Suspected Suicide and Self-harm Threat to Life Incidents in New Zealand Prisons 2016 - 2021

Thematic Report

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DEPARTMENT OF CORRECTIONS

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Office of the Inspectorate *Te Tari Tirohia*

Our whakataukī

Mā te titiro me te whakarongo ka puta mai te māramatanga
By looking and listening, we will gain insight

Our vision

That prisoners and offenders are treated in a fair, safe, secure and humane way.

Our values

We acknowledge the values of Ara Poutama Aotearoa (the Department of Corrections): **Rangatira** (Leadership), **Manaaki** (Respect), **Wairua** (Spirituality), **Kaitiaki** (Guardianship) and **Whānau** (Relationships).

Office of the Inspectorate values:

Respect	We are considerate of the dignity of others
Integrity	We are ethical and do the right thing
Professionalism	We are competent and focused
Objectivity	We are open-minded and do not take sides
Diversity	We are inclusive and value difference

Advisory

This report contains themes of suicide and self-harm.

If you are affected by these issues and need to talk to someone, nationwide New Zealand helpline services can offer support and information:

- Need to talk? Free call or text 1737 any time to talk to a trained counsellor
- Lifeline 0800 543 354 or 09 522 2999 or free text 4357 (HELP)
- Suicide Crisis Helpline 0508 828 865 (0508 TAUTOKO)
- Youthline 0800 376 633 or free text 234
- Samaritans 0800 726 666.

Karakia Waerea

Waerea te Pāpā	Clear the ground
Waerea te whare mauhere	Clear the prison
Kia wātea (wātea!)	To free any restriction
Unuhia, te ngao a Tū	Withdraw the energy created by Tūmatauenga
Unuhia te ngao a Whiro	Withdraw the energy created by Whiro
Kia wātea (wātea!)	To free any restriction
Utaina te mauri a Rongo	Insert the energy of Rongo
E tau ai, kia wātea (wātea)	To restore peace and place, to free any restriction
Tūturu o whiti whakamaua kia tīna	Bind together, tight and unbreakable
Haumi e!	United ready to progress
Hui e!	Unite as one
Tāiki e!	Come together
	As one

Karakia courtesy of Maxwell Matenga

Foreword

This report makes for a challenging read because the statistics represent the lives and sadly, in some cases, the deaths of people in prisons in New Zealand. This report provides insights for us all and lessons to be learned.

We should all be concerned about the deaths by suspected suicide of people who are imprisoned, and should adopt a prevention focused approach to managing people in closed environments. It is our duty to care about this and do all we can, individually, collectively and across sectors to prevent these deaths and serious self-harm events.

Firstly, I want to acknowledge those men and women whose deaths or serious self-harm events form the basis for this important work. Although anonymous, they are visible and heard in the pages of this report. I hope sincerely that our words convey messages they are not able to share. They are our silent witnesses. I also trust that the family and whānau of those who died by suspected suicide in prison are assured by this work that there is a strong commitment to do more to prevent further loss of life.

Secondly, and no less importantly, I acknowledge staff working at the Department of Corrections, Ara Poutama Aotearoa, who shared their experiences with us. Their experiences were invaluable in our search to better understand what more can be done to support staff in both prevention and postvention responses. Many staff have been significantly affected by dealing with a death in custody or a serious self-harm incident, with many now living with indelible memories that have undoubtedly crossed the barrier from their professional to their personal lives. I recognise both their work and the toll these events must invariably place on them.

My office investigates all deaths in prison in New Zealand, including deaths by suspected suicide. The report of each investigation is shared with the Chief Executive of the Department of Corrections, the Chief Ombudsman, and the relevant Coroner. However, they are not publicly released, as they are in some jurisdictions. These reports examine the circumstances of each death and, where appropriate, make findings and recommendations for improvement to systems, practices, and processes within the correctional environment. All of the reports for deaths by suspected suicide were reviewed by members of the review team as part of this investigation. In that regard, I also acknowledge the expertise of my inspectors, whose significant experience in custodial and clinical settings is critical to the careful and detailed examination of the circumstances of each death.

The genesis for this work was my, and others', concern that the number of suspected suicides and serious self-harm incidents in our prisons in New Zealand was increasing. Given our reports of deaths in custody are not published, it was, for me, imperative to examine and report on this area of concern publicly.

I consider this a companion report to my recently publicly released *Separation and Isolation: Thematic Report: Prisoners who have been kept apart from the prison population* as there are significant areas of commonality, with those separated or isolated whilst in prison often being involved in serious self-harm incidents or, sadly, dying by suspected suicide.

I welcome the Department's *Suicide Prevention and Postvention Action Plan 2022 – 2025* and trust the recommendations and areas for consideration I have made in this report will help to guide Corrections' work to reduce suicide and self-harm in our prisons.

To all those who have contributed to this work, I thank you for your care, compassion, and commitment. This report has taken time to complete with the challenges of undertaking our work during and post the COVID-19 pandemic, but I trust it is testament to our best endeavours to tackle what is perhaps the most challenging of subjects.

Janis Adair
Chief Inspector of Corrections

Executive Summary

Suicide and self-harm are significant issues in prisons in Aotearoa New Zealand and internationally. It is well known that many risk factors for suicide and self-harm – including suicidal ideation, a history of self-harm, and mental health diagnoses – are more prevalent in people in prison than they are in the general population.

In the five-year review period 1 July 2016 to 30 June 2021, there were 29 suspected suicides in New Zealand prisons. Numbers of suspected suicides in prisons have remained relatively stable since 1989/90, with an average of around three to six a year, although there have been some increases, with 11 people dying by suspected suicide in the 2015/16 year and in 2020/21.

When viewed in the context of a falling prison population, these increases may cause concern. However, it is understood internationally that as imprisonment rates drop, suicide rates in prisons increase. This is because the people remaining in prison are more likely to have committed serious and violent crimes and have higher rates of mental illness, both of which are associated with increased suicide risk. The proportion of people in New Zealand prisons who are on remand also increased across the review period, and being on remand is another risk factor for suicide and self-harm.

In the five-year review period, 158 people in New Zealand prisons were involved in 253 'self-harm threat to life' incidents. These were incidents where the person would probably have died if there had been no immediate intervention by staff. Across the review period, these incidents appear to have trended upwards, from 21 incidents in 2016/17, to a high of 84 incidents in 2019/20, followed by a slight drop to 58 incidents in the 2020/21 year.

Corrections has been taking action to mitigate against suspected suicide and self-harm incidents in prisons. Corrections has introduced mental health initiatives and invested in training and workforce development for staff. We acknowledge that without this work, suicide and self-harm threat to life incident numbers could be higher. We also acknowledge that there are no easy solutions when it comes to reducing suicide and self-harm incidents in prisons.

Furthermore, we note that the international literature highlights the importance of addressing "systemic hazards" which may also contribute to suspected suicide and self-harm threat to life incidents in New Zealand prisons. Systemic hazards go beyond correctional practices or processes, and are a result of wider systems that may, for example, lead to the imprisonment of mentally ill people or limited support services being available for people at risk of suicide or self-harm who are released from prison.

This review found, overall, that there were areas of good practice where people at risk of suicide and self-harm were identified and treated with skill and compassion. The most beneficial outcomes generally came about in situations where staff were well-trained and experienced, had sufficient resources, and good working relationships with each other and with outside providers such as forensic mental health services.

