) to show how systems impact forensic patients. It does this by analysing the criminal justice and medical systems within NSW and exploring the use of power within them. The theoretical frameworks of structural and symbolic violence enable better understanding of the complex medical and legal structures surrounding forensic patients detained within the NSW prison system. This project makes a close examination of four case histories within these systems. It highlights how systematic administrative errors impact forensic patients.

A number of key terms are used throughout this paper. Forensic mental health is the term used to describe an area within the Australian criminal justice system that pertains to individuals with a SMI or those who are mentally unwell. A forensic patient is a term used to describe an individual who commits a crime and is found mentally unfit under the Mental Health (Forensic Provisions) Act (NSW Legislation 2012). Mental health is a condition diagnosed by a psychiatrist according to the DSM (Galanek 2013: 197) which is the psychiatric manual used to define mental illness. Criminal Justice is the term used to describe law enforcement systems in many countries. Deinstitutionalisation refers to the NSW Government's cost saving measure to move forensic patients from psychiatric hospitals into the community.

The court documents refer to the four people in the case studies as suffering from schizophrenia. This thesis however will use the term SMI because schizophrenia tends to be a stigmatizing label. People who have been detained as a forensic patient have a SMI and can be classified by four different categories. 1) They are either not guilty by reason of mental illness; 2) are unfit for trial; or 3) are given a limited term under the Mental Health Act. 4) Those individuals sentenced under the Crimes Act who become mentally ill whilst in prison are transferred to a mental health facility, and these individuals are referred to as a forensic patient, although legislation states that they are termed a ‘prison’ or ‘correctional’ patient.

Forensic patients in prison who suffer from a SMI have the same human rights and the same right of access to medical care as those who are not in prison. The next chapter explains how the theoretical approach and research method of this study have been utilised to uncover violations of these rights.

Chapter 2: STRUCTURAL AND SYMBOLIC VIOLENCE AS A THEORETICAL FRAMEWORK FOR ANALYSING THE EXPERIENCES OF FORENSIC MENTAL HEALTH PATIENTS

Introduction

This study applies the social science framework of structural and symbolic violence to the experiences of forensic mental health patients in New South Wales. Paul Farmer (1999a; 1999b; 2003; 2005; 2009; Farmer et al. 2006) and Philippe Bourgois' (2009) theories are used to reveal how structures impact the actual experience of forensic patients when detained within the NSW prison system. The theory is used to highlight the structural causes responsible for constraining the agency of forensic patients. These structural causes progress to structural and symbolic violations. This theoretical framework highlights how structures impact unequally on forensic patients. In this study, the multiple structures including state bodies are shown to govern and limit the choices of forensic patients. The data is the documents that pertain to the four case studies of forensic patients. The data has been analysed using a critical approach to document analysis to show how forensic patients suffer specific forms of invisible violence which are normalised within the prison system.

Symbolic, structural, invisible and normalized violence

The initial concept of symbolic violence was coined by Galtung (1969) in the 1960s and developed by Pierre Bourdieu. Bourdieu (2000) describes how power is used to maintain social order and how this can be played out in violence which is embedded in social systems and acted out in everyday social practices. Pierre Bourdieu (2000) explains the notion of symbolic violence and how it links feelings and practices to social domination. It refers to mechanisms that lead individuals who are subordinated to 'misrecognise' disparity as being the natural order of things, and to blame themselves

for their place in society's hierarchies (Bourdieu 2000; Bourgois and Schonberg 2009: 17).

The purpose of this research is to explore the experiences of forensic patients and the ways in which violations are occurring. Systems are enacted through symbols, and by highlighting the symbols of power used within the structures, the ways in which power is dispersed are uncovered. Forensic patients are caught within complex state systems that reduce their agency and power. Forensic patients are already marginalised by the label SMI. Being labelled as suffering with a SMI is accompanied by the invisible label of non-compliancy (Farmer 1999b: 199). Forensic patients are forced into interactional encounters with state established experts of lawyers, psychiatrist and prison staff (Bourgois and Schonberg 2009: 16; Farmer 2003: 31; Farmer 1999a: 1486) in which power is dispersed through these 'experts'. This reinforces the disempowered positions of forensic patients.

The social practices that impact forensic patients are hidden within institutional systems. They are invisible largely because they are hidden between contradictions of legislation with policies. The structural forces researched here are economic, political, institutional and cultural. Framing the study within Farmer (2003; 2005; 2009) and Bourgois' (2009) theories of structural and symbolic violence is a way of explaining how power is dispersed downwardly within these structures to cause trauma for forensic patients who are at the bottom. Structural and symbolic violence describes the systematic ways whereby the State's social structures disadvantage or harm individuals (Bourgois 2009).

Bourgois (2009) contends that social hierarchies create suffering and inequalities because of symbolic domination. The top down approach that state institutions work with is a hierarchy that dominates forensic patients and leaves them with negligible avenues of agency (Bourgois and Schonberg 2009: 16, 17, 91; Jacob 2001: 296; Smark and Deo 2006: 2; Schubert 2008: 183; Eliasoph 1999: 480; Ife 2010: 30). The use of Bourgois' (2009: 17- 19) theory of symbolic, invisible and normalised violence shows that throughout history, violence has been significant to the administration of power in daily life. The prison officers' relationship with forensic patients is directly one of power over prisoners.

Bourgois (2009: 19) defines the processes of violence as the 'Pandora's Box of Invisible Violence'. He goes on to say that it has three forms. These are Symbolic, Structural and Normalised violence (Bourgois 2009: 19). The dominant exert power over the dominated, consequently creating feelings of unworthiness and exclusion, which impacts the experiences of forensic patients affecting their self-confidence; this is known as symbolic violence. Symbolic violence is exercised upon individuals in a symbolic, rather than a physical way. It may take the form of people being denied resources, treated as inferior or being limited in terms of realistic aspirations (Bourgois 2009). Symbolic violence creates marginalisation and barriers to social mobility, leaving forensic patients unprepared and excluded. This is implemented in ways that see people being treated as inferior and thus making them unable to access resources. This can occur through indirect, obvious, or unconscious barriers. An example of this can be medical and legal language known as academic jargon used by so called experts (Crossley 2005: 318). This is a form of symbolic violence which can give forensic patients the experience of being overwhelmed by this jargon. When elitist jargon is

used, this creates a barrier between forensic patients and the aspiration to succeed. Forensic patients experience overwhelming barriers when subjected to the criminal justice system. “The power of the so-called expert derives from their position” (Crossley 2005: 318). The state has power over forensic patients because the label of SMI subjects them to the authority of individual experts in the criminal justice system.

Structural violence is frequently invisible, unlike physical violence which leaves visible injury or bruising. Staff within these systems enact legitimate forms of violence through their positions of authority. It is this legitimacy that renders structural violence invisible. Structural violence occurs in state systems and may involve staff within medical systems such as Justice Health and Forensic Mental Health Network staff like doctors, nurses, and psychologists. It may also occur in legal systems and involve staff such as, Legal Aid, judges, solicitors, barristers, police, coroners, and the MHRT. Additionally, structural violence may occur in a state prison system with prison staff. The homicide of one inmate against another inmate is a form of violence which is physical. In contrast, the complex factors *leading* to the physical violence are invisible forms of violence because they are embedded within the structure. Thorough examination of forensic patients’ experiences is needed to source these invisible forms of violence and avoidable harms in order to avoid further symbolic and structural violence.

Paul Farmer’s (2003: 31; 2009) concept of structural violence provides a framework for analysing how structures constrain agency to the point where it is impossible for important human needs to be met. Forensic patients are subjected to structural oppositions that deny them their basic human needs and therefore constitute a violation of human rights. Farmer (2009: 12- 13) stated that structural violence is made up of

"historically given processes and forces that conspire to constrain individual agency". This theoretical framing is appropriate for this research because structural and symbolic violence are central to forensic patients' experiences. This is because it examines economic, social, and political inequality and its effects on human agency. Structural violence is an expression of the inequality of power and is typically based on racism, poverty, socio-economic inequality and discrimination (Farmer et al. 2006: 1686). The violence may be either unintended or deliberately hidden, nevertheless it amounts to 'extreme suffering' leaving those marginalised limited to carry the burden of suffering (Farmer et al. 2006: 1686). The fact that physical violence is observable means it frequently diverts from the less obvious forms of fear, coercion and subjectification which are expressions of invisible violence. This research explores the normalised violent practices of the prison system, or as Bourgois (2009: 19) states, institutionalised practices, ideologies, discourses, cultural values, daily interactions, and the routinised bureaucracies that render violence as invisible and produces social indifference. Individuals internalise discrimination and consequently realise their place within the social hierarchy as justified and accept it as the way things are.

The relevance of symbolic and structural violence to the case studies

The experiences of forensic patients detained in prisons are presented in the research data. The data exposed a range of varied experiences showing that forensic patients have been harmed by invisible forms of violence which occur when the institutions do not follow through on reports commissioned to improve policy (Farmer et al. 2006). The forensic patients in the four case studies in this research have, for over the last decade, been subject to symbolic, structural, invisible and normalised violence. According to Farmer (2005: 152; 2003: 152- 153) and Bourgois (2009: 17), oppressive

power structures need to be recognised and condemned as violence which is spread unevenly throughout the world. Bourgois and Schonberg (2009: 17) state that individuals internalise the discrimination they are subject to, and consequently realise their place within the social hierarchy "as deserved and as the 'natural way of things". They add that violence can be symbolic, structural, everyday, and have intimate dimensions which then become legitimised within the social world (Bourgois and Schonberg 2009: 16- 17).

Using homelessness in the USA as an example, Bourgois and Schonberg (2009: 17) say that symbolic violence is a particularly useful theoretical tool since most individuals believe that poverty and drug use is either sinful behaviour or an individual character flaw. This theory therefore can be effectively applied to individuals labelled as forensic patients as they are likewise assessed as having character flaws. Symbolic violence can be defined as a theoretical approach to human suffering, whereby social arrangements place individuals in harm's way and these social arrangements are structurally entrenched in economic and political organisations of the social world. In this study, forensic patients have had missing medical files and prescribed medications incorrectly entered into medical and case file notes. This is an example of how a vulnerable sector of society suffers when everyday violences are hidden within institutional organisations. The hidden violence persists and remains invisible towards the people it affects and impacts, constructing normalisation of the conditions to be viewed as ordinary by those suffering the most harm (Bougois and Schonberg 2009). Structural violence refers to societal arrangements that position populaces and individuals in harm's way. These arrangements are violent for the reason that they are the origin of injury to individuals - in this case forensic patients - "typically, not those accountable for continuing such

disparities" (Farmer et al. 2006: 1686). Forensic psychiatrists are not able to recognise these hidden violences, and even if they did are not trained to change them. Invisible forms of violence are mainly unnoticeable or 'misrecognised' by victims and protagonists, nevertheless power, hierarchies, and suppressed insult are legitimised as deserved and natural (Bourgois 2009: 17, 19).

This research will establish how social structures have emotional impact on forensic mental health patients and the cause of "how social forces get inside the person as it is easy on one hand to fall into the habit of seeing forensic mental health patients as blank sheets on which social pressures stamp their mark" (Connell, Ashenden, Kessler and Dowsett 1982: 76).

This research will try to understand forensic mental health patients' lives as projects rather than pre-set destinies; to understand people as active constructors "of what they have become and are becoming" (Connell et al. 1982: 77). Corrective Services in NSW is a state government department not just merely employees, whom have certain powers over forensic mental health patients (Connell et al. 1982: 138). Therefore, state employees' have significantly more authority, "where the only claim to authority lies in their professional expertise" (Connell et al. 1982: 138). Prison staff are all public servants being state employees (Connell et al. 1982: 206), taking their occupational position for the reason that "they actually thought they could do some good, serving the people continues to be a muted but significant part of what they think they are about" (Connell et al. 1982: 207).

The hospital within the prison and the prison itself are institutions, amongst other effects, a structure with power felt by the patients being able to oppress and intimidate people whilst generating resistance and resentment (Connell et al. 1982: 107). Dependent on circumstances this can progress and develop into patients having severe problems with authority (Connell et al. 1982: 107). The structures of the state have a top down patriarchal hierarchy form of administration whereby, there are specific and limited responsibilities with the staff (Connell et al. 1982: 177). It is not unique to discover state institutions constructing rules into policies "which are incomprehensible to the patients, or even opposed to them" (Connell et al. 1982: 177). Patriarchal structures establish power whereby the authority of state employees is a "major axis of relations among people" (Connell et al. 1982: 178).

Sociological speaking, power is at the crux of structural relationships independent of the will of an individual. Power is described by Dhal (1970) as the ability to influence others. In the case of forensic patients, power is used and abused by staff members working for the state. This dispersal of power is structurally repressive rather than coercive. Prison and medical staff demonstrate a legitimate ability to force others to act in ways that may not be of their choosing. An example of the loss of power experienced by forensic patients is forced sedation medication without adequate justification. This kind of power is hidden and invisible to all except the victim and perpetrator. This loss of power in the daily lives of forensic patients is the basis of this project.

Chapter 3: METHODOLOGY

Introduction

Methodology is the overall research framework and method is the process by which data is obtained. Different methodologies access different aspects of social reality and are affected by the underlying epistemology. The methodology for this project is qualitative documentary analysis used to interpret policy, legislation and practice to uncover how power is dispersed and utilised within systems. This research aims to uncover aspects of the social world and how power is dispersed within this structure. Specifically, this research explores the policies, legislation and the consequences regarding forensic mental health patients, their welfare, taking into account other relevant social entities such as gender, class and ethnicity.

This research project requires a methodology that can analyse the social structures, social practices and individuals' well-being within forensic mental health. The methodology of qualitative analysis within a realist framework is congruent with this research projects' epistemological approach of structural analysis. The method of documentary analysis highlights symbols of power used within the structures; therefore an analysis of these documents uncovers how power is dispersed. Furthermore, the method of document analysis can examine ways in which social practices constitute structures through repetition. Additionally, document analysis can inform the research about legislation in comparison to policy regarding forensic mental health. Consequently, this methodology is effective in uncovering how possible dissonances between legislation and policy may impact on the welfare of forensic mental health patients.

Document analysis via web-based research is used; “interviewing” the documents pertaining to the four forensic mental health patients, to provide the relevant information for the researcher (O’Leary 2014: 250- 251; Bryman 2012: 13). Certain passages were highlighted to identify concepts and colour coding regular occurrences was used to find concepts and make notations (O’Leary 2014: 250- 251).

The documents for analysis are available online, they consist of any records relating to the four patients consisting of court documents, state produced investigations like Hansard reports, parliamentary investigations, coronial inquiries, MHRT, Justice Health and Forensic Mental Health Network, Legal Aid New South Wales, and Corrective Services New South Wales and any policy and procedures to compare to the legislation in NSW namely the, Mental Health Act (2007) NSW, Mental Health (Forensic Provisions) Act 1990, Crimes Act 1900, Crimes (Sentencing Procedure) Act 1999 and 2005. The four case studies combine a documentary analysis of operational policies, legislation, court documents, coronial enquiries, parliamentary investigations and so on (Somekh and Lewin 2005: 37). For this project, forensic mental health patient experiences are explored by excavating documents. In this way knowledge will be produced which spotlights people who are otherwise marginalised.

Qualitative research aims for rich in-depth data which respects and reflects the views of the people being studied (Bryman 2008: 385; Bryman 2012: 425- 428; O’Leary 2014: 250- 251). Qualitative research provides optimal depth of understanding of individuals’ experiences. Statistics on this provide broad generalisations but lack the detailed insight into individuals’ experiences. This research explores the policies and legislation of specific social entities and how they impact the welfare of forensic patients detained

with the prison system. The thesis is an exploratory study of four SMI offenders known as forensic patients that have been held within the prison system in NSW, Australia. This project focuses on four case studies and has analysed a number of documents related to them as a way of exploring how the use and abuse of power is embedded in complex medical and legal structures relevant to forensic patients within the prison system. Case studies have been used with only a small number of hand-picked forensic patients for the reason that this provides depth of understanding (O'Leary 2014: 121, 130). Major themes emerged from the data based on the experiences of these forensic patients.

This project uses a realist ontology that sees the external world as existing independently of perception, in other words, the truth is out there whether it can be seen and understood or not, yet observation of a situation can influence perceptions of reality. This research project uses a realist but not positivist ontology because interpretations of facts change "depending on different truth regimes and are always related to power" (Leahy 2009: 2).

For this sociological research project, an epistemology of post-constructivism is used. An epistemological approach of post-constructivism supports the understanding of human experiences in criminal justice and medical systems. A post-constructivist approach aligns with the theoretical framework of structural and symbolic violence as theorised by Farmer et al. (2006) and Farmer (2003) and Bourgois (2009). The applied epistemological paradigm shapes the research and has substantial impact on the knowledge obtained (Williams 2006: 217). Any epistemological approach represents a particular position, and therefore has limits (Williams 2006: 218). It is not claimed that

the experiences described in the four case studies are universal but that the detailed analysis can lead to a deeper understanding of how symbolic and structural violence operate.