We also found that practice around assessing, treating and managing people at risk of suicide or self-harm was variable across the prison network. Our findings included:

- The quality of staff engagement with new prisoners and the assessment of suicide and self-harm risk in the Receiving Office was variable across the prison network.
- Staff did not always identify, manage, or provide suitable intervention for people withdrawing from alcohol and other drugs.
- In the review period, the proportion of prisoners on remand increased; remand prisoners experience many known risk factors for suicide and self-harm, including social isolation, restrictive regimes, uncertainty over court outcomes, alcohol and other drug withdrawal and lack of purposeful activity.
- Some prisoners experienced difficulties or delays in accessing healthcare or medication, including intervention for pain and insomnia, both of which are risk factors for suicide and self-harm.

- Intervention and Support Unit (ISU) environments tended to be stark, and prisoners held in them often experienced a restrictive regime with little to do and little opportunity for social interaction.
- Prisons that did not have Intervention and Support Practice Teams (ISPTs) could not always offer the same level of treatment and intervention to prisoners at risk of suicide or self-harm as prisons with ISPTs.
- Mentally unwell prisoners' admission to in-patient mental health facilities for treatment was sometimes delayed because no beds were available.
- Suicide postvention activities were variable across prison sites.
- Release planning was sometimes challenging as there were not enough suitable services available in the community, especially for people with high or complex needs.
- The impact of COVID-19 restrictions and ongoing staffing shortages on prisoners' wellbeing is not yet fully understood but is likely to be detrimental.

While Corrections invested in additional mental health services over the review period, an over-arching implementation and change strategy seems to have been lacking. This, alongside other issues, led to fragmented or over-burdened services in some areas, coupled with other areas where there were multiple people or services all attempting to help the same vulnerable people, but apparently without cohesive effort.

The Inspectorate review team welcomes Corrections' *Suicide Prevention and Postvention Action Plan 2022 – 2025* as a strategic approach to responding to the needs of people who are at risk of suicide and self-harm, their families/ whānau, and staff.

This report makes six over-arching recommendations and has 54 areas for consideration.

Recommendations

Overarching recommendations

1. Corrections must continue to review the strategic and operational leadership, resourcing, operating models and service delivery for prisoners vulnerable to suicide or self-harm as set out in its *Suicide Prevention and Postvention Action Plan*.
2. Corrections must continue its investment in additional training, development, and supervision for staff in recognising and responding to risk factors for suicide and self-harm, as set out in its *Suicide Prevention and Postvention Action Plan*, specifically including using trauma-informed approaches and managing alcohol and drug withdrawal.
3. Corrections must review its model of care for managing people at risk of suicide or self-harm in the Intervention and Support Units, and ensure there are sufficient resources to support the model of care.
4. Corrections must continue to work with agencies across sectors to explore how services for people with complex mental health needs can be coordinated and improved.
5. Corrections must regularly update its Suicide Prevention and Postvention Advisory Group about its progress towards the recommendations and areas for consideration in this report. The Office of the Inspectorate will report on progress publicly at periodic intervals.
6. Corrections must provide the Office of the Inspectorate with progress updates on the work to identify and mitigate against potential ligature points in cells across the prison network.

Areas for consideration:

Reception into prison

1. Corrections should consider how to improve the Receiving Office environment, including:
   - » ensuring there are safe and private areas to conduct all assessment
   - » adopting the Intervention and Support Unit therapeutic physical guidelines, or similar (as appropriate) to soften the environment.
2. Corrections should consider how to improve the quality of Receiving Office processes to ensure they are culturally responsive, person-centred and trauma-informed, including:
   - » staff have time to engage and build rapport with the people they are assessing
   - » staff have time to actively identify risk factors from all information available to them
   - » staff have time to assess distress and other risk factors for suicide and self-harm
   - » there are robust information-sharing processes so that staff have the time to share information with colleagues
   - » appropriately trained and experienced clinical mental health staff are available to assist in determining the risk of suicide or self-harm.

3. Corrections should consider the recently published evidence-based guideline (2022) from the UK National Institute for Health and Care Excellence (NICE) that provides standards for best practice in the assessment, management and prevention of self-harm.
4. Corrections should consider credentialling all staff who work in the Receiving Office to ensure they have had relevant training, including in using alcohol and other drug withdrawal tools, assessing distress, and checking IOMS alerts for self-harming behaviour.
5. Corrections should consider reviewing existing guidance for all staff about alerts for suicide and self-harm in IOMS. This should be done to ensure staff know when to create these alerts, how to check them, and when to remove them. Corrections should also consider creating new alerts that provide early warning signs to staff that a person may self-harm again.
6. Corrections should consider updating IOMS so that alerts (i.e. risk of suicide, risk of self-harm, at risk, and substance use alerts) are created automatically where appropriate, alerts are easily visible to staff, and alert definitions are available so that staff know when to apply them.
7. Corrections should consider the resourcing of Receiving Offices, particularly in high-volume receiving prisons.
8. Corrections should consider enhancing all mechanisms to share information between prisons and courts, probation, police, health, and other agencies.
9. Corrections should consider strengthening practice around the early assessment and treatment of substance withdrawal, including providing supportive information to newly received prisoners.
10. Corrections should consider alternative reception models, or aspects of the models.

Early days in prison

11. Corrections should continue to upskill custodial staff as set out in Focus Area 3 of its *Suicide Prevention and Postvention Action Plan*.
12. Corrections should consider offering more learning opportunities to custodial staff to enable them to recognise possible withdrawal symptoms from alcohol and other drugs, and understand the impact of withdrawal on behaviour.
13. Corrections should continue to consider how to better support people coming into prison who have English as a second language or others who have diverse cultural needs.
14. Corrections should consider establishing dedicated First Nights units that better support the induction process for people who are newly received in prison.
15. Corrections should consider reviewing the Shared Accommodation Cell Risk Assessment (SACRA) to ensure consideration is given to the protective factor that cell sharing may offer some people.
16. Corrections should consider how to better support and manage people on remand, including:
    - encouraging the consistent application of the Remand Management Tool to ensure prisoners are managed appropriately in the least restrictive regime possible
    - providing more meaningful activities for people on remand, particularly brief AOD interventions and programmes that teach psychological self-management tools
    - providing more time out of cell for people on remand to mitigate the isolation and provide more

opportunity for meaningful human interaction.

17. Corrections should continue to explore whether adopting peer support models, particularly in remand units, could be a beneficial form of support for newly received prisoners.

Healthcare in prison

18. Corrections should continue to upskill health staff as set out in Focus Area 3 of its *Suicide Prevention and Postvention Action Plan*. In particular, Corrections should consider incorporating the Primary Health Care Nurse Mental Health and Addiction Credentialling Programme into its mandatory training for those nurses who have not already had specialist mental health and addictions training.

19. Corrections should consider offering more learning opportunities to health staff to enable them to recognise possible withdrawal symptoms from alcohol and other drugs and provide appropriate education and intervention.

20. Corrections should continue its discussions with national and regional forensic mental health services about the effectiveness and application of the Mental Health Screening Tool.

21. Corrections should consider providing practice guidance for the use of health alerts in the electronic patient management system.

22. Corrections should consider whether responsibility for administering the ASSIST tool should be with Health Services or Case Management, and whether staff are appropriately trained and resourced to carry out this screening.

23. Corrections should consider how to ensure prisoners have more timely access to medication prescribers, including considering adopting more telehealth technology.

24. Corrections should consider how it can better support people who have acute and chronic insomnia and/or pain.

Life in prison

25. Corrections should consider how it can ensure that case officers are actively managing prisoners and documenting their interactions.

26. Corrections should consider offering prisoners more educational opportunities to support them in managing day-to-day stressors, including sessions for learning meditation, mindfulness, managing distress, managing anxiety, managing a traumatic brain injury, hearing voices, and dialectical behaviour therapy skills for those with borderline personality disorders or traits.

27. Corrections should consider expediting the approval processes for visits/telephone calls.

28. Corrections should consider offering greater access to family/whānau, including via telephones, visits and audio-visual options (for example, in-cell technology).

29. Corrections should consider ways to strengthen opportunities for family/whānau input and family/whānau-centred care, in particular for people with high and complex needs.

30. Corrections should consider expanding trauma counsellor roles across all prisons to align with demand.

31. Corrections should consider providing early intervention to support those at risk of suicide or self-harm, or those otherwise vulnerable, to remain in mainstream units.

32. Corrections should consider reviewing its process so that all Review Risk Assessments are completed according to best practice and in collaboration with health where necessary.

33. Corrections should consider the National Institute for Health and Care Excellence (UK) guidelines when reviewing its risk assessments, with a focus on psychosocial assessments, risk formulations and safety plans.

Going to an Intervention and Support Unit

34. Corrections should consider having a specialist mental health clinician leading the decision-making for people at risk of suicide and self-harm entering and leaving the ISU.

35. Corrections should consider whether ISUs should be clinically led and supported by custody to embed an evidence-based therapeutic culture, including:
    - ensuring risk assessments and care are individualised
    - learning from other models of care (e.g. Hikitia).

36. Corrections should consider having dedicated custodial and clinical staff in ISUs.

37. Corrections should consider providing more guidance to ISU staff about alternative approaches to using mechanical restraints for people who are actively self-harming.

38. Corrections should consider providing more guidance to custodial staff who are required to do constant observations, and should ensure that staff who have completed constant observations are appropriately debriefed.

39. Corrections should consider how to better support people with personality disorders, and continue to offer education and training for staff who are supporting people with complex personality traits.

40. Corrections should consider strengthening the reflective supervision model and resourcing this for custodial staff in all ISUs.

41. Corrections should consider how care plans can be better developed, reviewed and shared after a self-harm threat to life incident.

42. Corrections should consider evaluating the implementation and application of the new guidance for wellbeing checks.

43. Corrections should consider greater use of options such as telehealth, especially for situations where specialist mental health clinicians are required but are not immediately available (e.g. after hours or on weekends).

44. Corrections should consider establishing additional dedicated units that better support the assessment and care of vulnerable people (e.g. 'step-down' units from the ISU, or units for people who are new to prison, or people with a mental illness or a cognitive disability).

45. Corrections should consider, and keep under review, whether to establish ISUs in the prisons that do not currently have these.

46. Corrections should consider establishing a national formal escalation process for the care of forensically unwell people who are waiting for in-patient admission.

Postvention: After a suspected suicide

47. Corrections should continue to progress the postvention workplan as set out in 'Focus Area 8' of its *Suicide Prevention and Postvention Action Plan*, and report on progress to the Suicide Prevention and Postvention Advisory Committee.

48. Corrections should consider reviewing systems and policies to better support staff after a suspected suicide including:

    » strengthening debriefing processes to ensure all staff are offered meaningful support in the short, medium and long term

    » clarifying the roles and responsibilities of managers after an incident

    » ensuring debriefing sessions are facilitated by managers trained in debriefing.

49. Corrections should consider appointing a nominated suicide prevention and postvention coordinator at each prison, whose remit could include building relationships with external agencies and experts, including iwi, Māori health services, and local regional health service suicide prevention and postvention coordinators.

Release

50. Corrections should consider strengthening its efforts in multi-agency collaboration to address systemic issues in service provision for prisoners on release.

51. Corrections should consider reviewing the effectiveness of the discharge nurse role to decide whether it should be implemented nationwide.

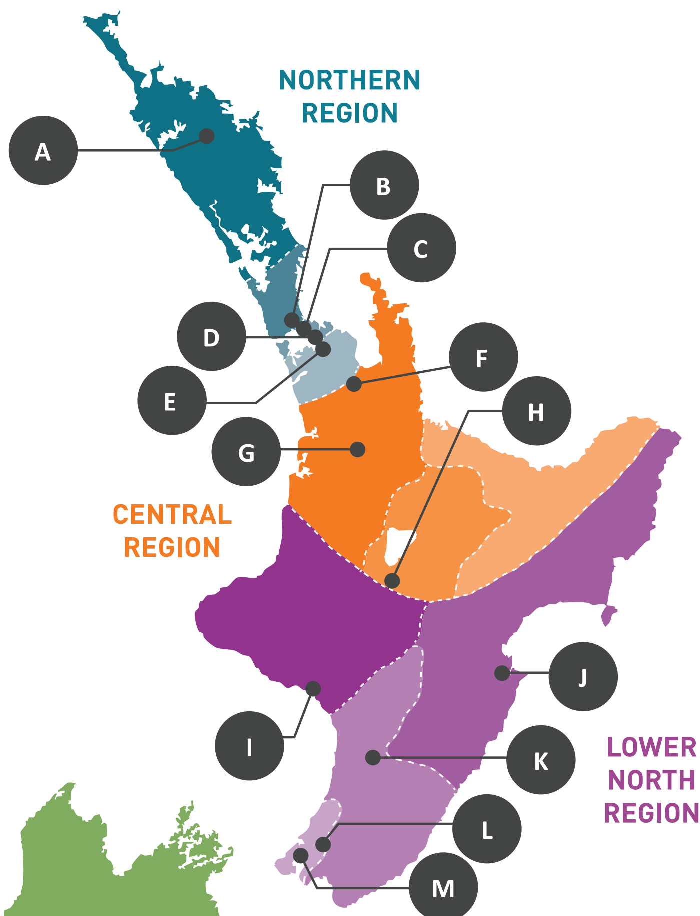
52. Corrections should consider collaborating with relevant external partners to collate and review data on deaths by suspected suicide within a relevant period (to be determined) after release.

Impact of COVID-19

53. Corrections must continue its review of its response to the COVID-19 pandemic to ensure learnings (particularly in relation to the quarantine of prisoners and the impacts of the restrictions on isolation, lack of contact with family/whānau, access to healthcare, and access to meaningful and constructive activities) are planned for in the event of a future pandemic, or other significant and prolonged restrictions on access by family/whānau, lawyers and other professionals, and volunteers.

54. Corrections should consider building on the new technological and flexible approaches that were introduced as a result of COVID-19 (e.g. telehealth, virtual visits on laptops, additional use of AVL, and more flexibility with timing of virtual visits).