State documents are sources of data like a window into social and institutional realities the documents reveal the underlying social reality which is otherwise invisible (Bryman 2012: 554, 549). The reason the data is being analysed is for evidence of the invisible, structural and symbolic violations that impact forensic patients. Critical realism is appropriate for this research because it is a way to understand the social world of individuals (Bryman 2012: 591). Critical realism is a specific form of realism that recognises the reality of the order of events. Critical realism is an approach based on the notion that we can only understand and change the social world if we identify the structures that lead to those practices (Bhaskar 1989: 2; Bryman 2012: 29). Bryman (2012: 29) states that critical realism implies two things. First, it implies, that, whereas, positivists take the view that the scientist's conceptualisation of reality actually directly reflects that reality, realists argue that the scientists' conceptualisation is simply a way of knowing that reality.

Documentary analysis is a way to explore any contradictions between legislation and policy implementation within criminal justice and medical systems (Mills, Durepos and Wiebe 2010: 4- 5; Diaswati, Barnes and Sampford 2012: 2). Documentary analysis uncovers what the implications are for forensic patients. This research project analyses state documents to explore dissonances between legislation and policy by examining the four case studies and the impacts upon their welfare. The analytical process involved firstly, examination of the legislation in contrast to policies. Secondly, the actions

carried out by staff within the prison system were examined to see whether they conflicted with the legislation and policies. The implications of these experiences for the forensic patients in the case studies were explored. Data was organised into themes and these themes were coded into different categories. These themes were then reduced to the primary themes which were found to be most repetitive through the analysis. The themes that emerged in this thesis are significant to an increased understanding of the field. Analysing the themes provided understanding into what has actually transpired in the experiences of the four case studies.

Limitations

All research needs to acknowledge its bias and limitations (O'Leary 2014: 250). The researcher acknowledges a sympathetic bias towards forensic patients and those diagnosed with a SMI who find themselves in a prison rather than in a hospital. The researcher has no personal connections with the people involved but through abstracted circumstances came to hear of one of the cases. The realisation that the experiences of this one case study were common to many forensic patients in the prison system compelled further research. This thesis is the culmination of that. Sympathy for the forensic patients within the prison system does influence the project but the researcher has maintained a reflexive stance to manage this bias. The small sample size can be viewed as a limitation since the findings cannot be generalised to a wider population (Bryman 2008: 187; Bryman 2012: 99- 100). However, the detailed analysis is hoped to increase understanding which may be transferable to similar situations elsewhere in Australia and similar societies.

Chapter 4: THE FOUR CASE STUDIES

The following four case studies illustrate the way in which the criminal justice system impacts in practice on people with serious mental illnesses.

Tarni

Tarni is an Indigenous woman who committed a robbery and an assault with intent to rob in mid-2001. She was diagnosed with chronic schizophrenia and a mild to moderate developmental disability. Due to Tarni's intellectual disability the Protective Commissioner is her legal guardian. On 24th June 2002 Tarni was sentenced in the District Court, under s.27 of the Mental Health (Criminal Procedure) Act (NSW Supreme Court 2011). Tarni was found unfit to be tried, on the grounds of SMI, and was ordered to be taken to and detained in a hospital. Tarni was a forensic patient within the meaning of the Mental Health Act 1990. On one prior admission, Tarni had absconded from Rozelle Psychiatric Hospital. Police had conveyed her back to Rozelle Psychiatric Hospital and as a consequence of her actions, she was then transferred to Mulawa Prison at Silverwater. At a later date she was transferred and placed in cell 16 of D Ward at the old Long Bay Prison Hospital.

Tarni reported suffering sexual harassment when in protective custody when male prisoners masturbated in front of her. She was subjected to cultural discrimination and suffered anguish. Additionally, she had fears for her own safety after being placed in a male prison in the old Long Bay Prison Hospital. Tarni had protracted and distressing civil legal proceedings with the State of NSW to protest her place of detainment within the prison system. This case was funded by Legal Aid. On the 16th July, 2002 Tarni was

discharged from the old Long Bay Prison Hospital and conveyed to Darlinghurst where she was detained at the Edgar Eager Lodge. The trauma of her experience from the masturbating men at the old Long Bay Prison Hospital resulted in Tarni verbalising threats of self-harm. Tarni's experiences highlight the vulnerability of people with SMI in the prison system.

Farsad

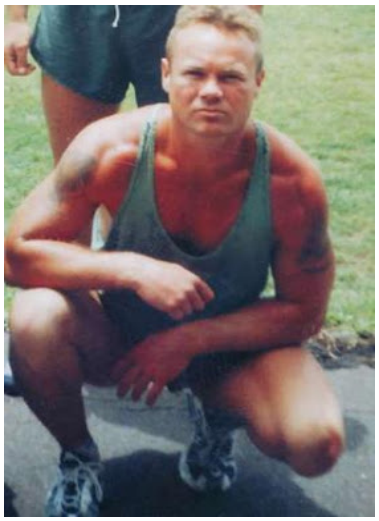
Farsad was born in 1958, and is now an Australian citizen after emigrating from Iran. Farsad was an Iranian translator. In 2002, Farsad intentionally lit a fire at the offices of Community Relations Commission in Ashfield NSW. This fire damaged the premises resulting in the death of a staff member. Farsad was arrested at the scene and held in custody at the old Long Bay Prison Hospital in both C and D wards. In 2004, the NSW Supreme Court found Farsad unfit by reason of SMI and diagnosed with paranoid schizophrenia and he was sentenced under the Mental Health (Forensic Procedure) Act. Farsad was transferred first to the new Long Bay Prison Hospital and then to the new Forensic Hospital at Malabar when it opened in early 2009. It is situated just outside the gates of Long Bay Prison grounds. He remains detained there today.

In January of 2005, Farsad experienced a physical assault by prison officers. This resulted in him being taken to hospital for the injuries inflicted upon him. He had two broken ribs and suffered a permanent back injury. On a second occasion of assault by prison officers and Justice Health staff, Farsad suffered multiple bruises and experienced severe pain for a number of days afterwards.

Farsad’s case contains incidents of being stripped naked and put into solitary confinement for days at a time without toilet paper. Physical assault, cultural

discrimination, sexual abuse, human rights abuses, enforced injections, and torture have been part of his experiences whilst detained in a prison. Farsad had to initiate legal proceedings to access his medical records, and publicise his name. He had to apply to the Supreme Court to try to stop the enforced injections, which have resulted in him now suffering a heart condition (Justice Action 2009: 12), ulcers and diabetes (O'Brien 2013: 11), all as a result of the side effects of anti-psychotic medications.

Scott



(NSW Community News Network Archive 2005a).

Scott Ashley Simpson was educated until Year 9, and spent little time out of custody for more than a decade. Scott had an extensive history of psychiatric hospitalisations and was diagnosed mid-2001with a SMI, as he was suffering with paranoid schizophrenia. He was known as violent, and renowned for making homicidal threats to his cell mates. He had made prior suicide attempts and had experienced delusional beliefs.

Scott was arrested and charged with malicious damage in March 2002, after striking a car windscreen with a baseball bat. Scott spent the night in police cells and the next day was conveyed by police to the Metropolitan Remand Reception Centre within

Silverwater prison. Scott assaulted another inmate in the reception area whilst waiting to be assessed by the Justice Health Nurse. Scott requested to be in protective custody as he had insight that he was a danger to himself and others. The Justice Health Nurse assessed Scott as a 'two out', which means to be detained only with one other inmate in a cell placement. Yet, he was not supposed to be ever placed 'two out' but always be detained '*one out*' after making homicidal threats to cell mates, and because of his violence.

Within minutes of Scott's placement into a cell with Andrew Mark Parfitt, a prisoner in protective custody who was a convicted sex offender, Scott's cell mate was found dead. The next day a forensic psychiatrist made a diagnosis that Scott was not suffering a SMI. As a consequence of this, ten days later he was transferred to the High Risk Management Unit, also known as SupaMax within Goulburn Prison due to the Andrew Parfitt tragedy.

Throughout Scott's incarcerations and hospitalisations he had been detained in Cumberland Psychiatric Hospital at Westmead (NSW Coroners Court 2006: 4), Grafton Prison (NSW Coroners Court 2006: 3), Metropolitan Reception and Remand Centre at Silverwater NSW (NSW Coroners Court 2006: 4), and the Multi-Purpose and High Risk Management Units in Goulburn prison (NSW Coroners Court 2006: 10- 11).

Scott's experience of being incarcerated was of punitive segregation, isolation, and sensory deprivation. These breaches of human rights led Scott to become so unwell that he needed hospitalisation. In March 2004, because he had to appear in court in Sydney, Scott was transferred to the old Long Bay Prison Hospital (area 2) where he endured 10

weeks alone in a cell for up to 22 hours per day. The Supreme Court found Scott not guilty by reason of SMI, for the death of Andrew Parfitt, and was sentenced under s.38 of the Mental Health (Forensic Procedure) Act (NSW Supreme Court 2004).

On 7th June 2004, Scott attended court for the prior malicious damage from March 2002, where those charges were withdrawn, and subsequently Scott was then returned to area 2 of the old Long Bay Prison Hospital. Scott was found dead in his cell within 7 hours. He had committed suicide by hanging himself. He was 37 years of age. Scott only had 3mg of paracetamol in his system at the time of his death. Scott sent his last letter to his mother three weeks before he died, desperate for help, and ended the letter with a scrawled "HELP ME".

Mike

Mike is an Indigenous man who was born in Wollongong in 1976. Mike's indigeneity comes from the maternal side of his family. In 1985, when Mike was nine years old, his parents had separated and his father was incarcerated. Along with his two older sisters, Mike went to live with his paternal grandparents in Tasmania. In 1992 when Mike was 16 years old he become a state ward after being charged with assault in Tasmania. In 1994, when Mike was 18 years old, he either lived with his sister at Bondi, or with his father and stepmother in Lidcombe. Mike's father died on 1st October, 1994. Mike and his partner have a son, who was born in October, 2002.

Mike committed three armed robberies with a dangerous weapon when he was 19 years of age. For these, he was detained at Parklea Prison in segregation. Mike was sentenced unfit to be tried, due to suffering a SMI, namely schizophrenia. Mike was detained at the old Long Bay Prison Hospital as a forensic patient under s.39 of the Mental Health

(Forensic Procedure) Act. Mike was transferred at the request of the MHRT to Kenmore Psychiatric Hospital within six weeks of his transfer at the end of January 2002. Mike had absconded from Kenmore Psychiatric Hospital and committed an armed robbery. Mike was arrested in March, 2002 and returned to the old Long Bay Prison Hospital. From the 31st December 2003, Mike was not medicated due to side effects. Mike had been stating continually for the eighteen months since September 2002 that he was homicidal, showing that he had insight into his illness. He was not prescribed any medication by his treating psychiatrist until 10th April 2004, after the Craig Behr tragedy.

On Wednesday 23rd March 2004, a Justice Health Psychologist informed prison staff that Mike posed not a risk to himself, but a 'high risk to others' and that it was highly likely he would seriously harm someone. Mike was detained '*one out*', to be kept strictly isolated, meaning alone in a cell. For the safety of others he was placed into cell 20 alone at the old Long Bay Prison Hospital.

On Saturday 27th March 2004, Mike was in his cell when two prison officers' placed Craig Behr in with him. Craig was a sentenced inmate who was in protective custody, and had been incarcerated since early October 2001 for aggravated break and enter, and sexual assault, and was due to be released in August 2009. Mike begged the two prison officers not to put Craig into his cell. Mike had a recorded history of being violent, unpredictable, and following through on his words. He stated he was feeling homicidal and that he would hurt any prisoner if he was made to associate with anyone. To this, the prison officers replied "You are full of shit" and shut the door (NSW Supreme Court 2006: 6). Within minutes Craig Behr was on the floor covered in blood with no visible

signs of life. Since the 'Craig Behr tragedy' in 2004, Mike has been continuously detained in segregation. Mike has since spent time in the Multi-Purpose and the High Risk Management Units and the new Long Bay Prison Hospital. Craig's parents Jerry and Janet Behr were informed by prison staff that their son had committed suicide.

In the NSW Supreme Court (2006), Mike pleaded fit to be tried, against the advice of his Senior Counsel (barrister). At the time Mike was detained as a forensic patient at the old Long Bay Prison Hospital. Mike was sentenced under both the Crimes Act and the Crimes (Sentencing Procedure) Act; nevertheless the Supreme Court Judge stated in his sentencing that Mike was to be detained as a 'forensic patient'.

Mike and his family and kinship networks have experienced distressing and protracted interactions with prison officers, Supreme Court, Legal Aid, Justice Health and Forensic Mental Health Network, MHRT, Health Care Complaints Commission, Human Rights and Equal Opportunity Commission, and the Ombudsmen. Mike's next of kin had to resort to getting the police and or senior prison officer's to do welfare checks on Mike at times. On another occasion Mike's next of kin were banned from visiting in 2013 and their extended kinship circle had to email Peter Severin, the new Commissioner of the NSW prison system to get the visits restored. During this time the next of kin could not attend MHRT hearings on the prison grounds.

Mike's experiences whilst detained in the prison system included being forcibly injected with anti-psychotic injections, having medication dosages incorrectly entered into his medical records, being ignored by Welfare after making requests for court transcripts, having missing medical records, continuous segregation, requests for his medical

records ignored, having medication administered into his meals by staff, suffering breaches of human rights that amounted to torture, suffering sexual harassment, being denied the right to change his treating doctor and then being subjected to harassment from the doctor and prison officers, having his cell card altered by prison officers, suffering debilitating side effects from various anti-psychotic medications, having severe restrictions put on the amount of paper work allowed in his cell (Morris 2013: 128- 129), and being denied a radio and or television.

Mike suffered when prison staff lied whilst under oath in the Supreme Court (2006) and a Coronial inquest (NSW Coroners Court 2009), with the Supreme Court Judge stating in Mike's sentencing that "a separate enquiry was needed" (Supreme Court 2006: 12-14). Although the Judge stated that Mike was to be moved in the medium term to Morisset Psychiatric Hospital, none of these recommendations were forthcoming. Mike is eligible to apply for parole in March, 2016 as he was sentenced under the Crimes Act. Because this sentencing has not been followed, Mike has not received rehabilitation and therefore is unlikely to be successful in any applications for parole.

Conclusion

This paper explores both the systems and the actors surrounding forensic patients and their experiences within the NSW prison system. Forensic patients are enmeshed by complex criminal justice and medical systems that will be explored at both macro, systemic levels and at the micro level of everyday lived experience.

Chapter 5: LEGISLATION, POLICY, PRACTICE AND PROCEDURE

Introduction

NSW Legislation outlines the laws that individuals are subject to; however each state within Australia has differing legislation. Policies and procedures must be guided by legislation. Whenever legislation is changed, policies and procedures must be updated. Likewise, when recommendations and reports regarding forensic patients are commissioned by the State, for instance the Royal Commission into Aboriginal Deaths in Custody also known as RCIADIC (1991), Coronial inquests, the Bluglass (1977), the Burdekin (1993), the Nagle (1978) and the Richmond (1983) reports, policies and procedures must also be updated. These reports have produced recommendations based on examples of actual harms to prevent future harms for forensic patients. These recommendations are intended to be implemented into policies and procedures. Forensic patients are legislated to be detained in a gazetted hospital (Australasian Legal Information Institute 2013; Australasian Legal Information Institute 2007a: 57).

NSW has limited secure hospitals since deinstitutionalisation. The claim has been that deinstitutionalisation would instil greater community focus. The NSW prison system has gazetted hospital cells for forensic patients within Long Bay Prison. In addition, there are a number of limited beds in the Metropolitan Special Purposes Centre and the new Long Bay Prison Hospital (NSW Institute of Psychiatry 2013). In 2008, the old Long Bay Prison Hospital was condemned then demolished. The new Long Bay Prison Hospital became operational by mid-2008, again located within the grounds of Long Bay Prison (Australasian Legal Information Institute 2011: 3).

On 24th April in 2008, the Director General of the NSW Department of Health published the government gazette list (NSW Supreme Court 2010: 8), as legislated in accordance under s.109 or schedule 2 no.12 of the Mental Health Act 1990 (Australasian Legal Information Institute 2007a: 57, 110; Australasian Legal Information Institute 2013). The published updated list contains all gazetted hospital cells within NSW specifically the NSW prison system.

In 2008, the new Long Bay Prison Hospital and the Forensic Hospital outside the grounds of Long Bay Prison were gazetted as a declared mental health facility under s.109 of the Mental Health Act 2007 (NSW Civil and Administrative Tribunal 2014: 2; NSW Institute of Psychiatry 2013: 1- 2). All these units are legislated to be managed and run by Justice Health, and Justice Health and Forensic Mental Health Network. Within NSW, only the Metropolitan Special Purposes Centre and the new Long Bay Prison Hospital are gazetted and managed by prison administrators.