New Zealand Prison Network



NORTHERN REGION

A. Northland Region Corrections Facility

B. Auckland Prison

C. Mt Eden Corrections Facility

D. Auckland Region Women's Corrections Facility

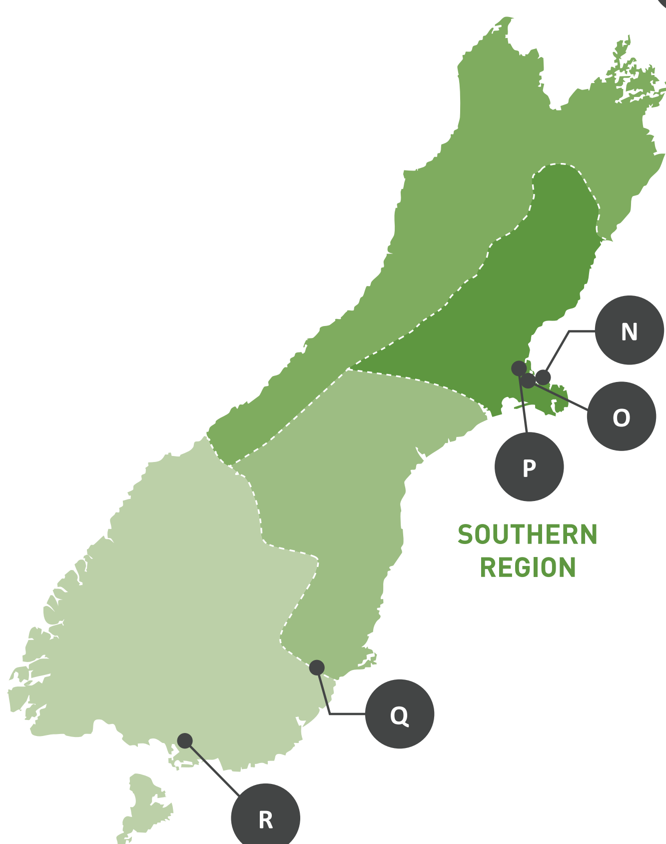
E. Auckland South Corrections Facility

CENTRAL REGION

F. Spring Hill Corrections Facility

G. Waikeria Prison

H. Tongariro Prison



LOWER NORTH REGION

I. Whanganui Prison

J. Hawke's Bay Regional Prison

K. Manawatu Prison

L. Rimutaka Prison

M. Arohata Prison

SOUTHERN REGION

N. Christchurch Men's Prison

O. Christchurch Women's Prison

P. Rolleston Prison

Q. Otago Corrections Facility

R. Invercargill Prison

Introduction

1. Suicide and self-harm are significant issues in prisons both here in Aotearoa New Zealand and internationally, and it is well known that many of the risk factors for suicide and self-harm are present in many people in prison. In such a high-risk population, it can be difficult for Corrections staff to predict who will and who will not be involved in a suicide or serious self-harm incident. It can be equally difficult for staff and clinicians to know which treatments and interventions will be successful for a particular person.

2. This report acknowledges that there are no easy solutions when it comes to suicide and self-harm prevention in prisons. However, there are practices and interventions that can help to save lives and reduce self-harm incidents. Corrections has a duty of care to all people in prison and must do everything it can to identify and mitigate the risk of suicide and self-harm.

3. Previous reports have tended to focus on either suicide or self-harm. While we acknowledge that many people who self-harm are not suicidal, a history of self-harm or attempted suicide is a significant risk factor for suicide (Rojas et al, 2019). We have therefore chosen to take a broader approach and have examined both suspected suicides and self-harm incidents where there was a threat to the person's life.

4. In the five-year review period from 1 July 2016 to 30 June 2021, there were 29 suspected suicides recorded in New Zealand prisons. We use the term 'suspected' because while all the deaths we examined appeared to be suicide, not all had yet been determined as suicide by the coroner.[1]

5. In the same five-year period, 158 people in New Zealand prisons were involved in 253 recorded 'self-harm threat to life' incidents. Since the review period ended, three of those 158 people have died by suspected suicide in prison.

6. In New Zealand prisons, self-harm incidents are categorised by custodial staff by seriousness: 'self-harm threat to life' or 'self-harm, no threat to life'. A self-harm threat to life incident is defined in the Corrections Services Schedule of Incident Categories for prisons as an "intentional act of harm to oneself which would most probably have led to death if there was no immediate intervention (includes all attempted suicides)." This review is confined to self-harm threat to life incidents.

7. Self-harm is the act of deliberately injuring one's body. Some self-harm threat to life incidents were suicide attempts, but some were not. Some self-harm, even when serious, can be a way of coping with difficult emotions or overwhelming situations.[2] Self-harm of this type is sometimes known as non-suicidal self-injury and people who engage in it do not intend to end their lives (Klonsky, Victor & Saffer, 2014).

8. We acknowledge that Corrections staff make every effort to preserve the lives of people involved in self-harm threat to life incidents. Our analysis of the 253 self-harm threat to life incidents during the review period confirmed that health and custodial staff saved lives with their timely and skilled responses.

9. It is important to note that the five-year review period includes fifteen months during which New Zealand, along with the rest of the world, was dealing with the effects of the global COVID-19 pandemic. COVID-19 disrupted—and continues to disrupt—many normal routines in prisons all over the world. New Zealand prisons are no exception. It must be recognised that COVID-19 has caused significant distress and hardship to many people both in and out of prison.

10. We also note that the Chief Ombudsman has welcomed this thematic review, expressed particular interest in three areas (reception into custody, risk assessments, and settings in Intervention and Support Units) and raised

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1 All deaths in prison are referred to the coroner who examines each case and determines the cause of death.

2 From https://mentalhealth.org.nz/conditions/condition/self-harm - retrieved 27 June 2022.

concerns about the increase in suspected suicides in prisons from seven in 2019/20 to 11 in the 2020/21 reporting year.[3]

People in prison are more vulnerable to suicide and self-harm

11. People in New Zealand prisons have significantly higher rates of suicide and self-harm than people in the general population. Compared to the general population, people in prison are twice as likely to have ever thought about suicide, and four times more likely to have ever attempted it (Indig, Gear & Wilhelm, 2016).

12. Prisoners have a higher incidence of known risk factors for suicide and self-harm than people in the general population. For example, nearly all (91%) people in New Zealand prisons have a lifetime diagnosis of a mental health or substance use disorder, compared to 40% of people in the general population (Indig et al, 2016). Prisoners with a mental health disorder (such as an anxiety or mood disorder) have the highest rates of recent or lifetime suicidal behaviour; almost two thirds (62%) of people in New Zealand prisons meet the diagnosis for either a mental health disorder or a substance use disorder (Indig et al, 2016).

13. A recent international meta-analysis confirmed that the prevalence of mental health disorders is higher in both men and women entering prison than in the general population: "…they have more psychotic disorders (4% for males; 4% for females), depression (10% for males; 12% for females) personality disorders (65% for males; 42% for females), alcohol and drug misuse/dependence (18-30% for males; 10-24% for females) and post-traumatic stress disorder (4-21% for males; 10-21% for females)". The study also pointed out that "Prisoners are also exposed to unique risk factors associated with their incarceration, such as single-cell occupancy, hopelessness from serving a life sentence, and the institutional environment (e.g. overcrowded conditions, isolation protocols and risk of violence)." (Stijelja & Mishara, 2022).

14. As with mental health disorders, people in prison are more likely than those in the general population to be diagnosed with a personality disorder, which is a known risk factor for suicide and self-harm (Favril, Yu, Hawton & Fazel, 2020). A study in 2016 found that 33% of prisoners in New Zealand had a lifetime diagnosis of a personality disorder (Indig et al, 2016).

15. Having a history of trauma is a risk factor for suicide and self-harm, and people in prison are more likely than those in the general population to have histories of early and multiple traumas. One study found that, in New Zealand, 52% of women in prison and 22% of men have a lifetime diagnosis of post-traumatic stress disorder (PTSD) (Indig et al, 2016).

16. Evidence suggests that while men in prison are more likely to die by suicide, women are more likely than men to self-harm, and more likely to report a lifetime history of suicidal ideation and attempts (Stijelja & Mishara, 2022). In New Zealand, a 2016 study found (in line with international evidence) that women in prison have higher rates of suicidal behaviours than men, including ever thinking about suicide (44% of women compared to 34% of men) and ever attempting suicide (29% of women compared to 19% of men). The study also found that 75% of women in prison had had a mental health condition diagnosed in the last 12 months (compared to 61% of men) (Indig et al, 2016).

17. People in prison who die by suicide are more likely to be convicted of homicide, violent and sexual offences than other prisoners (Zhong, Senior, Yu, Perry, Hawton, Shaw & Fazel, 2021), and one theory of suicide suggests that comfort with violence or habituation to pain and fear can increase the chance of suicide (Joiner, 2005). Currently, over 80% of the New Zealand prison population have convictions for violence in their offending histories. Additionally, 35% have a gang affiliation, which is a known predictor of violence. We understand prisoners with

[3] Letter to the Office of the Inspectorate from the Office of the Ombudsman, dated 13 September 2021.

gang affiliations have more than doubled in the last ten years.

18. There is evidence to suggest that the prison environment itself may contribute to heightened risk of suicide or self-harm, due to factors including isolation from support networks, the quality of prisoner/staff and prisoner/prisoner relationships, the degree of order or disorder in the prison, prisoner numbers, the impact of transfers, and access to meaningful activity (Alleyne, 2017).

19. The World Health Organisation (WHO) provides a useful framework for considering risk factors and appropriate interventions for suicide in the general population, and this can be applied to prisons (WHO, 2014). Significant here is the recognition that risk factors for suicide go beyond an individual's histories and pathologies. Rather, risk factors accumulate at different levels: society, community, relationships, and the individual.

20. Although people in New Zealand prisons are generally more vulnerable to suicide and self-harm, some protective factors may be present for some prisoners. The WHO notes that protective factors for suicide include strong personal relationships, religious or spiritual beliefs that give a sense of cohesion, and lifestyle practices of coping (such as an attitude of optimism, help-seeking, and making healthy lifestyle choices about diet, sleep and exercise).[4] In prisons, other possible protective factors mentioned in the literature include time spent out of a prison cell and time spent in purposeful activities (Stephenson, Leaman, O'Moore, Tran & Plugge, 2021) and cell-sharing (Zhong et al, 2021; Jones, 2017).

Mitigation efforts

21. The Department of Corrections (Corrections) recognises that risk factors for suicide and self-harm are present in most people in prison and has been taking steps to support the mental wellbeing of prisoners and reduce suicide and self-harm rates. Key initiatives implemented during the review period included:

    » Primary mental health 'Packages of Care' where prisoners with low to moderate mental health needs could access a suite of therapeutic interventions from counsellors.

    » The Mental Health and Reintegration Service which introduced 'Improving Mental Health' clinicians into prisons and Community Corrections sites. This service also introduced trauma counsellors and social workers into the three women's prisons.

    » The Intervention and Support Practice service, which introduced multi-disciplinary Intervention and Support Practice Teams to three (later expanded to six[5]) prisons to provide mental health support to people with moderate to severe mental distress, and with a particular emphasis on supporting those vulnerable to suicidal and self-harming behaviour.

    » The introduction of clinical nurse specialists (mental health) at all prisons without an Intervention and Support Practice Team.

22. In 2019, Corrections introduced *Hōkai Rangi: Ara Poutama Aotearoa Strategy 2019 – 2024*, (Department of Corrections, 2019a) which expresses Corrections' "commitment to delivering great outcomes with and for Māori in our care and their whānau, so that we can begin to address the significant over-representation of Māori in the corrections system." At the heart of the strategy are six pou (areas of focus for change) that will contribute to the oranga (wellness and wellbeing) of people in prison. In addition, Hōkai Rangi directs Corrections to take a humanising and healing approach to how it manages people in prison. This strategy could have a positive effect on suicide and self-harm rates.

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[4] WHO recommends caution about the role of religious beliefs, as some, such as stigmatisation of suicide, may discourage help-seeking behaviours and others encourage suicide in specific circumstances.

[5] In July 2022, a seventh Intervention and Support Practice Team was being developed at Otago Corrections Facility.

23. In the same year (2019) the New Zealand Ministry of Health released *Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024* for Aotearoa New Zealand (Ministry of Health, 2019). *Every Life Matters* acknowledges that suicide prevention needs a whole-of-society and whole-of-government approach. Corrections is a part of that approach.

24. In 2022, Corrections introduced its *Suicide Prevention and Postvention Action Plan 2022-2025* (Department of Corrections, 2022). *Every Life Matters* "stands as the basis for" the Corrections *Suicide Prevention and Postvention Action Plan*, which represents Corrections' intention to "take deliberate and targeted action to address the problem of suicide". Corrections has also formed a Suicide Prevention and Postvention Advisory Group to "oversee the development of the plan and ensure its successful implementation".

The purpose of this thematic review

25. The purpose of this thematic review, as stated in our Terms of Reference, is to:

   » collect and analyse the data surrounding all suspected suicide and self-harm threat to life incidents in New Zealand prisons across the five-year review period 1 July 2016 – 30 June 2021

   » use the data to identify causative factors and trends for suspected suicide and self-harm threat to life incidents in New Zealand's prisons

   » consider the role and efficacy of the systems, practices and processes that were in place during the review period

   » consider how people can be kept safe and identify where serious harm could be prevented so that new approaches can be developed to provide better outcomes for those in prison.

This review will build on the findings of previous reviews, including Suicide in New Zealand Prisons 1 July 2010 to 30 June 2016 (Jones, 2017), and the Suspected Suicide Thematic Review, which examined eight[6] suspected suicides that occurred in New Zealand prisons during the 2019/20 financial year.[7]

Methodology

26. For this thematic review, the Inspectorate review team examined the available data including:

   » the international and local published and unpublished literature about the causes and risk factors for suicide and self-harm, and efforts to prevent harm to people in prison

   » death in custody reports for suspected suicides that occurred during the review period, as conducted by the Office of the Inspectorate

   » internal reviews and evaluations conducted by Corrections

   » statistical and demographic information, including that taken from the Corrections Business Reporting and Analysis (COBRA) tool and MedTech (the electronic patient[8] management system used by Corrections health professionals)

   » custodial practice information from the Integrated Offender Management System (IOMS)

   » policy and practice information from Corrections

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[6] Our review estimates that there were seven suspected suicides in the 2019/20 year. Numbers of suspected suicides may be different in different reviews as cases have not necessarily come before the coroner for a cause of death to be determined.

[7] Department of Corrections Health Services Internal Memorandum dated 22 September 2020 from Senior Advisor Mental Health to Deputy Chief Executive Health, Suspected Suicide Thematic Review.

[8] Health staff at Corrections usually refer to the people in their care as patients

- information on relevant learning and development provided to Corrections staff across the review period
- information on relevant investment in mental health and addictions services introduced by the Corrections across the review period.

27. In addition, the Inspectorate review team invited a selection of subject matter experts to participate in formal and informal interviews. Subject matter experts included psychologists, mental health clinicians, and senior Corrections managers, including health, mental health, Māori health, and custodial managers. A total of 23 interviews were conducted with subject matter experts. Follow-up questions were asked by email or in telephone calls.
28. Two inspectors conducted focus groups with custodial staff at two men's prisons and one women's prison. Custodial staff were invited to discuss the strengths and weaknesses of the current systems and processes for managing prisoners at risk of suicide and self-harm, including how staff were able to identify and work with this group. A further focus group was planned for a third men's prison, but this had to be cancelled due to the COVID-19 Omicron surge in March 2022.
29. The Inspectorate review team completed case studies by examining the clinical histories and life circumstances for six people who were involved in self-harm threat to life incidents during the review period. Some of the information from these case studies is presented in this report. The information has been anonymised to protect people's privacy. The purpose of these case studies is to highlight the often complex circumstances surrounding self-harm threat to life incidents, while at the same time protecting the privacy and mana of the people concerned.
30. Lastly, we drew on the knowledge and experience of our team of Inspectors who have completed many investigations, prison inspections and thematic reviews where prisoners were interviewed. We have also drawn on prisoners' concerns from complaints they had made to the Office of the Inspectorate.