Forensic patients are subjected to complex medical and criminal justice systems that each have their own legislation, policies and procedures and regulations within structures established by the State. For the purpose of this thesis, the policies and procedures that will be linked to legislation are from other State departments and within NSW. Forensic patients are subject to legislation, policies and regulations from the MHRT, Justice Health, Justice Health and Forensic Mental Health Network, the NSW Health Department, Legal Aid, Health Care Complaints Commission, the Administrative Appeals Tribunal, Coroners Court, Ombudsmen, and the Anti-Discrimination Board. Firstly the legislation surrounding forensic patients will be detailed.

Conflict with legislation

A forensic patient found unfit to plead, or be tried for an offence under the Mental Health Act or the Mental Health (Forensic Provisions) Act detained within the prison system, must be detained in a gazetted hospital. If a forensic patient is not detained in a gazetted hospital it amounts to false imprisonment. The four case studies have been subject to the effects of policy conflicting with legislation. For example, Mike's detainment in Cell 20 in D Ward of the old Long Bay Prison Hospital, the Multi-Purpose and High Risk Management Units within Goulburn Prison, and Parklea Prison; Tarni's detainment in Mulawa Prison and cell 16 in D Ward of the old Long Bay Prison Hospital (NSW Supreme Court 2010: 6; NSW Court of Appeal 2013: 3); Scott's placement in the Multi-Purpose and High Risk Management Units within Goulburn Prison, Silverwater Prison, Grafton Prison, and in D Ward of the old Long Bay Prison Hospital; and Farsad's detainment in C, and D ward (area 2) in the old Long Bay Prison Hospital (Australasian Legal Information Institute 2008: 4).

Prison administrators argued in Farsad's matter at the Administrative Appeals Tribunal, that old Long Bay Prison Hospital was both a gazetted prison and a hospital, and that is where SMI prisoners are detained (Australasian Legal Information Institute 2008: 4). The MHRT being legislated under the Mental Health Act 2007 NSW for the treatment, detention and care of forensic patients is in contradiction to the published prison policies and procedures that stated that forensic patients are managed conjointly by Department of Corrective Services and MHRT "for continued detention, care and/or treatment" (Corrective Services NSW 2012: 7). The MHRT can apply to the Supreme Court on behalf of forensic patients (NSW MHRT 2004: 48). As shown in the findings of this thesis, The MHRT has claimed not to know that they have semi-judicial powers.

The MHRT has a wide range of powers that enable it to conduct mental health inquiries, make and review orders, and hear some appeals, about the treatment and care of people with a SMI (NSW MHRT 2004: 48).

Forensic psychiatrists are also legislated under both the Mental Health Act and the Mental Health (Forensic Provisions) Act to practice in gazetted hospitals. This sub-act of the legislation allows for all-encompassing treatment, allowing any forensic psychiatrist to prescribe any medication they deem fit, even against the forensic patients' wishes, with no safeguard or defence for the individual's civil and human rights. A notable difference is evident in "the Mental Health Act 1996 (TAS)" which is in contrast to NSW stating that forensic patients cannot be subject to enforced medication by the treating psychiatrists when they think fit (Justice Action 2013: 13). Prison policies and procedures are worded that can see the forensic psychiatrists compliant to their operations within the institutions, although these compromise their autonomous judgements with the healthcare they provide for forensic patients (Pont, Stöver and Wolff 2012: 476).

The MHRT is responsible for regularly reviewing forensic and prison patients who are also prisoners, making recommendations to the Minister for Health on their release or their "continued detention, care and/or treatment" (Department of Corrective Service 2005: 87). All forensic patients, that is prisoners jointly managed by Department of Corrective Services and MHRT, are to be given an appropriate security classification. Prisoners under the management of mental health assessment team are to be classified, with consideration given to any advice from the mental health team (Department of Corrective Service 2005: 119).

Placement in special units for prisoners with intellectual disability should only be made following discussion with the Disability Services Unit. The results of a cultural assessment of an Aboriginal inmate when available may be of assistance in determining suitable placement for that inmate (Department of Corrective Service 2005: 119). All forensic patients, that is prisoners jointly managed by Department of Corrective Services and the MHRT, are to be given an appropriate security classification (Department of Corrective Service 2005: 132).

Policy

The NSW prison 'Inmate Case Management Procedures Manual' states that under the Mental Health Act 1990 in Chapter 5 s.97 and s.98, forensic patients must be transferred to hospitals (Department of Corrective Service 2005: 86; Corrective Services NSW 2000: 27). Further into these same documents, contradictions become evident: the prison policy manual states that female prisoners with an intellectual disability are to be managed at a prison. Male patients in the same category, or with a SMI who can cope in mainstream prison locations, are also to be managed in prison (Department of Corrective Service 2005: 210). Prison policy states that male prisoners with an intellectual disability or SMI are to be provided with appropriate duty of care. When male forensic patients cannot manage in mainstream prisons they are to be placed in separate units, where these vulnerable prisoners receive additional support, instead of being placed in a hospital. Consultation between the case management team, manager, deputy manager, classification & placement and the disability services unit (Department of Corrective Service 2005: 210) must occur first. Prison policy states that before prisoners with intellectual disability are placed in a two out cell, alerts must be checked to ensure prisoners are not put at risk (Department of Corrective Service 2005: 210). Prison policy states that prisoners with an intellectual disability, under no

circumstances, are be placed in a ‘two out’ cell with any another inmate who has alerts on the system in relation to them being a sexual predator (Department of Corrective Service 2005: 210).

Prison policies state that prisoners are categorised as serious violent offenders if they receive a sentence of two years or longer, and have a history of at least two violent offences (Department of Corrective Service 2005: 236). Prison policies and procedures state that prison staff can refer prisoners to the acute crisis management units to provide a short-term crisis intervention (Department of Corrective Service 2005: 246). Prison policy also states that SMI prisoners are ineligible to this unit; SMI prisoners must be referred to Justice Health staff (Department of Corrective Service 2005: 248- 251). SMI prisoners can be placed in this unit but only until a bed is available at the new Long Bay Prison Hospital (Department of Corrective Service 2005: 251). Any prisoner with an acute mental illness who experiences an escalating risk of suicide or self-harm is to be referred to the acute crisis management unit for care under Justice Health and Forensic Mental Health Network (Department of Corrective Service 2005: 251). The NSW prison system operates a mental health hotline twenty four hours a day to assist prison officers manage those individuals experiencing any kind of mental imbalance. Occasionally female prisoners on intensive behaviour management regimes are referred to the male acute management unit (Department of Corrective Service 2005: 251).

Prisoners that are intellectually disabled, aged, frail, sex offenders, and female prisoners are considered for admission only with additional documentation regarding discharge arrangements and their special needs (Department of Corrective Service 2005: 252). Prisoners identified with predatory behaviours are excluded (Department of Corrective

Service 2005: 261). All prisoners on anti-psychotic medication must be on a management plan prior to assessment onto the program (Department of Corrective Service 2005: 277).

Prisoners are managed in the High Risk Management Unit only after prison staff have established that the prisoner cannot be managed safely within the mainstream of the prison. Throughout the reception phase at the High Risk Management Unit, prisoners are placed into segregated custody (Department of Corrective Service 2005: 222). Prison policies state that managing prisoners' behaviour relies on the application of management practices in controlling those behaviours (Department of Corrective Service 2005: 300).

Prison policies (2005: 32) state that under s.23 of the Privacy and Personal Information Protection Act 1999 permission for any inmate's case file notes needed by the police for the purpose of investigating criminal offences include the entire inmate's case file to be provided (Department of Corrective Service 2005: 32).

Legal Aid is available for a wide range of criminal and civil law matters where the applicant is at "special disadvantage". An applicant at special disadvantage is a person who has substantial difficulty in dealing with the legal system by reason of a substantial psychiatric condition, developmental disability, intellectual impairment or a physical disability. Additionally, there are merit tests which are used for all criminal and civil law matters, for example, State matters. In State law matters, Legal Aid considers whether it is reasonable in all circumstances to grant Legal Aid, taking into account, among other criteria, whether the applicant has reasonable prospects of success and

whether providing legal assistance will benefit the applicant. A merit test is applied to: most non-criminal matters (civil, family, care and protection, administrative law and veterans' matters), appeals in criminal matters, Supreme Court bail matters (Legal Aid NSW 2013: 4).

The NSW Government Health (2014: 8) delegations manual, Public Health amendment no. 62 under s.21 of the Health Administration Act 1982 part 5, states that detained forensic patients must be placed in a gazetted hospital or other place than a prison. Forensic patients under the Mental Health (Forensic Provisions) Act s76.d states that patients under the care of Justice Health and Forensic Mental Health Network need to be detained in a gazetted hospital or other place than a prison (NSW Government Health 2014: 8). NSW Government (2014: 1) states that a forensic patient is a person who a court has found unfit to be tried for an offence, and therefore must be detained in a declared mental health facility, prison or other place (NSW Government 2014: 1).

Ministry of Health NSW policy outlines the sedation practices surrounding forensic patients and the circumstances in which sedation may be used on a patient. The Policy Directive states that chemical restraints "should only be used in extreme circumstances when other forms of management of a least restrictive nature have proved unsuccessful" (NSW Health 2007: 17). An injection without consent should be given only in the interest of the immediate physical safety of the patient or those in his or her vicinity (NSW Health 2007: 17). If a forensic patient is in segregation they are clearly not a danger to themselves or others. "Chemical restraint through the overuse of sedation is not an acceptable form of restraint and is not used in NSW" (Ministry of Health NSW 2012: 5). Ministry of Health NSW policy on inpatient psychiatric facilities states that

"restraint should only be applied for the minimum time necessary and its application must take into account the principle of care in the least restrictive manner, safeguarding the vulnerable forensic patients" (2012: 34).

Criminal charges of assault can be laid for breaches of the Policy Directive and should act as deterrent to overmedicating doctors. The problem arises from the difficulty in separating 'sedation' from 'treatment.' Updating is needed on the guiding principles of patient care to reduce the ability of doctors to exert excessive authority over mental health patients.

Conclusion

This chapter has shown significant parts of legislation and policy which bear relevance to forensic patients and especially the case studies used in this study. It is of importance to note that prison policy states that forensic patients are to be managed in prison facilities only with security, whilst Justice Health are legislated with the care for forensic patients in a gazetted hospital which consists of multi-disciplinary teams consisting of forensic psychiatrists, medical professionals, nursing staff and allied health professionals. Forensic patients are subject to the complexities of the medical and legal systems which as shown in this chapter, are convoluted and imprecise.

Chapter 6: STRUCTURAL AND SYMBOLIC VIOLENCE IN THE CASE STUDIES

Introduction

This chapter discusses the forms of structural and symbolic violence that have been found to occur within the NSW prison system, in relation to the four case studies. Different forms of institutional and social failings have had negative consequences for imprisoned forensic patients. Factors in the political and economic world create certain social arrangements, which become entrenched. These social arrangements have been found to impact forensic patients. The cause is structural and it goes further to create symbolic violence, harming forensic patients. This chapter examines various examples of structural violence including power and hierarchy, medicalised abuse, the perversity of prison culture, lack of accountability of prison and medical staff, occlusion of documents, human rights abuses, and torture of forensic patients. There is a causal chain of events whereby structures are found to impact the agency of forensic patients, which is explained in this chapter. This research found that the actual lived world of forensic patients was vastly different to the bureaucratic world constructed for forensic patients from the words of policy and legislation.

The hierarchical social arrangements in the prison system define and contribute to structural violence of forensic patients. These social arrangements are shaped by the political and economic social world outside the prison. The forensic patients also suffer from the wielding of symbolic violence because they are at the bottom of this hierarchy. The categorisation of them as having a SMI and having committed a crime seems to provide social justification for further discrimination. Together these two labels disempower and perpetuate stigma in the forensic patients' social world. This form of

violence becomes internalised by individuals: it becomes the routinised order of things. This is further reinforced by the institutionalised structures within the prison system and the routinised order of things then becomes normalised. Symbolic violence within the prison system is invisible and this makes its effects even more insidious.

Because of the crimes they have committed forensic patients are not a part of mainstream society. Legislative structures further obscure the existence of forensic patients. They are invisible from mainstream society. The dual roles of the prison and medical systems contribute to this due to a contradiction of aims: on one hand to keep the community safe; and on the other hand to consider the rights of inmates and/or patients. Instead of respecting a forensic patient's inalienable human rights as a citizen, these systems are contributing to their isolation and invisibility by way of the power granted to staff within the system structures.

Analysis of the data in this research project reveals that the systems and structures in place for forensic patients actually fail forensic patients on every level. This has been found to be evident in the denial of legal aid, medical misconduct, and attempts to hide and control the actions of state staff members, all of which have negatively impacted forensic patients. The power exerted by staff members operating within the system demonstrates structural and symbolic violence. It renders not only forensic patients invisible, but also their families and kinship networks, dissolving any individual agency or justice.

The false imprisonment of forensic patients

Exploration of court documents showed evidence that state power is responsible for violations committed against forensic patients. The Department of Corrective Services

was found to override other state systems such as the MHRT and Justice Health for the sake of greater funding, authority and power. Document analysis revealed that power was being misused by state employees (prison staff, medical staff and MHRT staff) and this manifested as systematic administration errors. These errors were found to have dire consequences in the lives of forensic patients.

Document analysis of court reports *NSW Supreme Court Criminal Division 2004; NSW Supreme Court 2010; High Court of Australia 2013; and NSW Court of Appeal 2013* revealed that placing forensic patients in gazetted prison cells is against the law. The law states they should be detained in a gazetted hospital cell. Not only is it against the law, it amounts to false imprisonment (NSW Supreme Court 2010: 6). This is an example of institutional failings that have real consequences in the lives of forensic patients. Burtle (2010) describes institutional failings such as these as invisible violence. Farmer (2003: 184, 185) explains how ill-advised public policies create structural violence that leads to symbolic violations. In this case, the violation against forensic patients is one of disempowerment because forensic patients detained in gazetted prison cells, as opposed to being placed in gazetted hospital cells, suffer significant loss of rights. This violation reduces life quality and worsens mental illness.

The case of Tarni exposes a number of these structural and symbolic violations. Tarni was placed in a gazetted prison cell at both Mulawa prison and the old Long Bay Prison Hospital. Tarni suffered as a consequence of this administrative failure resulting in a violation of her dignity and safety. She was forced to watch men masturbating in front of her at the old Long Bay Prison Hospital, which caused her to suffer extreme anxiety and stress (NSW Supreme Court 2010: 10). This resulted in her threatening self-harm.

Tarni was Indigenous, and had an intellectual disability with an intelligence quotient of 70. She also had a severe mental illness. Despite her vulnerabilities, authorities directed her to be detained in ways that contradicted legislation. Her suffering was a result of prison staff ignorance of their own policies. The prison system exerts power over the MHRT (National Association of Practising Psychiatrists 2002: 32). The MHRT is legislated with Tarni's care, detention and treatment. Tarni asked to be moved back to Mulawa prison because she wanted to be back in the women's prison (NSW Supreme Court 2010: 9). The ensuing High Court of Australia (2013) litigation proved that incorrect placing of forensic patients within prison cells is a form of false imprisonment and a gross structural violation of human rights.

There appears to be inconsistency in the way in which cases are considered meritorious to receive Legal Aid funding grants. Legal Aid legislation states there should be regard for individuals and their access to legal representation. This is legislated to be readily available and easily accessible to disadvantaged persons throughout NSW (Australasian Legal Information Institute 2014: 4). In early 2014, Mike was denied a grant of Legal Aid funding, despite his case being identical to Tarni's. Tarni's case was funded by Legal Aid all the way to the High Court of Australia (2013) and won. Legal Aid were reticent to represent Mike because his incorrect placement within a prison cell, according to his barrister, amounted to false imprisonment and court proceedings would reveal this breach. Yet this issue of placement within a gazetted prison cell instead of a legally sanctioned hospital cell allows for further discrimination of prisoners because prison cell placement prevents prisoners from having any voice or rights in court. This form of structural violence contributes to the powerlessness and mutedness of the prisoner, which the legal structure should protect against.

Further evidence of structural violence is found in Scott Simpson's case. Scott's placement in gazetted prison cells denied him the right to medical services, delegated him to punitive segregation, and prevented his mother from visiting. Prison administrators and their staff have been found to ignore legislation and policies pertaining to forensic patients. This appears to occur as a consequence of the way power is dispersed downwards in hierarchies. It is as though staff become dehumanised and institutionalised to the extent that they are desensitised to the consequences of their authority. Farmer (1999a: 1486) attributes this to the "reigning ideologies" of state systems, especially those that favour "efficacy over equity" (1999a: 1486).

Jordan (2011) describes the social world of prison staff noting the staff sees themselves as an unvalued, unappreciated occupational group. The cultural world within prisons affects the staff and the way that they apply policies and procedures. In this way the contradictions between legislation and policy are impacted by social worlds. For example, conforming to occupational cultures was evident, especially bullying. Prison healthcare staffs have a high level of sickness and poor job satisfaction. Staff need more training so the focus remains on the "the care of and contact with inmates in his or her charge so that care and contact remain crucial" (Jordan 2011: 1064).

Deinstitutionalisation has also contributed to structural violence of forensic patients. Farmer's work (2003: 185) supports findings that economic cost cutting and ill-advised public policies create structural violence that leads to symbolic violations of patients. For example, instead of being placed in the community as per the ill-advised public policies, forensic patients are placed in prisons. This subjects them to incorrect placement within the prison system, with no regard for the MHRT. The policies clearly

state that forensic patients within the prison system must be detained in a gazetted hospital cell (NSW Government 2012: 4). This study focuses on four prisoners; each of whom were placed in gazetted prison cells, not hospital cells, at different times and locations throughout their detainment.

Pont et al. (2012: 476) discuss the impact of prison culture in creating negative institutional cultures that prevents the staff from detecting or reporting cases of abuse. Haney (2003: 125- 128) also discusses how prison culture affects staff behaviour. For example, staff place inmates in segregation or SuperMax, which is a maximum security prison within a prison, even though this is a violation of human rights and amounts to torture. Current prison culture creates a problem leading staff to behave in inhumane ways such as isolating and segregating inmates, which causes psychological distress (Haney 2003: 8). The results of this are "psychiatric risks" and "harmful psychological consequences" for inmates, which has deeper implications for forensic mental health patients (Haney 2003: 130).

Forensic patients are the most vulnerable type of prisoner. Mike's case demonstrates the extreme vulnerability of forensic patients. The Commissioner of the NSW prison system admitted failure in duty of care on the grounds of negligence in placing Craig Behr in Mike's cell when he was homicidal. This negligence was not taken into consideration when Mike was sentenced for Craig Behr's death (General Purpose Standing Committee 2005: 16). As a consequence, Mike received a harsher sentence. This demonstrates the utter hopelessness of the prisoner's situation in terms of having a voice for justice. The way that power is dispersed down through the system to oppress and brutalise the forensic patients results in annihilation of their position as an entity. As

Justice Whelan of the NSW Supreme Court (2006: 12) stated in Mikes sentencing, a public or judicial inquiry was needed. This kind of inquiry would use the powers of the Royal Commissions Act or the Special Commissions Act. However no such inquiry has been held.

Forensic patients suffer the harsh conditions of the prison system. Mental illness can emerge from the incarceration experience or exacerbate a pre-existing mental illness and an incorrect placement can further impact inmates (Olley et al. 2009: 815). Prisoners have been found to develop symptoms of pre-existing mental illness from incarceration (Olley et al. 2009: 815). Clearly then, the prison system is no place for an individual with a SMI. It is unclear why legislation is being breached in this way. There is not a single published study of solitary or SuperMax like confinement in which non-voluntary confinement lasting for longer than 10 days, where participants were unable to terminate their isolation at will that failed to result in negative psychological effects. The damaging effects ranged in severity and included such clinically significant symptoms as hypertension, uncontrollable anger, hallucinations, emotional breakdowns, chronic depression, and suicidal thoughts and behaviour (Haney 2003: 132).The implications for forensic patients of this form of structural violence are dire. In the example of Scott, and his placement in protracted segregation, it resulted in his death.

One can only imagine the despair felt by Scott. Scott not only had a SMI, he was segregated. Doctors were denied access to him by prison staff for security reasons, meaning he was not receiving medication for his SMI. According to Farmer's theory of social suffering based on structural violence (1999a), social and economic inequities determine "who will be at risk for assaults and who will be shielded" (1999a: 1486).

The system failed to protect Scott and he committed suicide. Mike has also been in protracted segregation since 2004 in the same units Scott was held, specifically, the Multi-Purpose and High Risk Management Units within Goulburn prison (Berry 2007: 5). Thus, the harm has continued and findings in the coronial inquest into Scott's death have remained unheard. This reinforces structural violence because it reinforces the powerlessness of these inmates.

Power and hierarchy

Power wielded by the state is structured in a top down manner, backed by neoliberal principles. This is evident in the economically justified measures that have seen forensic patients placed in prisons rather than in community psychiatric hospitals.

Professor Bluglass (Justice Action 1997: 27) reports:

> There is no significant comprehensive psychiatric service for mentally abnormal offenders, this gives a very definite impression of a prison dominated culture, rather than the therapeutic environment, which results from policy decisions and legal requirements. The consequence is domination by prison culture which is highly unsatisfactory for a proper forensic evaluation of patients suffering from SMI and a serious inhibition in the ability to provide a proper quality of treatment and rehabilitation.

All four case studies contained common themes of hierarchical power abuse. Tarni's case saw the instigation of court proceedings against the state for her placement in a gazetted prison cell instead of a gazetted hospital cell. Farsad was labelled 'a vexatious litigant' for numerous legal proceedings against the state. In 2013, Mike's kinship networks attempts, by post and email, to have the right to access his medical records from the Director of Justice Health and Forensic Mental Health Network and be heard by the Mental Health Advocacy Service were ignored. Scott was placed in punitive segregation after the Andrew Parfitt tragedy despite his SMI, as was Mike after the Craig Behr tragedy. Both Mike and Scott were homicidal and suffering a SMI and prison staff placed sex offenders with them at two different prison locations. Scott was

segregated for over two years with twenty-three hours per day isolation before committing suicide. The hierarchical system houses structural violations via administrative errors for which no-one is made accountable.

Structural violence experienced by forensic patients also manifests in a denial to have a change of doctors. The right to access medical care was denied when Mike verbally requested to change his psychiatrist. This denial was based on the rhetoric of 'clinical appropriateness'. Mike's extended kinship network lodged a formal request however, the same Assistant Director who denied Mike the right to change his treating doctor, had appointed himself as Mike's new treating psychiatrist. This shows how forensic patients lose their liberty upon imprisonment and are denied the human right to a choice of medical practitioner (Australian Human Rights Commission 2009). Lucas (1999: 11) stated that fragmentation also occurs between health and correctional systems and that "medicine and psychiatry are not easy to practise in institutions which have a primary aim of confinement and control of an often difficult inmate population". Pont et al. (2012: 477) claim that there is a lack of knowledge by prison administrators. They see a need for greater understanding of medical law and ethics and the role of health care professions within prisons, as healthcare professionals in prisons infringe the principles of ethics. This is because of dual loyalty to both prison authorities and forensic mental health patients. This is whereby medical practitioners have dual loyalty conflicts (Pont et al. 2012: 475).

Furthermore, since being deinstitutionalised, forensic mental health has entered the realm of medical and legal systems. Within corrective services the differences in policy between medical and criminal systems have created problems. Medical ethics conflict

"with professional duties to a patient and obligations, express or implied, to the interests of a third party such as an employer, an insurer, or the state" (Pont et al. 2012: 475). Further evidence by Pont et al. (2012: 475) stated that health care workers in prisons should act exclusively as caregivers, and that any medical assessments required by the courts or prosecutors for legal purposes, or security systems, should be carried out by independent medical professionals whom are not involved in the care of the forensic mental health patients.

Bourgois and Schonberg (2009: 18) found that structural power dimensions can go overlooked and remain unrecognised by all people in the system regardless of whether they suffer or benefit. Violations of human dignity cannot remain overlooked merely because they are entrenched in localised prison cultural traditions (Farmer 1999a: 1488). As Goffman (1968) pointed out, the hierarchical structures of prisons hide the way power is illegitimately carried out and blame the victim. Institutions subject prisoners to forms of power and control through segregation, through over-medication that deprives prisoners of their dignity, and through pressure to conform to the norms of these institutions.

Further findings of the study reveal the inherent powers within the medical and prison systems, which allow for collusion of prison and medical staff in decisions to forcibly medicate prisoners. Structural violence was also found upon analysis of various documents that reported medicalised abuse. The downward dispersal of power that exists in institutionalised hierarchies such as the prison system results in structural violence so extreme, that in some cases of excess medicalization, it amounts to torture.

Medicalised abuse

Issues of control and abuse of power were uncovered in the document analysis. Justice Health and Forensic Mental Health Network staff were found to be excessively medicating forensic patients as a form of behaviour control in the prison system. Medication used for behaviour control is a questionable issue. Behaviour that constitutes harm to the prisoner or others is seen as a legitimate reason for control by medication (Ministry of Health NSW 2012: 5). However, medicating as a way to control the forensic patients themselves, purely for reasons of maintaining power constitutes abuse. This abuse is possible because of the collusion between prison and medical staff. Farmer (2003: 9) states that the practice of medicine in prison settings creates great structural violence. He sees that in these situations, medical practice acts against the vulnerable.

'Mental illness' and 'prisoner' are labels that are used to stereotype and stigmatise people, and these labels allow abuse. Forensic patients need to be in a therapeutic hospital environment away from the prison context if they are to have any measure of re-integration into society (Bluglass 1997). The abuse occurs because prison culture and prison staff exist in a context of hierarchical power, which breeds abuse and perpetuates violence.

Hanley and Ross (2013: 341) point out that the current research shows there is a lack of accountability within forensic mental health services in Australia which is supported by Pont et al. (2012: 475) stating that no legal sanctions apply to violators of medical ethics. Consequently, legislation fails to meet the needs of the mentally ill with untreated inmates in corrective services and research supports this (Rogers 2008: 95).

On the basis of the foregoing analysis, it is possible to conclude that the current legislation is failing to meet the basic needs of mentally ill inmates.

There are deviations of acceptable standards of care occurring in prisons. An example of this was revealed when Mike's kinship network contacted the Heath Care Complaints Commission on the 31st March, 2014 over enforced medications. Their complaints pertained to his new treating psychiatrist, also the self-appointed Assistant Director of Justice Health and Forensic Mental Health Network, forcing three ant-psychotic injections on Mike within a 12 hour period on the 19th February, 2014. Mike was routinely given daily tablets for mood disorders. He was also routinely given anti-Parkinson tablets to counter the tremors from fortnightly anti-psychotic injections. On this occasion he refused to take these tablets for reasons of personal health ideology. In response, staff forcibly injected Mike with anti-psychotic medication as if his version of the horror he was experiencing might be a delusion. On this instance, Mike had been locked in segregation prior to the forced injections, yet staff persisted in forcing the medication on him for non-compliance.

Mike had also routinely refused blood tests to monitor his health for similar reasons. This ideological premise for refusing blood tests had been respected, yet the three injections were forcibly administered. This constitutes a violation of Mike's human rights (Gosden 1999: 2- 3). The United Nations (1991; 1993: 989- 1005) states that 'involuntary patients' are denied the right of informed consent to medicalised treatment. This effectively disempowers the forensic patient because they are an 'involuntary patient'.

Ministry of Health NSW (2012: 5) health policy is congruent with human rights in so much that:

> "Chemical restraint" is a term used to describe a pharmacological method used solely to restrict the movement or freedom of a consumer. Chemical restraint through the overuse of sedation is not an acceptable form of restraint and is not used in NSW.

Yet the Ministry of Health NSW (2012: 5) policy goes on to state:

> Medications used as part of a treatment plan to manage a mental disorder or mental illness are not considered chemical restraint. Emergency sedation or rapid tranquillisation that is used to manage disturbed behaviour resulting from a mental disorder or mental illness is not considered chemical restraint in NSW.

Sedative medication can be appropriately used for the management of disturbed behaviour.

This conflict of policy allows such forced medications to exist with very little if any accountability. This conflict in policy demonstrates how structural violence occurs. The Health policy states that chemical restraint is not used, yet that same policy legally *allows* medication of persons with a SMI. This gives staff the green light to go ahead with forced injections of forensic patients. Here, the labelling of people with a mental illness allows violations of human rights. Add to this the label of 'prisoner' and one can clearly see that this minority group suffers extreme infringements of human dignity with no recourse to protection, advocacy or resistance. When prison and medical staff are granted legitimate power over forensic patients, they are found to act in the interests of the institution and their position within it. Symbolic violence occurs when staff use their position of power to benefit themselves and harm prisoners. The wellbeing of the prisoner is subverted to the order of the institution. According to Szasz, "the therapeutic state swallows up everything human on the seemingly rational ground that nothing falls outside the province of health and medicine" (2001: 515). Szasz believes that a solid wall must exist between psychiatry and the State if civilised society is to remain civil (2001: 515).

Forced medications put the Hippocratic Oath into question (Australian Medical Association NSW 2004: 1). It can be clearly seen that the Code of Ethics (Royal Australian and New Zealand College of Psychiatrists 2010: 4) is open to interpretation.

> Psychiatrists shall respect patients' culture, ethnicity, language and religion. Psychiatrists shall be especially mindful of respect for autonomy given their statutory role in treating a proportion of their patients involuntarily. Psychiatrists shall endeavour to relieve the suffering of those whose autonomy is impaired through loss of capacity from mental illness. When a patient's autonomy is impaired compulsory intervention and treatment may be justified, especially where there is risk of self-harm or risk to others. The purpose of such intervention is ultimately to promote patients' welfare and autonomy.

And:

> Psychiatrists shall ensure that each patient's consent for treatment is provided without coercion. A failure to dissent is not equivalent to consent (Royal Australian and New Zealand College of Psychiatrists 2010: 5, 10).

Forensic patients do not have the same protection as people who are not prisoners. Forensic patients do not have the same rights as people without a mental illness. Therefore, being imprisoned and having a diagnosed with a SMI renders a person vulnerable to barbaric violations, and an existence of powerlessness, and voicelessness, with no human rights whatsoever.

De-sensitisation of prisoners

Further evidence of power abuse and injustice was found in the case of Farsad. Farsad was physically assaulted on two occasions by Corrective Service officers. On one occasion, Farsad suffered two broken ribs and a permanent back injury, whilst being forcibly medicated (Justice Action 2009: 11, 12). On the second occasion he was assaulted and he was denied access to medical treatment. On yet another occasion, Farsad was not given toilet paper for a number of days (Justice Action 2009: 12). This amounts to symbolic violation enacted by the staff and represents an abuse of institutional power.

In May 2012, the MHRT was emailed and posted two identical letters from two people within Mike's kinship network, asking why Mike was detained in the Multi-Purpose Unit within Goulburn prison. These identical letters were based on legislation and policies and procedures. Providing clear evidence of the hierarchical abuse of power Mike was subject to. The response from the forensic team leader at the MHRT the next day stated the court sentenced Mike under the Crimes Act for a determined term of imprisonment, and that it is the responsibility of Commissioner of the prison not the MHRT to review Mike's placement. This is in fact incorrect, nonetheless the emailed and mailed submissions have been placed on Tribunals files for future panels and they review his care and treatment. To merely file away Mike's kinship network's correspondence in the MHRT file, is a serious failure in duty of care, particularly given that the tribunal has a highly qualified Queens Counsel (barrister) on their committee to deal with issues of this nature. This disempowers and further marginalises forensic patients by this abuse of power by the Tribunal, which is legislated with the care, detention and treatment of forensic patients and as such represents symbolic violence.

Human Rights and abuse, torture, segregation

Human rights are universal and do not exclude forensic patients (Ife 2010: 96- 97). The findings of this research are that the NSW prison system policies violate the human rights of forensic patients, in particular with regard to their healthcare, education and torture. Evidence indicates that isolating mentally ill persons exacerbates symptoms and increases their risk of harm (Australian Human Rights Commission 2009; Mullen 2008). They require human contact and interaction to improve their mental health (NSW Government 2008: 3). Forensic patients have the right to access education within the prison system; however, Farsad faced a four year court battle for the right to education. This is a clear breach of human rights (Justice Action 2012; Fletcher 2012).

Having to fight in a court over the right to an education demonstrates how marginalised forensic patients are and is a form of symbolic violence.

Farsad described his position as such:

> I am a patient with patients' rights, an inmate with inmates' rights and a human being with human rights. These rights have been fundamentally and severely violated by unprofessional and sadistic state government employees in the positions of psychiatrists, psychiatric nurses and prison officers. They are required to go by the law, regulations, policy and procedures, codes of conduct practice and ethics, but they don't (Justice Action 2014: 1).

When a prisoner is segregated, they are placed in a solitary cell and subjected to extensive periods of isolation, and sensory deprivation. Inmates are allowed out of their cells for one hour per day; visits are one hour per week (Australian Human Rights Commission 2009; NSW Council of Civil Liberties 2006). Evidence states that segregation is inhumane (Lucas 1999: 8; NSW Community News Network 2005a) Scott's death is a prime example of the harm that placement in one of these desensitising units can cause.