Limitations

31. We acknowledge that this review has some limitations, which we set out here.
32. For a variety of reasons, including COVID-19 restrictions and ethical considerations, we did not interview people in prison who had self-harmed, or the family/whānau of people in prison who had self-harmed or died by suspected suicide. We welcome Corrections' intention, as stated in its *Suicide Prevention and Postvention Action Plan* (Department of Corrections, 2022), to conduct "a series of interviews with people in our care and management who are willing to share their experiences of suicidal distress/behaviour to better understand relevant risk and protective factors and interventions that might be helpful." We encourage Corrections to expand their plans to include family/whānau in these interviews if possible.
33. Our literature review surveyed "causes of suicide and self-harm and efforts to prevent harm to people in prison", especially focusing on the literature from 2015 onwards. This focus may mean some relevant literature, for example literature with a mental health or addictions focus, was omitted.
34. We scheduled interviews with frontline health staff for this review, but were unable to complete them due to the impacts of COVID-19. Instead, we have used relevant quotes which were obtained from health staff during previous inspections/reviews.
35. Information within the electronic patient management system (MedTech) or IOMS did not cover all the topics we reviewed, or the information was not necessarily recorded (for example, these systems did not contain reliable data on prisoners' family/whānau relationships, such as whether they were parents or not).

36. The suspected suicide and self-harm threat to life statistics we use in this report come from the Corrections Business Reporting & Analysis (COBRA) tool, which is in turn informed by components of incident reports entered by custodial staff in IOMS. We are aware that our statistics may differ slightly from statistics previously published in other sources, such as Corrections Annual Reports. We do not consider that these minor differences are significant, nor do they have any bearing on the statements we make or the areas for consideration we have identified.

37. We included previous reviews of suspected suicides in New Zealand prisons in our literature review, and reference these in this report. However, we did not evaluate Corrections' progress in addressing the recommendations made by these reviews.

At a Glance

Snapshot of the New Zealand prison population

Compared to the general New Zealand population, prisoners are:[9]

Top international risk factors for suicide in prison[10]

Risk factor	Suicide odds ratios[11]
Suicidal thoughts during the current period in prison	15.2
History of attempted suicide	8.2
History of self-harm	7.1
Occupation of a single cell	6.8
Current psychiatric diagnosis	6.4
Current diagnosis of depression	4.9
Being prescribed psychotropic medication	3.8
Being on remand	3.6

9 Figures from Indig, Gear & Wilhelm, 2016.

10 Figures from Zhong et al, 2021.

11 Odds ratios look at the odds a particular risk factor was present in a case group (e.g. people who died by suicide in prison) versus a control group (e.g. people who did not die by suicide in prison). For example, this table shows that people who died by suicide in prison were 15.2 times more likely to have had suicidal thoughts during the current period in prison than those in the control group.

Top international risk factors for self-harm in prison[12]

Risk factor	Suicide odds ratios
Current or recent suicidal ideation	13.8
History of suicidal ideation	8.9
Current diagnosis of major depression	9.3
Current diagnosis of personality disorder	9.2
Any current psychiatric diagnosis	8.1
Previous self-harm	6.6
Being held in solitary confinement	5.6

Twenty-nine prisoners involved in a suspected suicide in New Zealand prisons (1 July 2016 – 30 June 2021)[13]

12 Figures from Favril, Yu, Hawton & Fazel, 2020.

13 Numbers for suspected suicides have been presented as counts only (not percentages) due to the low amounts of data.

158 people involved in 253 self-harm threat to life incidents in New Zealand prisons (1 July 2016 – 30 June 2021)

Literature Review Summary

39. A review of the recent literature contributed to our analysis of suspected suicide and self-harm threat to life incidents in prisons. The review included the available literature on risk factors for suicide and self-harm in prison, and more holistic models of health and wellbeing from te ao Māori.

40. We found that much of the recent literature examines risk factors for suicide or self-harm in prison, or describes interventions aimed at reducing suicide or self-harm. There was less literature evaluating such interventions or describing what works to prevent suicide and self-harm.

41. Many studies link measurable risk factors to suicide and self-harm. These studies typically compare samples of people who die by suicide or people who self-harm with samples of people who do not, to see whether there are differences between them.

42. In an international meta-analysis of 77 studies published in 2021, the risk factors showing the strongest links to suicide in prison were: suicidal thoughts during the current period in prison (odds ratio (OR) 15.2), a history of attempted suicide (OR 8.2), a history of self-harm (OR 7.1), occupying a single occupancy cell (OR 6.8), a current psychiatric diagnosis (OR 6.4) and having a diagnosis of depression (OR 4.9). The same study found that being on remand was also a significant risk factor (OR 3.6), as were being convicted of homicide, (OR 3.1), alcohol misuse (OR 2.5) and serving a life sentence (OR 2.4) (Zhong et al, 2021).

43. The meta-analysis highlighted the emergence of two risk factors for suicide that had not been identified in previous reviews: a diagnosis of depression, and an absence of social visits. They also found that an index sexual offence was associated with increased risk of suicide (previously this association had been less certain) (Zhong et al, 2021).

44. A 2021 study that examined prisoners who thought about suicide compared to those who actually attempted it, found that those who attempted it were more likely to be violent offenders, to have a history of non-suicidal self-injury, a self-reported mental disorder diagnosis, and substance use issues (Favril & O'Connor, 2021).

45. In New Zealand, a 2016 study confirmed that high rates of psychiatric disorders and addictions are common in the New Zealand prison population (Indig et al, 2016). A 2017 New Zealand study found that of those prisoners who took their lives between 2010 and 2016, 79% had a record of drug or other dependence, 51% had a diagnosed mental health condition, and 44% had a history of self-harm (Jones, 2017).

46. An international meta-analysis covering 50 years of studies of self-harm in prison found that risk factors showing the strongest links to self-harm in prison were: current or recent suicidal ideation (OR 13.8), lifetime history of suicidal ideation (OR 8.9) and previous self-harm (OR 6.6). The meta-analysis also found that any current psychiatric diagnosis was strongly associated with self-harm (OR 8.1), particularly major depression (OR 9.3) and borderline personality disorder (OR 9.2), followed by psychotic disorder, anxiety disorder and substance use disorder (Favril et al, 2020).

47. Custody-specific factors that increased the risk of self-harm among prisoners included solitary confinement (OR 5.6), violence or assault perpetration (OR 3.8) having disciplinary infractions, such as for assaulting another prisoner (OR 3.5), sexual or physical victimisation (OR 3.2), and being threatened with violence (OR 2.6). Poor social support and no social contact or visits increased the odds of self-harm to a lesser extent (OR 2.3) along with not working in prison (OR 1.9) (Favril et al, 2020).

48. Childhood abuse increased the risk of self-harm in prison. Among the factors with the strongest associations with self-harm were childhood sexual abuse (OR 3.9), childhood physical abuse (OR 3.2) childhood emotional abuse (OR 3.0), and a family history of suicide (OR 3.0) (Favril et al, 2020).

49. Regarding 'what works' to prevent suicide and self-harm in prisons, the literature provides mixed evidence (Winicov, 2019). Some success in suicide prevention with male prisoners was achieved with a cognitive-behavioural therapy programme (Pratt, Tarrier, Dunn, Awenat, Shaw, Ulph & Gooding, 2015). Similarly, a small pilot to reduce harm and psychological distress among young offenders found that a "psychotherapy intervention" reduced the incidence of self-harm (Forster & Shaw, 2018).

50. Some authors found support for multi-factored prison interventions, while noting that evaluation designs were limited (Borschmann, Carter, Butler, Southalan, Willoughby, Janca & Kinner, 2020; Barker, Kõlves & De Leo, 2014). Multi-factored or multi-faceted interventions refer to prison-wide plans to prevent suicide. These might include mental health screening for new arrivals, diagnosis of mental health disorders, referral for treatment and care planning, out-patient treatment when required, and training for staff.

51. For Māori, the literature around suicide and self-harm prevention contains themes including the importance of a strong grounding in culture and tikanga Māori, an ethic of care (manaaki), a focus on whānau and relationships, empowerment (whakamana), healing wairua (spirit), and teaching specific coping skills to keep people safe (Kāhui Tautoko Consultancy Ltd, 2014). The literature also indicates that suicide and self-harm prevention initiatives in prison need to be co-developed with Māori, and, in specific prison sites, with mana whenua of that area (Cameron, Pihama, Millard, Cameron & Kopu, 2017).

52. The literature also highlights nationwide systemic issues and the importance of multi-agency working. A recent UK report into improving prisoner death investigations and promoting change in prisons includes a key recommendation that: "To help prevent further deaths, reports into self-inflicted prisoner deaths should not only examine and make recommendations on policy and procedural compliance by staff within individual prisons, but also highlight 'systemic hazards' – e.g. the warehousing of severely mental ill people in prisons … which are key contributors to self-inflicted deaths." The review goes on to say that "reducing deaths in prisons in a significant and sustained way will not be achieved unless 'systemic hazards' are also addressed" (Shalev & Tomczak, 2023).

53. We note that "systemic hazards" are present in New Zealand and that these may contribute to suspected suicide and self-harm threat to life incidents in prisons.

54. The importance of a multi-agency approach in reducing risk factors for self-harm is also highlighted in the conclusion of the international meta-analysis of self-harm incidents in prisons mentioned above (Favril et al, 2020). The authors remark: "Strategies to address these risk factors will potentially require interventions at all levels of the criminal justice system, including diverting people before prison, purposeful activities, and social support, and maintaining these approaches on release. Implementing these interventions will require a multisectoral approach across health, social care, and criminal justice."

55. Overall, the literature appears to support the idea that a multi-faceted, multi-agency approach is required to support wellbeing for prisoners. This approach may include providing a humane physical environment with models of care that offer some choice to prisoners, and culturally responsive therapies that address identified needs, build skills, and that seek the involvement of wider supports (such as family/whānau) where agreed to by prisoners.

56. It is also clear that there is a great need for more evaluation of efforts to reduce suicide and self-harm in prisons.

Demographic and Statistical Analysis

Introduction

57. This section provides demographic and statistical information about suspected suicide and self-harm threat to life incidents in New Zealand prisons in the five-year review period 1 July 2016 to 30 June 2021. Additional statistical information is given in the most relevant sections of this report and in Appendix A.

58. All suspected suicide and self-harm threat to life incidents in prisons are considered notifiable and severe by Corrections and require immediate notification to an incident line (day or night), followed by an Integrated Offender Management System (IOMS) incident report within two hours of the incident.

59. Additional clinical information for this section has been taken from prisoner health records in Corrections' electronic patient management system. We also reviewed Office of the Inspectorate death in custody reports for the suspected suicides, taking particular notice of the findings and recommendations in those reports.

60. We note the limitation on examining statistics when these are removed from the personal circumstances surrounding them, however, data analysed in this way may show useful trends that can inform further enquiry.

Suspected suicide statistics

Overview

61. In the five years from 1 July 2016 to 30 June 2021, there were 29 suspected suicides recorded in New Zealand prisons (see Figure 1). There was an increase in suspected suicides in the 2020/21 year, with 11 suspected suicides recorded. The average across the five years was six suspected suicides a year.

Figure 1: Suspected suicides in New Zealand prisons by financial year 2016/17 to 2020/21

Financial year	Suspected suicides
2016/17	1
2017/18	7
2018/19	3
2019/20	7
2020/21	11
TOTAL	29

62. To give some context to the suspected suicide figures in the review period, in 2017 it was reported that "since 1 July 2000, Corrections has generally experienced between three to six suicides in prisons each year" (Jones, 2017). In the six years before the review period (i.e. 1 July 2010 to 30 June 2016) 39 prisoners took their own lives in New Zealand prisons, an average of 6.5 deaths a year, with 11 deaths by suspected suicide in the 2015/16 year.

63. Compared to people in the general population in New Zealand, people in prison are more likely to die by suicide. In our review period, 29 people in prison died by suspected suicide, compared to 3,149 people in the general population who died by suspected suicide during the same period.[14] When we calculate the rates per 100,000 of population for the review years, the difference becomes clear (see Figure 2).

Figure 2: Comparison of deaths by suspected suicide in the general population of New Zealand and deaths by suspected suicide in New Zealand prisons, by rates per 100,000 of population, for the review period

Financial year	Number of deaths by suspected suicide in the general population in New Zealand[15]	Rate per 100,000 (general population)	Number of deaths by suspected suicide in New Zealand prisons	Rate per 100,000 (prisoners)[16]
2016/17	579	11.5	1	4
2017/18	668	12.8	7	32
2018/19	655	12.9	3	14
2019/20	632	11.9	7	32
2020/21	615	11.8	11	56

64. In the review period, the overall prison population decreased from a maximum of 10,820 prisoners on 26 March 2018, to 8,397 at the end of our review period on 30 June 2021. The numbers of prisoners held on remand decreased more slowly, with 3,408 people on remand at 30 June 2018 compared with 3,048 at 30 June 2021. This is significant as evidence suggests that being on remand is a risk factor for suicide and self-harm.

65. In addition, while the overall prison population decreased throughout the period, there is a common perception amongst Corrections staff and managers that those people remaining in prison are more complex, with more mental health and addictions issues. This perception is supported by the literature. A 2016 study found that rates of diagnoses for prisoners had increased across all mental health and substance disorder categories when compared to data from 1999 (Indig et al, 2016). There is no reason to suppose that this trend reversed across the review period. In addition, internationally, researchers have found that as imprisonment rates drop, suicide rates in prisons increase (Fazel, Ramesh & Hawton, 2017). This may be because the people remaining in prison are more likely to have committed more serious and violent crimes or have higher rates of mental illness, both of which are associated with increased suicide risk (Fazel, Cartwright, Norman-Nott & Hawton, 2007).

Demographics

66. Our review found prisoners in their thirties were the largest group who took their lives (11 of 29, or 38%) with the average age being 35.7 years. Prisoners in their thirties were also the largest group in prison (37% remand and

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14 Statistics provided by the New Zealand Ministry of Health and Office of the Chief Coroner of New Zealand via their Suicide Web Tool and downloaded on 22 May 2023. https://tewhatuora.shinyapps.io/suicide-web-tool/

15 Ibid.

16 These rates are highly volatile due to the small sample size of prisoners when compared to the general population.

30% sentenced prisoners were in their thirties at June 2020). One person who died by suspected suicide was 18 and three were over 50. Similar numbers were in their twenties (seven) or forties (six).