Another right that is commonly violated with forensic patients is their human right to be free from torture as shown in the Universal Declaration of Human Rights adopted in 1948. This violation occurs with the isolation of forensic patients in corrections. Segregation is a serious violation of human rights, which amounts to torture (Universal Declaration of Human Rights, 1948). Systematic failures by prison staff to address human rights were found to be evident in Mike's case. Mike was put into solitary segregation after the Craig Behr tragedy in 2004. Dr Lewin the prison system's own forensic psychiatrist, criticised such treatment of forensic patients in isolation. He stated "solitary confinement is not a medical treatment…there is no circumstance in which it is appropriate in the care of a mentally ill person…" (Australian Human Rights Commission 2009). Scott's case has already shown how prolonged segregation affects

the mental health of prisoners. Scott committed suicide as a direct result of segregation, being segregated for 2 years and 2 months before his suicide. Mike was put into isolation in 2004. He remains there to this day.

The structural and symbolic violence in the prison system is so entrenched it appears normalised to the staff working within. Although instances of compassionate and ethical objectivity exist, the medical staff were also found to be constrained by the embedded oppressions within the prison institution. Prison psychiatrist Dr Lewin expressed alarm at the treatment of Scott Simpson when he was handcuffed during his consultation with the doctor (NSW Coroners Court 2006: 11).

> Dr Lewin stated in evidence that he was so concerned about being unable to get Simpson into hospital that he threatened to call the Minister. He described his exasperation in these terms: I have never had a higher index of concern about a patient. I felt powerless because it was absolutely apparent that he needed to be cared for in hospital and this was not happening (NSW Coroners Court 2006: 11).

Although Dr Lewin voiced his concern, the psychiatrist did not take action to ensure the wellbeing of Scott. It would seem that the powerful and imposing prison institution demanded compliance. Dr Lewin placed his allegiance to the institution ahead of his 'duty of care' to Scott. In this case, the structures of the institution were so powerful that Dr Lewin's medical ethics were conflicted.

Occlusion

Further evidence of structural violence is uncovered through occlusion of information by people with enough power in the legal or prison structures to have protection for their misdemeanours. Documents that are purported to represent truth and stand as testimony for the moral order of prisoners and society were found to have been partially reported. Others were found to be selectively reported. Additionally, there is evidence

of incomplete medical records, occlusion through lack of transparency, and cover-ups. These amount to forms of structural violence against forensic patients.

In Mike's case, the NSW Supreme Court (2006) and Coronial Inquest (NSW Coroners Court 2009) had requested Mike's medical and corrections case files from Department of Corrective Services and Justice Health under subpoena. Court examination of these documents revealed that they had been whited out (NSW Coroners Court 2009: 30; NSW Supreme Court 2006: 13- 14). It was also found that his medical records were partially missing. It is a criminal offence to alter or 'white out' a cell card and represents both structural and symbolic violence resulting in prisoners being further punished. In Mike's case, the erasure of the whiteboard notification after the Craig Behr tragedy, regarding Mike's cell placement to be '*one out'* due to his homicidal urges. Half of Mike's medical records were not supplied to the coronial inquest after Craig Behr's death. These subpoenaed medical reports would have showed that Mike was not on his anti-psychotic medication at the time of the tragedy (NSW Supreme Court 2006: 7- 8; General Purpose Standing Committee 2005: 18). There was also occlusion of evidence through selective reporting. This contributes to a scenario where staff were wielding symbolic violence within the muffled walls of the prison system, and colluding with each other to cover up their corruption.

Conclusion

This chapter has shown how imprisoned forensic patients suffer from structural and symbolic violence within the prison system. Different forms of institutional and social failings have been shown to negatively impact forensic patients whilst imprisoned. Factors in the political and economic world have been shown to create certain social arrangements, which become entrenched in the prison system with harmful

consequences for forensic patients. Findings show that the causes of these damaging impacts are structural and that these structural causes go on to create symbolic violence, which is detrimental to forensic patients. Document analysis of the data revealed considerable evidence of structural and symbolic violence emerging in the way forensic patients are gazetted, the way that power is dispersed downwards through the prison hierarchy. This results in violations of human rights that amount to torture, incorrect detainment, occlusion of information, medicalised abuse, and a lack of accountability on the part of prison and medical staff, all manifestations of corrupt conduct. Perhaps the most significant finding from the data is the muting of forensic patients' voices. This research exposes a world where there is a total blanketing of the rights of forensic patient rights and an arrestation of agency. The findings of this research project uncover contradictions between legislation and policy and the subjective interpretation of their implementation by medical and prison staff. This interpretation has been shown to be heavily influenced by power within the system. Forensic patients suffer from the weight of this power hierarchy and this project has attempted to reveal the impacts of these consequences.

Chapter 7: CONCLUSION

Introduction

This research project has analysed a number of documents including court proceedings, government reports, parliamentary investigations, personal correspondence, and coronial inquests. These documents revealed the experiences of forensic patients detained within NSW Australia prisons. The results show how structural violence creates symbolic and material violations within medical and criminal justice systems. These violations have been found to impact forensic patients negatively, even to the point where mental illness may be exacerbated. Forensic patients are detained in prison to protect society. Detainment is the punishment; however, this exploratory study has revealed how the prison system houses structural and symbolic violence and how this further punishes forensic patients. Structural and symbolic violence are invisible and normalised within the NSW prison system. Imprisonment is designed to penalise individuals for crimes they have committed, not to subject prisoners to further punishment. This study has explored the numerous ways that violence is normalised within the prison system.

Power is utilised in the hierarchy of the prison system in ways that violate forensic patients. Evidence in this study shows that prison staff use physical violence for behaviour management and this can be described as cruelty. Staff cruelty has been raised in royal commissions and in court but there is no accountability and no charges are brought against staff. The people who hold authority in the hierarchy of the prison system were found to use their expertise to manoeuvre technical jargon to the point that abuse of power occurred. Abuse of power in the system was so normalised that prison

culture is shown to be a social perversity; an inversion of social norms. Disregard for normal social boundaries of respect and justice are everyday practices. Acts of coercion, intimidation and bullying are normalised within the prison system. Coercive practices occur between the hierarchies of prison staff, and also between prison staff and forensic patients. The hierarchical structure of the prison system generates power abuse within it, but is also an institution that houses structural violence where symbolic violence reinforces the powerless position of the forensic patient. The violence of the structure does more than control behaviour; it impacts forensic patients physically, mentally and emotionally.

Medicalised abuse is one form of structural violence. Structural violence has been uncovered in the way that non-compliance is handled by the use of the word 'treatment' in enforced injections, however; the word non-compliance prevents future release. Enforced medication has been shown to be an expression of discrimination against prisoners who have mental illness. Medicalised abuse is allowed through the collusion of prison staff and medical teams which allow it to be hidden, even though it is unethical for treating doctors not to speak up about mistreatment of forensic patients.

Segregation is known to be an inhumane treatment that constitutes torture and thus a human rights abuse. Treatment of forensic patients in the prison institution is punitive. There is no equality in the system for forensic patients. The label of mental illness becomes a symbolic violation that causes more inequality. This adds to the dehumanisation of prisoners with mental illness in the prison system. The prison system restricts forensic patients' autonomy. The only way for them to have agency within the

system is through legal action, yet they are muted, disabled and further punished when this direction is taken.

Forensic mental health patients are stigmatised because they have a mental illness and this is used as a reason to deny them from accessing education. This disengagement with education prevents them from the necessary rehabilitation for their release, resulting in longer imprisonment. Denial of education takes prisoners' power for their own rehabilitation and thus limits their opportunity for release. Self-determination of forensic prisoners is further limited by labelling. This stigmatising label shapes the attitudes of prison staff towards forensic mental health patients such that they are seen as incapable of decision-making.

Occlusion of information is occurring in NSW prisons as a form of structural violence. This violence occurs through partial evidence supplied upon subpoena, incomplete and altered medical records, lack of transparency, missing medical records and reports, and selective reporting. This impacts on forensic patients by limiting their right to access information and creating unjust and incorrect judgements and outcomes.

Contradictions between legislation and policy implementation impact on forensic patients by muting them. The system for forensic patients is a failing system because reform is not being implemented effectively. Lack of staff training, and replication of prison culture that is based on dated ideologies are preventing positive change. Structural violence occurs when the legislation is either misinterpreted by policymakers when writing the policies or when the staff who are implementing the policies are allowed too much room for loose interpretation. Because forensic patients are

essentially voiceless, there is no room for policy feedback from those who are impacted most by it. The mutedness of prisoners creates a situation where the system allows legitimised lack of accountability by staff. Contradictions between policy and the actual implementation of these policies is providing for system to fail forensic patients. The violations against forensic patients are where the state abuses its power**,** resulting in harms to forensic patients.

Prison staff follow policies and procedures yet they conflict with the legislation creating structural and symbolic violence. The people who write the legislation hold enormous structural legal power yet may have little understanding of the actual experiences of prisoners. The people who interpret the law into policy may have scarce understanding of forensic patients' needs. Prison and medical system staff have authoritative voices that protect their positions within the system. In contrast, forensic patients are rendered mute and this voicelessness prevents them from achieving any kind of justice. This exploratory study has shown how structural and symbolic violence affects every aspect of life quality for forensic patients and that their experiences are hidden.

Limitations

This exploratory study has certain limitations. No participant observations or interactive interviews were conducted. Only four case studies were analysed although this provided sufficient data for a study of this size. A larger study could provide analysis of a greater number of case studies and would potentially uncover more evidence of a similar nature.

Further research and future directions

In NSW prison systems there is very good identification and articulation of problems but very poor implementation to effect reform. Examples of this are the Nagle, Richmond, Bluglass, and Burdekin reports, the RCIADIC, and coronial inquests. There is a lack of political will to follow through with such reports and recommendations. One of the most unexpected findings of this research project was the lack of progress in reform of the prison system. There have been numerous reports and recommendations over the last 50 years pertaining to mental health and prisons in NSW. These reports repeatedly found a lack of staff accountability within these systems. This simply does not get addressed. Until staff are made accountable for the effects of their actions on prisoners, this cycle will not change.

Regarding medical certification of mental illness in prisoners, it would be better for a third psychiatrist be called in when there is conflicting assessments between two doctors. This would prevent incorrect diagnosis determining the placement of prisoners. Greater accountability of doctors is needed regarding the use of medications, especially the reporting of side effects experienced by forensic patients.

It is important to acknowledge that individuals who face reviews and have been sentenced under the Crimes Act and/or the Mental Health Act are legislated under the care, detention and treatment of the MHRT, not the Department of Corrective Services. This is important because currently individuals with mental illness are being falsely imprisoned. This constitutes a breach of legislation. These prisoners must be detained in a gazetted hospital cell as per the current legislation.

An enquiry needs to address all deaths in custody, placement of forensic patients, and prison and medical staff brutality. Systematic administrative errors need to be addressed to ensure that the current illegal practice of placing forensic patients into gazetted prison cells ceases. Forensic patients need to be correctly placed in gazetted hospitals as per NSW legislation.

Conclusion

Structural and symbolic violence have been found to be a normalised part of the prison system. These forms of violence are so deeply embedded in legal and medical institutions that the expressions of such violence are invisible to those who are not subject to their effects. Violence that would be considered barbaric outside of the prison system is hidden behind the prison institutions' walls. Prison culture was found to be constructed around hierarchical power abuse. Because there is a lack of accountability of prison and medical staff, the abuse of power does not change. The forensic patients are branded with a double label: having a mental illness and being a criminal. This labelling further disempowers and stigmatises forensic patients. This deprives these prisoners of any personal agency. The failings of the criminal justice and medical system directly impact on the welfare of forensic patients and their kinship networks. These system failures are a consequence of lack of adherence to legislation, policies and procedures. In some cases this has resulted in deaths. Lack of staff accountability leads to further punishment of prisoners.

Overall, this study confirms that there is a generalised obfuscation of real life experiences of forensic patients in the prison system, and that this occurs between legislation, policy and the implementation of policies. Conclusively, forensic patients suffer stonewalling from every State system that they come into contact with, resulting

in muting. This sociological study highlights the need for forensic patients to have their voice heard.

ACRONYMS

CCTV	Closed Circuit Television
DSM	Diagnostic and Statistical Manual
ICAC	Independent Commission Against Corruption
IT	Information Technology
MHRT	Mental Health Review Tribunal
NSW	New South Wales
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SMI	Serious Mental Illness
SORC	Serious Offenders Review Council
TAFE	Technical and Further Education
USA	United States of America

REFERENCES

Australasian Legal Information Institute (1991) *Royal Commission into Aboriginal Deaths in Custody* [Accessed on: 19th April, 2015] Available at: <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/>

Australasian Legal Information Institute (2002) *Public Sector Management Act 1988 no 75* [Accessed on: 6th March, 2015] Available at: <http://www.austlii.edu.au/au/legis/nsw/repealed_act/psma1988235/s75.html>

Australasian Legal Information Institute (2007a) *Mental Health Act 2007 No 8* [Accessed on: 6th March, 2015] Available at: <http://www5.austlii.edu.au/au/legis/nsw/num_act/Mental Health Act2007n8155.pdf>

Australasian Legal Information Institute (2007b) *Mental Health (Forensic Provisions) Act 1990* [Accessed on: 22nd April, 2015] Available at: <http://www.austlii.edu.au/au/legis/nsw/consol_act/Mental Health Act2007128/>

Australasian Legal Information Institute (2008) *Administrative Decisions Tribunal Appeal Panel of NSW: Commissioner of Corrective Services v Dezfouli [2008] NSWADTAP 85* [Accessed on: 22nd April, 2015] Available at: <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/nsw/NSWADTAP/2008/85.html?stem=0&synonyms=0&query=Dezfouli%20NSWADTAP%2085>

Australasian Legal Information Institute (2011) *Administrative Decisions Tribunal of NSW: Dezfouli v Corrective Services NSWADT 11* [Accessed on: 22nd April, 2015] Available at: <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/nsw/NSWADT/2011/11.html?stem=0&synonyms=0&query=Dezfouli>

Australasian Legal Information Institute (2013) *Mental Health (Forensic Provisions) Act 1990* [Accessed on: 22nd March, 2015] Available at: <http://www.austlii.edu.au/au/legis/nsw/consol_act/mhpa1990355/s41.html>

Australasian Legal Information Institute (2014) *Legal Aid Commission Act 1979* [Accessed on: 6th March, 2015] Available at: <http://www.austlii.edu.au/au/legis/nsw/consol_act/laca1979183/>

Australian Human Rights Commission (2009) *In the Coroner's Court of NSW Inquest into the Death of Scott Simpson File No. 988/04*: Written Submissions of the Human Rights and Equal Opportunity Commission [Accessed on: 11th May, 2015] Available at: <https://www.humanrights.gov.au/inquest-death-scott-simpson>

Australian Institute of Health and Welfare (2013) the health of Australia's prisoners 2012. Canberra: AIHW. 1- 195. [Accessed on: 9th June, 2015] Available at: <http://www.aihw.gov.au/publication-detail/?id=60129543948>

Australian Medical Association NSW (2004) *By-Laws and Constitution: Code of Ethics* [Accessed on: 16th May, 2015] Available at: <http://amansw.com.au/about/ama-nsw-by-laws-and-constitution/>

Baldry, E (2009) 'Australian Prisons: A Booming Industry'. *Debate*. 4: 31- 34.

Berry, C (2007) Control at what cost? *The psychological impact of incarceration in the Supermax. Seminar Paper presented to the Australian Institute of Criminology. Supermax - Past and Present*. Public Interest Advocacy Centre Ltd. 1- 8 [Accessed on: 1st May, 2015] Available at: <http://www.piac.asn.au/sites/default/files/publications/extras/07.10.24-PIAC-Supermax.pdf>

Bhaskar, R (1975) *A Realist Theory of Science*. Leeds Books. Leeds: United Kingdom.

Bluglass, R (1997) *Review of Forensic Mental Health Services NSW.* NSW Corrections Health Service. Matraville, N.S.W.

Bourdieu, P (2000) Pascalian Mediations. Translated by Richard Nice. *Stanford University Press*. Stanford: California.

Bourgois, P (2009) Recognizing Invisible Violence: a thirty year Ethnographic Retrospective. In Barbara Rylko-Bauer, Linda Whiteford, and Paul Farmer, eds (2009) *Global Health in Times of Violence.* Santa Fe, NM: School of Advanced Research Press. 18- 40.

Bourgois, P and Schonberg, J (2009) *Righteous Dopefiend*. University of California Press. Berkeley and Los Angeles, California: USA.

Bryman, A (2008) *Social Research Methods*, 3rd ed. Oxford University Press. New York: USA.

Bryman, A (2012) *Social Research Methods*. 4th ed. Oxford University Press. New York: USA.

Burdekin, B (1993) *National Inquiry into the Human Rights of People with Mental Illness: Launch of Report.* Australian Government Publishing Service Commission: Canberra.

Burtle, A (2010) *Structural Violence: Inequality and the harm it causes* [Accessed on: 12th May, 2015] Available at: <http://www.structuralviolence.org/structural-violence/>

Carroll, A., Scott, R., Green, B., Dalton, T., Brett, A and McVie, N (2009) Forensic Mental Health orders: Orders without Borders. *Australian psychiatry*. 17(1): 34-37.

Connell, R.W., Ashenden, D. J., Kessler, S and Dowsett, G. W (1982) *Making the Difference; schools, families and social division*. Allen and Unwin. Sydney: Australia.

Corrective Service NSW (2000) *Inmate Classification and Case Management Procedures Manual 1979* [Accessed on: 6th March, 2015] Available at: <http://csa.intersearch.com.au/csajspui/handle/10627/601>

Corrective Service NSW (2012) *Operations Procedures Manual section 1 Boards and Tribunals* [Accessed on: 21st January, 2015] Available at: <http://www.correctiveservices.nsw.gov.au/information/open-access-information/policies-defined-gipa-act/offender-management-operations-documents/operations-procedures-manual/section-1-boards-and-tribunals>

Crossley, N (2005) *Sage Key Concepts: Key Concepts in Critical Social Theory.* London. Sage Publications Ltd.

Dahl, R (1970) *Modern Political Analysis*. 2nd ed. Englewood Cliffs, NJ, Prentice Hall.

Department of Corrective Services (2005) *Inmate Classification and Placement Procedures Manual* [Accessed on: 22nd April, 2015 Available at: <http://www.docstoc.com/docs/155219603/Inmate-Classification-and-Placement Case-Management>

Diaswati, M., Barnes, P, H and Sampford, C (2012) Why stagnant? Behind the scenes in Indonesia's reformed state asset management policies. In *14th International Schumpeter Society Conference (ISS)*. 2-5 July 2012, Brisbane, QLD.

Eliasoph, N (1999) "Everyday Racism in a Culture of Political Avoidance: Civil Society, Speech and Taboo". *Social Problems*. 46(4): 479- 502.

Farmer, P (1999a) Pathologies of Power: Rethinking Health and Human Rights. *American Journal of Public Health.* (89): 1486- 1496.

Farmer, P (1999b) *Infections and Inequalities: the Modern Plagues.* University of California Press. Berkeley: USA.

Farmer, P (2003) *Pathologies of Power: Health, Human Rights, and the New War on Power*. *University of California Press Ltd*. London: England and Berkeley: USA.

Farmer, P (2005) *Pathologies of Power: Health, Human Rights, and the New War on Power*. 2nd ed. *University of California Press Ltd*. London: England and Berkeley: USA.

Farmer, P (2009) On Suffering and Structural Violence: A View from Below. Race/Ethnicity: Multidisciplinary Global Contexts, *Race and the Global Politics of Health Inequity*. 3(1): 11- 28.

Farmer, P, E., Nizeye, B., Stulac, S and Keshavjee, S (2006) Structural Violence and Clinical Medicine. *PLoS Med*. 3(10): e449, 1686- 1691. [Accessed on: 16th April, 2015] Available at: <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0030449>

Felthous, A. R (2009) Introduction to this Issue: Correctional Mental Health Care. *Behavioral Sciences and the Law*. (27): 655– 659.

Fletcher, A (2012) *The Optional Protocol to the UN Convention against Torture: Submission to the Joint Standing Committee on Treaties*. Monash University: Castan Centre for Human Rights Law [Accessed on: 6th March, 2015] Available at: <http://www.hreoc.gov.au/legal/submissions_court/intervention/simpson.htm>.

Foucault, M (1977) *Discipline and Punish: The Birth Place of the Prison*. Penguin. London: United Kingdom.

Foucault, M (1989) *Madness and civilization: a history of insanity in the Age of Reason.* Routledge. London: United Kingdom.

Galanek, J. D (2013) The Cultural Construction of Mental Illness in Prison: A Perfect Storm of Pathology. *Culture, Medicine and Psychiatry*. New York. 37: 195-225.

Galtung, J (1969) Violence, peace, and peace research. *Journal of Peace Research.* 6(3): 167– 191.

General Purpose Standing Committee (2005) *Examination of proposed expenditure for the portfolio Areas Juvenile Justice*. No. 3. Parliament of Australia. Canberra. 1-35 [Accessed on: 15th May, 2015] Available at: <http://www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/e96ebc1cfc00156fca257084007efdeb/$FILE/04%20Justice%20Juvenile%20Justice%2022%20Sept%202005.pdf>

Goffman, E (1961) *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates*. Chicago: Aldine Publishing Company.

Goffman, E (1968) *Stigma: notes on the management of spoiled identity*. Penguin Books. Harmondsworth: Middlesex.

Gosden, R (1999) "Coercive psychiatry, human rights and public participation", with commentaries by Chris Bowker, Peter Macdonald and Denise Russell and a response by the author, in Brian Martin (ed.), *Technology and Public Participation* (Wollongong, Australia: Science and Technology Studies, University of Wollongong). 143- 167.

Haney, C (2003) Mental Health Issues in Long-Term Solitary and "Supermax" Confinement. *Crime and Delinquency*. Vol. (49)1. 124-156

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

High Court of Australia (2013) *State of NSW and TD by her Tutor the Protective Commissioner of NSW* [Accessed on: 26th April, 2015] Available at: <http://www.austlii.edu.au/cgibin/sinodisp/au/cases/cth/HCATrans/2013/209.html?stem=0&synonyms=0&query=TD%20BY%20HER%20TUTOR>

Huxter, M. J (2013) Prisons: The Psychiatric Institutions of Last Resort? *Journal of Psychiatric and Mental Health Nursing*. 20: 735-743.

Ibell, B. M (2004) An Analysis of mental health care in Australia from a social justice and human rights perspective, with special reference to the influences of England and the United States of America 1800- 2004. *Australian Catholic University*. Melbourne. 1- 392.

Ife, J (2010) *Human Rights from Below: Achieving Rights through Community Development.* Cambridge University Press, Port Melbourne, VIC.

Jacob, K. S (2001) "Community care for people with mental disorders in developing countries: Problems and possible solutions." *The British Journal of Psychiatry.* 178: 296- 298.

Jansman-Hart, E. M., Seto, M. C., Crocker, A. G., Nicholls, T. L and Cote, G (2011) International Trends in Demand for Forensic Mental Health Services. *International Journal of Forensic Mental Health*. 10(4): 326- 336.

Jordan, M (2011) The prison setting as a place of enforced residence, its mental health effects, and the mental healthcare implications. *Health and Place*. 17: 1061- 1066.

Justice Action (1996) *Map: NSW Imprisonment Centres* [Accessed on: 21st March, 2015] Available at: <http://www.justiceaction.org.au/oldWebsite/Prisons/NSWprisons.html>

Justice Action (1997) *Framed Supports the Forensic Mental Health Review* [Accessed on: 16th April, 2015] Available at: <http://www.justiceaction.org.au/oldWebsite/Framed/Iss31_40/Frmd_34/Frmd34.html>

Justice Action (2009) *The Right to Refuse Treatment for Involuntary Patients* [Accessed on: 10th April, 2015] Available at: <www.justiceaction.org.au/cms/images/.../mntlinvolntrymedcn1109.pdf>

Justice Action (2012) *Court Challenge - Mental Patients Education Rights* [Accessed on: 10th April, 2015] Available at: <http://justiceaction.org.au/cms/images/stories/mediareleases/media%20release%20february%2020.pdf>

Justice Action (2013) *Mad in Australia: The State's assault on the Mentally Ill*. Sydney Australia. 1- 26 [Accessed on: 2nd February, 2015] Available at: <http://www.justiceaction.org.au/cms/images/stories/CmpgnPDFs/madinaust260613.pdf>

Justice Action (2014) *Mental Health Campaigns* [Accessed on: 10th April, 2015] Available at: <http://justiceaction.org.au/human-rights/55-campaigns/current-campaigns/mental-health/cases/saeed-dezfouli/285-2015-03-09-01-27-04-619>

Leahy, T (2009) 'Humanist Realism: A Sociological Toolkit for Activists; Debates about epistemology in recent Social Sciences'. Ch. 2: 1- 24. *Gift Economy.* Newcastle: Australia [Accessed on: 16th April, 2015] Available at: <http://gifteconomy.org.au/files/HumanistRealismCh02.pdf>

Legal Aid NSW (2013) *Policies* [Accessed on: 6th March, 2015] Available at: <http://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0008/7757/Policies-in-brief-Oct-2013-draft-change.pdf>

Legal Aid NSW (2014) *Mental Health Advocacy Service* [Accessed on: 21st January, 2015] Available at: <http://www.legalaid.nsw.gov.au/what-we-do/civil-law/mental-health-advice>

Lucas, W. E (1999) *Mental Health and Criminal Justice*. In 3rd National Outlook Symposium on Crime, Canberra, 22-23 March 1999. Canberra: Australian Institute of Criminology. 1- 14 [Accessed on: 1st May, 2015] Available at: <http://www.aic.gov.au/media_library/conferences/outlook99/lucas.pdf>

Mandela, N (1995) *Long Walk to Freedom: 'A tale of anger and sorrow, love and joy, grace and elegance'.* Little Brown Book Group. London: United Kingdom.

Mental Health Coordinating Council (2011) *The Mental Health Rights Manual: A Consumer Guide to the Legal and Human Rights of People with Mental Illness in NSW*. 3rd ed. 1- 171 [Accessed on: 10th April, 2015] Available at: <http://mhrm.mhcc.org.au/>

Mills, A, J., Durepos, G and Wiebe, E (2010) *Encyclopaedia of Case Study Research: Document Analysis.* Sage Publications, Inc. Thousand Oaks. 319- 321. [Accessed on: 9th June, 2015] Available at: <http://dx.doi.org/10.4135/9781412957397.n120>

Ministry of Health NSW (2012) *Health Policy: Aggression, Seclusion & Restraint in Mental Health Facilities in NSW. Doc No.: PD2012_035* [Accessed on: 20th May, 2015] Available at: <http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_035.html>

Morris, B (2013) *Protest, Land Rights and Riots: Post-colonial struggles in Australia in the 1980s*. Aboriginal Studies Press. Sydney: Australia.

Mullen, P (2008) *Forensicare*, in Justice Action [Accessed on: 15th April, 2015] Available at: http://justiceaction.org.au/cms/component/k2/itemlist/category/119-reports

Nagle, J (1978) *Report of the Royal Commission into NSW Prisons.* NSW Government Printer. Sydney: Australia. 1- 623. [Accessed: 21st March, 2015]. Available at: www.csu.edu.au/__data/assets/pdf_file/0003/.../Nagle-John-Flood.pdf

National Association of Practising Psychiatrists (2002) *Submission to the NSW Legislative Council Select Committee on Mental Health: Inquiry into Mental Health Services in NSW Part I – Report*. 1- 39 [Accessed on: 21st January, 2015] Available at: <www.napp.org.au/.../submis_NSWLCSC_mental_health_may05.doc>

NSW Civil and Administrative Tribunal (2014) *Dezfouli v Justice Health and Forensic Mental Health Network NSWCATAD 188* [Accessed on: 22nd April, 2015] Available at: <http://www.caselaw.nsw.gov.au/decision/54a63ffa3004de94513dc834>

NSW Community News Network Archive (2005a) *Human Rights, Civil Rights, Democratic Rights, Politics, Police & Prisons: Inquest into the death in custody of Scott Simpson* [Accessed on: 12th May, 2015] Available at: <http://nswcnna.blogspot.com.au/2005/11/inquest-into-death-in-custody-of-scott.html>

NSW Community News Network Archive (2005b) *'Killing Rational' and Prisoner Control in NSW* [Accessed on: 12th May, 2015] Available at: <http://nswcnna.blogspot.com.au/2005/02/killing-rational-and-prisoner-control.html>

NSW Coroners Court (2006) *Inquest into the death of Scott Ashley Simpson File no.988/04* [Accessed on: 21st January, 2012] Available at: <http://www.coroners.justice.nsw.gov.au/agdbasev7wr/_assets/coroners/m40160115/dic2006.pdf#xml=http://search.justice.nsw.gov.au/isysquery/67a48947-2faa-441d-964e-ac3b68d6e0e0/1/hilite/> note: the link is now broken however, the researcher can provide a copy on request

NSW Coroners Court (2009) *Jurisdiction: Coronial Name of Deceased: Craig Anthony Behr File number: 354/2009* [Accessed on: 22nd March, 2012] Available at: <http://www.coroners.lawlink.nsw.gov.au/agdbasev7wr/_assets/coroners/m40160113/12_behrcraig.pdf> note: the link is now broken however, the researcher can provide a copy on request

NSW Council of Civil Liberties (2006) *High Risk Management Unit* [Accessed on: 21st May, 2015] Available at: <http://www.nswccl.org.au/docs/pdf/DCS%20inquiry.pdf>

NSW Court of Appeal (2013) *State of NSW v TD NSWCA 32*[Accessed on: 29th April, 2015] Available at: <http://www.caselaw.nsw.gov.au/action/pjudg?s=1000,jgmtid=163267>

NSW Department of Health (2011) *Request by member of NSW Police Force for the assessment of an alleged mentally ill or mentally disturbed person at a facility, Mental Health Act 2007, Section 22.* Government Printers. Canberra [Accessed on: 6th May, 2015] Available at: www.health.nsw.gov.au/mhdao/Documents/Legislation/nh606722.pdf

NSW Government (2008) *Hansard Report: Long Bay Correctional Complex Hospital Lock-In Hours*. Government Printers. Canberra [Accessed on: 11th May, 2015] Available at: <http://www.parliament.nsw.gov.au/prod/parlment/hansart.nsf/V3Key/LC20081113007>

NSW Government (2012) *Policy Directive: Forensic Mental Health Services.* 1- 97 Government Printers. Canberra [Accessed on: 12th May, 2015] Available at: <www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_050.pdf>

NSW Government (2014) *NSW MHRT: Forensic Patients.* Government Printers. Canberra [Accessed on: 21st January, 2015] Available at: <http://www.mhrt.nsw.gov.au/forensic-patients/>

NSW Government (2015) *Justice Health and the Justice & Forensic Mental Health Network.* Government Printers. Canberra [Accessed on: 2nd February, 2015] Available at: <http://www.justicehealth.nsw.gov.au/about-us/our-services/forensic-mental-health-youth-services>

NSW Government Health (2014) *Policy Manual: Combined Delegations Manual* [Accessed on: 26th March, 2015] Available at: <http://www.health.nsw.gov.au/policies/manuals/Documents/combdeles-a62.pdf>

NSW Government Justice (2015) *Corrective Services: Visits - iPhone App* [Accessed on: 22nd March, 2015] Available at: <http://www.correctiveservices.justice.nsw.gov.au/find-a-prison-or-office/csnsw-mobile-apps/visits-iphone-app2 >

NSW Health (2007) "Policy Directive: Seclusion Practices in Psychiatric Facilities' policies/a-z/s.asp, 17, PD2007_054 [Accessed on: 22nd March, 2012] Available at: <http://www.health.nsw.gov.au>

NSW Institute of Psychiatry (2013) *Declared Mental Health Facilities* [Accessed on: 16th May, 2015] Available at: <http://nswiop.nsw.edu.au/images/departments/special/mha/declared_mh_fac_gazettals_with_ward_2013-10-31.pdf>

NSW Law Reform Commission (2010) *People with cognitive and mental health impairments in the Criminal Justice System: an overview* [Accessed on: 21st January, 2015] Available at: <http://www.lawreform.justice.nsw.gov.au/Documents/cp05.pdf>

NSW Legislation (2012) *Mental Health (Forensic Provisions) Act 1990 No 10* [Accessed on: 9th April, 2015] Available at: <http://www.legislation.nsw.gov.au/viewtop/inforce/act+10+1990+cd+0+N/>

NSW MHRT (2004) *MHRT: Annual Report*. 1- 56 [Accessed on: 10th April, 2015] Available at: <http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/annualrep2004.pdf>

NSW Supreme Court (2004) *Regina v Scott Ashley Simpson NSWSC 233* [Accessed on: 29th April, 2015 August] Available at: <http://www.lawlink.nsw.gov.au/scjudgments/2004nswsc.nsf/000000000000000000000000000000/62bff905a1e88b23ca256e6600235b8c?opendocument>

NSW Supreme Court (2006) *Regina v Heatley: Justice Whealy 1199* [Accessed on: 10th April, 2015] Available at: <http://www.lawlink.nsw.gov.au/scjudgments/2006nswsc.nsf/000000000000000000000000000000/2d22ba3425a896a4ca25722500745839?opendocument>

NSW Supreme Court (2010) *TD v State of NSW 368SC* [Accessed on: 29th April, 2015] Available at: <http://www.lawlink.nsw.gov.au/scjudgments/2010nswsc.nsf/000000000000000000000000000000/7edfd346e654de2dca257714000b199d?opendocument>

NSW Supreme Court (2011) *TD, By Her Tutor, The Protective Commissioner of NSW v State Of NSW: Justice Hall 763* [Accessed on: 10th April, 2015] Available at: <http://www.caselaw.nsw.gov.au/action/pjudg?jgmtid=153512>

NSW Supreme Court Criminal Division (2004) *The Application of Russell John Cox NSWSC 1341* [Accessed on: 21st January, 2015] Available at: <http://www.austlii.edu.au/cgibin/sinodisp/au/cases/nsw/NSWSC/2004/1341.html?stem=0&synonyms=0&query=title(russell%20john%20cox%20)>

O'Brien, P (2013) *Affidavit NSW Supreme Court* [Accessed on: 16th May, 2015] Available at: <http://www.justiceaction.org.au/cms/images/stories/CmpgnPDFs/affpo230913.pdf>

O'Leary, Z (2014) *The Essential Guide to Doing Your Research Project*. London: Sage Publications.

Olley, M. C., Nicholls, T. L and Brink, J (2009) Mentally Ill Individuals in Limbo: Obstacles and Opportunities for Providing Psychiatric Services to Corrections Prisoners with Mental Illness. *Behavioral Sciences and the Law*. 27: 811- 831.

Pont, J., Stöver, H and Wolff, H (2012) Resolving Ethical Conflicts in Practice and Research: Dual Loyalty in Prison Health Care. *American Journal of Public Health.*102 (3): 475- 480.

Richmond, D (1983) *Inquiry into Health Services for the Psychiatrically Ill & Developmentally Challenged*. Parliament of NSW: Sydney.

Rogers, D (2008) Out of Sight, Out of Mind: Mentally Ill in Queensland Correctional Centres. *Queensland Student Law Review.*1 (2): 88- 100.

Royal Australian and New Zealand College of Psychiatrists (2010) *Code of Ethics* [Accessed on: 16th May, 2015] Available at: <https://www.ranzcp.org/Mental-health-advice/Complaints-about-psychiatrists.aspx>

Schubert, D. J (2008) 'Suffering/symbolic violence.' In Grenfell, Michael (ed) *Pierre Bourdieu: Key Concepts.* Acumen Publishing Ltd: Stocksfield. 183- 198.

Singh, C (2011) *Deaths in custody: Sweeping changes, but coroners critical of inquiry.* In Crikey [Accessed: 21st March, 2015]. Available at: <http://www.crikey.com.au/2011/06/08/deaths-in-custody-sweeping-changes-but-coroners-critical-of-inquiry/>

Smark, C and Deo, H (2006) "Social and Historical Power Plays: A Foucauldian Gaze on Mental Institutions", College of Business Symposium, *University of Wollongong*, Australia. 1- 10.

Somekh, B and Lewin, C (2005) *Research Methods in the Social Science*. London: Sage Publications.

Szasz, T (2001) "The Therapeutic State: The Tyranny of Pharmacracy". *The Independent Review.* (4): 485-521.

United Nations (1991) *Principles for the protection of persons with mental illness and the improvement of mental health care*. New York: United Nations, Secretariat Centre for Human Rights.

United Nations (1993) Commission on Human Rights, 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care,' reproduced in Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*. Canberra: Australian Government Publishing Service. 989- 1005.

Wacquant, L (ed.) (2002) Dissecting the Prison [special issue]. *Ethnography* 3(4): 371-584.

Williams, C. C (2006) 'The epistemology of cultural competence'. *Families in Society.* 87(2): 209- 220.

Yannoulidis, S (2012) *'Mental State Defences in Criminal Law'.*Ashgate Publishing Ltd.

Appendix A: Introduction to the Criminal Justice System

The Australian legal system is based on the presumption of innocence until proven guilty, but it is not applied equally to everyone. The Australian judicial system is very complex and incorporates parts of the British legal system which was based on the Magna Carta. The complexity of the system is such that forensic patients are unlikely to understand the implications of the law and its process. This in itself represents a form of symbolic violence as forensic patients have small likelihood of understanding the legal system.

When an individual in NSW - whether they have committed the crime or not - is charged with committing a crime, they can be fined or given self-surety bail by police. If they are refused bail by the police they face court, either that day or the next day. If bail is refused in court they will be transferred to a prison.

The NSW criminal justice system has a hierarchically structured, four tiered court system: the Local, District and Supreme Courts, and then the highest tier, the High Court of Australia. When an individual is sentenced under the Crimes Act by either a Magistrate or a Judge, and are determined as being 'fit to plead', the courts have multiple options for sentencing them. The sentence can be a period of incarceration, a community corrections order, home detention, periodic detention, an intensive corrections order, a bond, or a fine. If an individual is sentenced to a period of incarceration, a date for the earliest possibility for release on parole will be provided. When sentenced under the Crimes Act the legislation states that individuals must be detained in a government gazetted prison cell.

If an individual is determined to be unfit to be tried, a judge or a magistrate may place them under the Mental Health Act. In this case the charges are dismissed, no record of conviction is recorded and no determined sentence is given. 'Unfit to plead' is always supported by medical reports that are ordered by the court. Three reports are normally obtained one for the defence, one for the prosecution, and one for the court, which are used to create argument to determine if an individual is to be found either fit or unfit. The defence obtains their report from the treating psychiatrists and the prosecution obtains a report from an independent forensic psychiatrist. These reports are submitted

to the court. The court may also order their own independent report. The Mental Health Act legislation states that individuals suffering from a SMI must be detained in a gazetted hospital, or a hospital cell, also referred to as a declared mental health facility. These individuals are referred to as forensic patients. They are subject to a 'limiting term of incarceration' in which no release date is specified, whereas, prison patients have a determined parole and release date. Prison patients are also referred to as correctional patients.

Australian states have different mental health legislation; however both the Crimes Act and the Mental Health Act differ quite significantly. If an individual sentenced under the Crimes Act becomes mentally unwell whilst incarcerated, they can be made an involuntary patient, and then become subject to the Mental Health Act and reviews by the MHRT. They can be detained in a gazetted hospital also known as a declared mental health facility, and then transferred back to a gazetted prison cell when they are not considered to be suffering a SMI.

The NSW prison system is legislated to only detain individuals sentenced under the Crimes Act in a gazetted prison cell. The NSW prison system is only legislated for maintaining security of anyone placed in a gazetted hospital cell located on their premises that they are under either the Mental Health Act and/or the Mental Health (Forensic Provisions) Act. The MHRT has the legislated responsibility for individuals under both the acts and also that they are to be detained in a gazetted hospital cell. Ultimately the MHRT has the legislated responsibility for these individuals regarding their detention, care and treatment, and must undertake regular reviews of individuals under both Acts (NSW Government 2012: 1; Department of Corrective Services 2005: 87).

Prisoners are kept in 'segregated custody' if it is considered that their associations with other prisoners are a threat to the personal safety of any other person, the security or the good order and discipline of the prison. Within each class the prison staff may direct that the following prisoners be kept separate from other prisoners: prisoners who have never been incarcerated before, or who would be at risk if not separated from other prisoners, and especially prisoners in protective custody. Segregation and protective custody are two very different terms: segregation is 'to protect other prisoners from the prisoner on segregation' whereas protective custody is to protect the prisoners from

other prisoners. Most sex offenders are placed in protective custody. A prisoner cannot be held in either protective custody or segregation for more than 14 days unless on direction of the Commissioner, and that cannot be longer than three months for either protective custody or segregation. If any more time is required, the minister must be notified, and all these directions must be in writing. Prisoners can request they be held in protective custody if the association with another inmate constitutes or is likely to constitute a threat to personal safety of an inmate, or on written request by the Commissioner.

After prisoners are sentenced, they are given an 'inmate classification' which determines the placement and the prison that an inmate will be placed at, which can then affect access to programs. It also determines prisoners' privileges within the system, with classification and placement reviewed every 6 months. Generally, all sentenced prisoners are expected to work and are encouraged to participate in vocational education and training programs as well as rehabilitation programs.

The Serious Offenders Review Council is an independent statutory authority advising on the security and classification, placement and case management of prisoners classed as serious offenders. The Serious Offenders Review Council also known as the SORC also advises the state parole authority concerning the release of Serious Offenders and provides reports about these offenders to the Supreme Court, the Attorney General and Minister of Justice. Another of SORC's functions is to review segregation orders. In addition SORC deals with daily enquiries from facilities, the Minister's office, Department of Corrective Services executive, Ombudsman, corrections intelligence group, official visitors, community corrections officers, and the legal profession, as well as prisoners and their families. SORC deals with approximately 7% of prisoners who are serving sentences for murder, or have spent at least 12 years in custody.

Appendix B: Legislation

Legislation in NSW Australia states that people who commit crimes face the criminal justice system. The Mental Health Act has made changes since 2008, however all four case studies were sentenced before these changes came into effect, and thus the laws at time of sentencing have been applied to these cases. When an individual faces court, a judge can order a psychiatric evaluation under s.51(2) or schedule 2 s.55(2) of the Mental Health (Forensic Provisions) Act (Australasian Legal Information Institute 2007a: 92- 95; Australasian Legal Information Institute 2013: 51). This evaluation provides the court a report on an individual's fitness to plead either: unfit or fit (Australasian Legal Information Institute 2007a: 6). When a psychiatrist determines that an individual suffers a mental impairment, the individual will be found not guilty by reason of mental illness, and/or unfit to be tried, and thereafter referred to as a forensic patient. If an individual is fit to plead they are sentenced under the Crimes Act (Australasian Legal Information Institute 2007a: 6). If an individual is unfit to plead they are subject to the Mental Health Act. Individuals found unfit to be tried, on the grounds of being not guilty by reason of mental illness (NSW Government 2015: 1) are detained as legislation states in the Mental Health (Forensic Provisions) Act, in a gazetted hospital. An incarcerated inmate can be reviewed by the MHRT under s.51(2) of the Mental Health (Forensic Provisions Act) 2007 and made an involuntary inmate (Australasian Legal Information Institute 2007a: 140).

The legislation in the Mental Health Act 1990 states that:

> "Mental illness" means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: (a) delusions, (b) hallucinations, (c) serious disorder of thought form, (d) a severe disturbance of mood, (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d), (Australasian Legal Information Institute 2007b).

A gazetted prison cell is a cell that has been legally gazetted by the Government to hold a prisoner who is sentenced under the Crimes Act (NSW Supreme Court Criminal Division 2004). In contrast, a forensic patient sentenced under the Mental Health Act or the Mental Health (Forensic Provisions) Act is legislated to be detained in a hospital cell. A gazetted prison cell and a gazetted hospital cell are different cell types. A person

sentenced under the Crimes Act is deemed fit to plead, whereas a person sentenced under either the Mental Health Act or the Mental Health (Forensic Provisions) Act is deemed unfit to plead.

Police and health care professionals exercising functions are held liable under legislation of the Mental Health (Forensic Provisions) Act 1990 (Australasian Legal Information Institute 2007b). Legislation under s.22 of the Mental Health Act 2007 states that NSW Police can be requested to check on the welfare of individuals with SMI, for example forensic patients detained within the prison system, hospitals or anywhere within the community (NSW Department of Health 2011: 1- 2).

The Australasian Legal Information Institute (2013: 41) states that under the Mental Health (Forensic Provisions) Act in s.76c(1) a forensic or prison patient detained within a prison are under the prisons' functions, for security, good order and safety. Section 76d(2) states that a forensic patient detained in any part of the NSW prison system is bound by the prison security conditions in accordance with relevant Crimes (Administration of Sentencing) Act 1999, NSW legislation, and all regulations applying to forensic patients.

Forensic patients are involuntary patients and legislated to be detained in a gazetted hospital. Legislation states that if an inmate sentenced under the Crimes Act becomes mentally unwell whilst incarcerated, they can then be made an involuntary prison patient who is then subject to the MHRT, similar to forensic patients (Australasian Legal Information Institute 2007a: 43). If any individual ceases to be either a forensic or prison patient they can be detained as an involuntary patient (Australasian Legal Information Institute 2007a: 43).

The following were the only legislated hospital cells at the old Long Bay Prison Hospital with the NSW prison system; all other cells outside the following gazetted hospitals are in fact gazetted prison cells.

On 4 June 1999, the NSW Government Gazette (No. 66) published a declaration made by the Director General of the NSW Department of Health pursuant to s.208 of the Mental Health Act (Australasian Legal Information Institute 2007a: 113) to the effect

that the following premises within the old Long Bay Prison Hospital were declared to be a hospital for the purposes of the Mental Health Act, specifically: 'Ward A; Ward C, beds 1 to 15 in the East Wing, only; and Ward D, beds 1 to 15 in the East Wing, only.' The declaration did not extend to bed (or cell) 16 of D Ward", (NSW Supreme Court 2010: 8; NSW Court of Appeal 2013: 6).

Outside the gates of Long Bay Prison in late 2008, the new Forensic Hospital was opened as a declared mental health facility under s.109 of the Mental Health Act 2007" which is a gazetted hospital (NSW Civil and Administrative Tribunal 2014: 2).

The High Court of Australia accepts the defence of insanity where the mental disorder is "such as that they could not appreciate the physical thing they were doing and its consequences as morally wrong" (Yannoulidis 2012: 15). When a doctor can determine a mental impairment, the person will be found not guilty because of the mental impairment and then called a forensic patient. Legal incapacity brought on by SMI results in forensic patients being subject to the Protected Estates Act 1983 (NSW Court of Appeal 2013: 2).The Australasian Legal Information Institute (2013) states that legislation must give a person sentenced under the Crimes Act a determined sentence from a court, whereas forensic patients not guilty of an offence are given a limiting term of incarceration.

Legislation declares that judges and the MHRT must have regard for patient welfare regarding administration of medication to forensic patients (Australasian Legal Information Institute 2007a: 17; 20; 21; 33; 38- 39; 44). The Mental Health Act legislation s.73 also states that there must be transparency regarding administration of medication/s to forensic patients. Under schedule 3 in the 'Statement of patients' rights' in the Mental Health Act 1990, it is stated that forensic patients can be administered appropriate medical treatment against their will for a mental condition, in an emergency to save their life or prevent serious damage to a forensic patients' health, however, forensic patients must not be given excessive or inappropriate medication (Australasian Legal Information Institute 2007a: 101- 102). Legislation under the Mental Health Act 2007 states that forensic patients should receive the best possible treatment in the least restrictive environments and medication should only be prescribed for diagnostic and therapeutic needs and not for punishment (Australasian Legal Information Institute 2007a: 36).

Staff employed by the Department of Corrective Services, Justice Health, Justice Health and Forensic Mental Health Network, Department of Health, Ombudsman, Health Care Complaints Commission, MHRT and Legal Aid are all employees of the State. State employees are legislated by the Public Sector Management Act 1988 NSW, for the purpose of this research. Under s.75 of the Public Sector Management Act 1988, legislation states that all state employees are punishable for any breaches of discipline (Australasian Legal Information Institute 2002: 1).

The Australasian Legal Information Institute (2014: 4) states that under the Legal Aid Commission Act 1979 that Legal Aid be available to any disadvantaged persons in NSW, and that any choice expressed by the legally assisted person for a particular private practitioner be observed. Legal Aid may determine priorities in the provision between different persons or different classes of persons, and different classes and matters and give assistance and make grants, on such terms and conditions as it thinks fit, to persons or bodies within NSW for the provision by those persons of bodies of Legal Aid (Australasian Legal Information Institute 2014: 3).

The Mental Health Advocacy Service is a division of Legal Aid that specialises in representing forensic patients who are subject to reviews with the MHRT (Legal Aid NSW 2014: 1). The Australasian Legal Information Institute (2007a: 40) states that the MHRT is legislated to notify the Minister of Police, Attorney General, and the Minister of Health when a forensic patient is released.

A forensic patient is then under the Mental Health Act and or the Mental Health (Forensic Provisions) Act, as they are legislated under the Minister of Health rather than the Minister of Department of Corrective Services. The Minister of Health is legislated to review forensic patients every six months to make recommendations that determine if they are a ‘risk to the community’.

If any inmate on remand or a sentenced inmate under the Crimes Act becomes mentally unwell whilst incarcerated within the prison system can be transferred from a prison to a hospital. They are then made an involuntary patient. Individuals can be ordered to be transferred to a hospital by a psychiatrist and a medical practitioner in order that they can certify that an individual is suffering with a SMI or has a mental condition as

defined by the Mental Health Act 1990 (NSW), (Mental Health Coordinating Council 2011: 1; Australasian Legal Information Institute 2013: 20). The MHRT then also is legislated as having the responsibility for undertaking reviews on prison patients' placement, and care regarding their mental health treatment whilst incarcerated within a prison (NSW Government 2014: 1; Australasian Legal Information Institute 2007a: 23).

In 2009, Parliament made amendments so that all decisions pertaining to forensic or prison patients can only be made by the MHRT (NSW Law Reform Commission 2010: 9; Australasian Legal Information Institute 2007a: 23). Transfers from a gazetted hospital cell or declared mental health facility to a prison cell can only occur when the MHRT is satisfied that the prison patient is not mentally unwell (Australasian Legal Information Institute 2007a: 130). The legislation in the Mental Health Act 2007 gives equal powers to both the MHRT and the NSW Supreme Court regarding those patients subject to the Mental Health Act.

The legislation under s.162 of the Mental Health Act 2007 states that the publication of names, pictures or any information that identifies an individual who is subject to the Act are prohibited except with the consent of the MHRT (Australasian Legal Information Institute 2007a: 76).

Appendix C: Regulations

Regulation within prison which are meant to regulate life and contact with the outside world.

Prisoners are permitted to receive visits and make telephone calls to nominated family, friends and legal representatives which are all recorded via the controlled telephone system, as well as send and receive mail. Some personal property can be kept in cells and a limited amount of money can be kept in the prisoners 'personal monies' account. The general manager of a prison can direct a strip search, and prison officers at every prison can strip search prisoners when they consider it appropriate, whilst having due regard for dignity and self-respect, consistent with the conduct of an effective search.

Prisoners must comply with any call for muster, bell, whistle or siren, the routine and hours of work at the facility, breath tests for alcohol, and urine tests for drug screens. Any contravention of any of the provisions in the Crimes (Administration of Sentences) Act is considered a prison offence. There are a number of prison offences under the Crimes (Administration of Sentencing) Regulations 2008. They are set out in clauses 124 to 146 and s.2v of the regulations. The range of sanctions that may be imposed by the general manager of the prison includes: reprimand and caution, withdrawal of privileges for up to 56 days, inclusive of no television, radio, films, videos, CDs and DVDs leisure activities, ability to purchase goods (buy up), contact visits, keeping of approved property, confinement to a cell for up to 7 days with or without privileges, imposing a penalty may be deferred conditionally for up to 2 months, and cancellation of payments for up to 2 weeks. Serious offences can be referred to the visiting magistrate who can impose more extensive punishments including sentencing prisoners to a further 6 month incarceration. Anything deemed a criminal offence will be referred to the Local Court by the visiting magistrate.

Prisoners are allowed to receive a maximum of $100 per week to be deposited into their ‘buy up’ accounts. Prior approval with prison staff is needed to set up an individual deposit system either by BPAY or through post offices run by Australia Post. Family and kinship networks need to first visit the inmate and then they are allocated a Visitor

Index Number (VIN), whereas, prisoners are allocated a Master Index Number (MIN). Family and kinship networks contact the prison to apply for a depositor reference report which then provides a personalised customer reference number to deposit money. However, those applying for a depositor reference report need to provide their own bank account details to the prison. This enables prisoners to then purchase toiletries, magazines, food and make telephone calls. Prisoners are allowed to send mail. All incoming and outgoing mail is screened by prison staff, and it must not contain threatening, abusive, obscene, or have indecent content. Prisoners are allowed one phone call per week at the prisons expense. Except for prisoners in the High Risk Management Unit, prisoners can call local, international and mobile numbers. For prisoners in High Risk Management Unit, the person the inmate wishes to call goes under rigorous security and screening measures. Visiting the High Risk Management Unit requires prior police clearance, a process which takes around 6 weeks. For prisoners in the High Risk Management Unit to make a telephone call out of the unit, the landline or mobile phone number must be registered to the person they nominate to call, so evidence of a telephone bill in the nominated person's name must be produced, showing name address and telephone number. This means High Risk Management Unit prisoners cannot call prepaid phones.

Prisoners can have visitors, however different facilities have different rules regarding visiting. The length of visits can vary in duration: most maximum security prisoners can have a one hour visit per week. Visitors must take proof of identity at each visit and may need to provide the reason for visit.

Appendix D: Visiting and Prison Locations in NSW

The people whose stories are told in this thesis have been incarcerated in units with Goulburn Prison, the hospitals within Long Bay Prison, Parklea Prison, Silverwater Prison, Silverwater Women's formally known as Mulawa Prison, and Goulburn Prison. Two of the people had family and kinship networks members in Penrith, and the researcher has detailed the travel times to each facility for those family and kinship networks members.

Goulburn Prison, in Maud St Goulburn, is approximately two hundred kilometres south west of Sydney. Goulburn Prison primarily houses maximum security prisoners, although it does have a minimum security section as well. Within Goulburn Prison there are a few segregation units: the multi-purpose unit that houses segregated prisoners, and the High Risk Management Unit which is a separate gazetted prison to the rest of Goulburn Prison. Prisoners can undertake courses whilst in Goulburn Prison. Goulburn Prison runs nationally recognised courses so prisoners can obtain qualifications whilst incarcerated. The Adult Education and Vocational Training Institute provide courses at Goulburn Prison in literacy, numeracy, and communications courses in all centres. Many centres offer vocational courses such as Information Technology (IT), Horticulture, Construction, Visual Arts and Contemporary Craft. Goulburn Prison allows one visit a week when prisoners are in multi-purpose unit or High Risk Management Unit for 1 hour, however if a visit was made in the week previously another cannot be booked until Wednesday mornings from 9am; photo identification must be provided, and items are not allowed into the visits in these units (not even a drink). Visitors are searched at the main entrance, retina scanned, x-rayed with shoes removed and jackets or jumpers, and then re-scanned just inside High Risk Management Unit on entry to that section. Visits in High Risk Management Unit are from 9.15am until 1pm Saturdays and Sundays only. Families visiting Goulburn Prison from Sydney have a long trip. It is a 4.5 hour round trip from Penrith, on the outskirts of Sydney, by car, or in excess of 9 hours by public transport, including three changes of trains and bus and a 3km walk from Goulburn station.

The Long Bay Prison on Anzac Parade, Matraville, is in the south western suburbs of Sydney. The closest train station is Central Station. Long Bay Prison is a maximum security jail and includes the new Long Bay Prison Hospital. The old Long Bay Prison Hospital was previously located in the same grounds. The new Long Bay Prison Hospital houses 120 maximum security prisoners in four different wards. The hospital is jointly administered by prison and medical staff. These staff are from the Department of Corrective Services and the Department of Health. The Department of Health administers Justice Health, and the Justice Health and Forensic Mental Health Network. Visits to the new Long Bay Prison Hospital are permitted on a Saturday, Sunday and Monday, at 8.45am, 10.45am or 1.15pm. A visit to Long Bay Prison is nearly two and a half hours round trip by car from Penrith, and a four hour round trip, involving a train and two busses, by public transport. Visitors are allowed to bring $10 in coins to purchase items from the vending machines i.e. cans of soft drink, water, chips and chocolates.

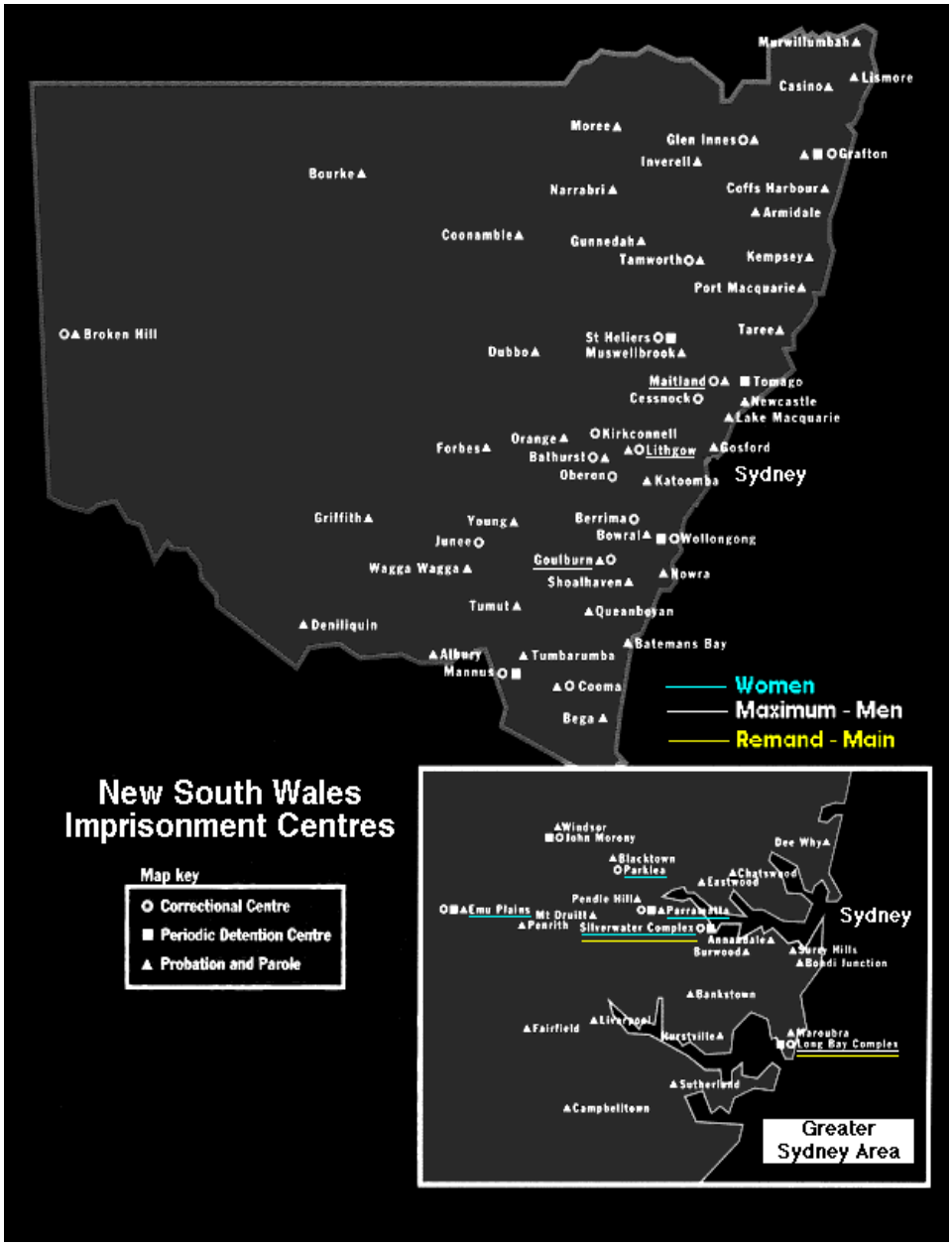
Parklea Prison is a maximum security prison and is located at 66 Sentry Drive, Parklea, in the north western suburbs of Sydney. Parklea Prison has been privately run since 2009. Prisoners are allowed a one hour visit, twice weekly, between 8.45am and 11am or 12.15pm and 2.45pm on any day except Tuesdays. To visit an inmate if living in Penrith it is a two hour round trip by public transport involving a train and then a bus, or a one hour return trip by car.

Silverwater Prison is located 21 kilometres west from Sydney Central Business District at Holker Street, Silverwater, and has a few sections, including the Metropolitan Reception and Remand Centre, a maximum security prison which has a reception and screening area. This prison houses approximately 950 male prisoners. Prisoners are taken there directly from court and are held there whilst on remand, or if they are to attend court for sentencing, before being sent to their centre of classification. The Adult Education and Vocational Training Institute at Silverwater Prison provide courses for prisoners in literacy, visual arts, IT, and English as a second language. Distance study is supported where possible with some offenders studying through university or TAFE. Study packs are available in art, literacy, and IT for those who are unable to attend regular classes or where access is difficult. An inmate legal portal (a secure internal

network) allows prisoners to access relevant legal information during class. The Metropolitan Reception and Remand Centre has a fully equipped law library to help prisoners access relevant legal information. The library also provides prisoners with access to a range of fiction, non-fiction and reference books. The Metropolitan Reception and Remand Centre has a medical clinic, and prisoners have satellite consultations with Justice Health and Forensic Mental Health Network to conduct clinics for SMI prisoners.

Prisoners can have a 1 hour visit twice a week on a Monday, Wednesday, Thursday, Friday, Saturday and Sundays between 8.45am and 11am or 11.45am and 2.45pm. Silverwater provides work opportunities for prisoners in textiles: the Metropolitan Reception and Remand Centre operate a textile workshop which produces inmate clothing and linen, as well as garments for hospitals and nursing homes. The Metropolitan Reception and Remand Centre laundry services the complex and court cells; prisoners assemble, repair and package airline passenger headsets. Prisoners maintain the areas of gardens and landscaping within the Metropolitan Reception and Remand Centre. Mulawa Prison (now referred to as Silverwater Women's) is also located on the same grounds and is a maximum security prison with a reception and screening area. Mulawa Prison visits are from Thursdays to Sundays and public holidays from 8.30am and 11.15am or 12.30 and 3pm. Women in protective custody or those considered extremely high risk have visits on Mondays, Wednesdays, Thursdays and Fridays 8.15 and 10am. Visitors must be pre-booked and registered to visit. Mulawa Prison has educational facilities the same as the above, inclusive of the law library and medical clinic. Travel times are similar to Parklea Prison.

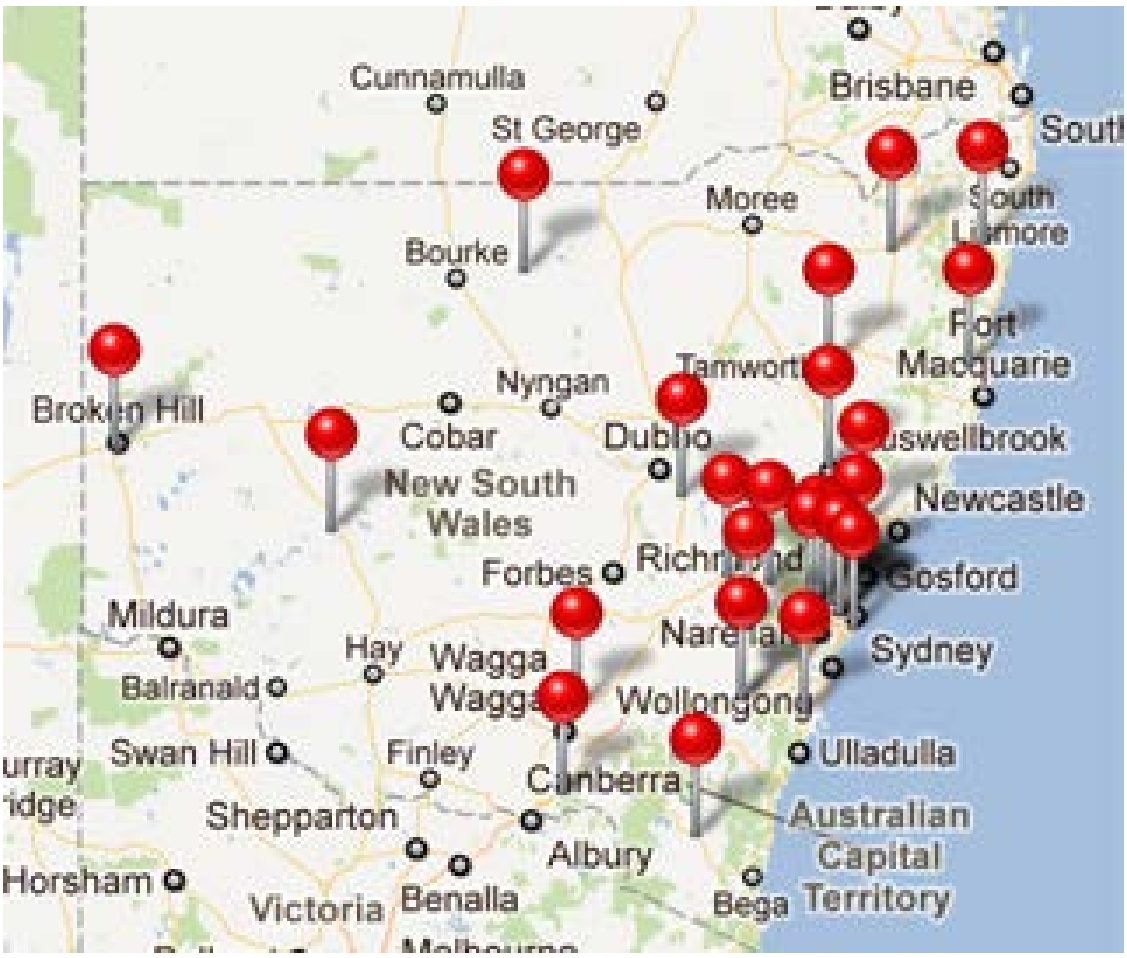
Grafton Prison is located 650 kilometres north of Sydney, at 170 Hoof Street Grafton, a 5 kilometre walk from Grafton railway station. Grafton Prison houses 64 prisoners who come into custody in the northern rivers region. It is a medium security prison which also has a minimum security section and a reception and screening area. Visitors can take a maximum of 4 adults, and children must be supervised.



(Justice Action 1996).

Location of Correctional Centres in NSW

This map gives an indication of how far families travel to visit prisoners.



(NSW Government Justice 2015).