67. Of the 29 people involved in a suspected suicide, 27 (93%) were men and two (7%) were women. Since men constituted around 93% and women around 6–7% of New Zealand's total prison population during the review period, neither group was over-represented in the suspected suicide statistics.

68. Nine (31%) of the 29 prisoners involved in a suspected suicide identified as Māori. Around 52% of the prison population (at 30 June 2020) identified as Māori, so Māori prisoners were not over-represented in these statistics. Māori are over-represented in the prison population, however, with around 17% of people in the general New Zealand population identifying as Māori at 30 June 2020.

Prisoner profile

69. Twenty-two (76%) of the suspected suicides were by people with a remand status (17 remand accused, five remand convicted). Seven people were sentenced, with three of them serving a life sentence.

70. Eleven people (38%) were in prison for the first time.

71. Four people (14%) died within seven days of being received into prison. A further 14 (48%) died within their first hundred days; seven of the 14 were in prison for the first time. Six people (21%) died between 101 and 365 days since reception, and five people (17%) had been in custody for more than one year before their death.

72. The charges relating to eighteen (62%) of the 29 people were serious and involved violent offending. Thirteen people (45%) had gang associations. Ten people (34%) were being managed on a segregation order.

Physical and mental health

73. Twenty (69%) of the 29 people involved in a suspected suicide had a diagnosis of a mental health condition, of which 14 were being treated with medication for conditions including: anxiety, depression, panic attacks, attention deficit hyperactivity disorder, personality disorders, post-traumatic stress disorders, phobias and major mental illnesses such as schizophrenia. Fourteen of the 20 people had multiple mental health classifications. Six of the 20 had a diagnosis of some form of personality disorder.

74. Nineteen (65%) of the people involved in the 29 suspected suicides were noted to have had previous suicidal ideation, suicide attempts or self-harming behaviours. Thirteen of the 19 had spent time in an Intervention and Support Unit, and another had been in a 'safe cell'.[17]

Self-harm threat to life incident statistics

Introduction

75. In the five years from 1 July 2016 to 30 June 2021, 158 people in New Zealand prisons were involved in 253 recorded self-harm threat to life incidents (see Figure 3).

76. Figure 3 shows that self-harm threat to life incidents increased and then decreased during the review period, with 21 incidents in 2016/17, 84 incidents in 2019/20, and 58 incidents in 2020/21.

77. Historically, rates of self-harm threat to life incidents were lower, with, for example, only six incidents recorded in both 2011/12 and 2012/13. However, in 2013/14 there were 21 incidents, and in 2015/16 there were 26.

[17] A 'safe cell' is a special cell in a prison that has no Intervention and Support Unit. It is used to keep a person safe until they can be moved to a cell in a prison with an Intervention and Support Unit.

78. Over the review period there were also 2,554 self-harm incidents in New Zealand prisons where there was no threat to life. These less serious incidents appear to be increasing and ranged from 341 incidents in 2016/17, to 605 incidents in 2020/21 and 629 in the year 2021/22. The scope of this review did not include an analysis of these 'no threat to life' self-harm incidents, however, we give this information as context.[18]

Figure 3: Self-harm threat to life incident numbers in New Zealand prisons by financial year over the five-year period 2016/17 to 2020/21

Financial year	Number of self-harm threat to life incidents
2016/17	21
2017/18	34
2018/19	56
2019/20	84
2020/21	58

Demographics and personal histories

79. Eighty-one people (51%) who self-harmed were under 30 years of age.

80. The average age of people involved in a self-harm threat to life incident was 31, with an age range of between 17 and 65 years at the time of the incident.

Figure 4: Age band breakdown of people involved in self-harm threat to life incidents in New Zealand prisons from 1 July 2016 to 30 June 2021

Age band	Number of people
Under 20	12
20 - 29	69
30 - 39	42
40 - 49	25
50 - 59	8
60 - 69	2
TOTAL	158

81. Of the 158 people who self-harmed, 129 (81%) were men and 29 (18%) were women. Two of the women were trans-women.

82. As in the general population, women in prison were more likely to self-harm than men. Women were over-represented in self-harm threat to life incidents in New Zealand prisons in our review period. Women constituted around 6-7% of the general prison population (Office of the Inspectorate, 2021) but 29 (18%) of the people

[18] Figures received by email 29 August 2022 from Corrections Research Requests.

involved in a self-harm threat to life incident in the review period were women. Nineteen of these women engaged in multiple self-harm threat to life incidents, which meant that 58 (24%) of the 253 self-harm threat to life incidents involved women.

83. The main ethnicities represented were Māori (74 people, or 47%), New Zealand European (60 people, or 38%) and Samoan (6 people, or 4%). Māori rates were proportionate to the general prison population with around half of people in prison identifying as Māori.

Figure 5: Ethnicity of people involved in self-harm threat to life incidents in New Zealand prisons from 1 July 2016 to 30 June 2021

Ethnicity	Number of people
Māori	74
New Zealand European	60
Pacific Islander	10
Other	14
TOTAL	158

84. The majority of the 158 people (117 or 74%) were on remand, while the remaining 41 people (26%) had been sentenced (See Appendix A, Figure 11).

85. The majority of the 158 people (98 or 62%) were in prison on violence related charges. Other people were on charges relating to dishonesty, sexual offending, breaching public order, drugs and traffic offences (see Figure 6).

86. At the time of their self-harm threat to life incident, 66 people (42%) had an 'active' incident or misconduct.[19]

Figure 6: Charge description for people involved in self-harm threat to life incidents in New Zealand prisons from 1 July 2016 to 30 June 2021

Charge description	Number of people
Violence	98
Dishonesty	24
Sexual	13
Breach of public order	10
Drugs	10
Traffic	3
TOTAL	158

[19] An 'active' incident is one that has not yet been reviewed by the site and closed by the delegated authority.

Circumstances of the self-harm threat to life incident

87. Sixty-four people (40%) had court appearances around the time of their self-harm threat to life incident, and twelve (7%) had attended New Zealand Parole Board hearings.

88. Thirty-eight people (24%) who were involved in a self-harm threat to life incident were in prison for the first time.

89. At the time of the self-harm threat to life incident, 91 people (58%) were in a mainstream unit. Sixty-seven people (42%) were in an Intervention and Support Unit (ISU) or At-Risk Unit (At-Risk Units changed their names to Intervention and Support Units in 2018).

90. The most common methods of self-harm were asphyxiation by hanging (161, or 64% of 253 incidents) and laceration (54, or 21% of 253 incidents). These were the most common methods for both men and women. Other methods included swallowing items and banging their head against a hard surface (see Appendix A, Figure 12).

91. The most common time of day for self-harm threat to life incidents was 6pm – 7:59pm with 57 (23%) of the 253 incidents occurring during this time. Self-harm threat to life incidents tended to be more common during the day or in the evening, with most occurring between 10am and 9pm (see Figure 7).

Figure 7: Time of day, by two-hour periods, of self-harm threat to life incidents in New Zealand prisons from 1 July 2016 to 30 June 2021

Time of Day	Number of Self-Harm Threat to Life Incidents
12am – 1:59am	7
2am – 3.59am	3
4am – 5:59am	8
6am – 7:59am	10
8am – 9:59am	14
10am – 11.59am	24
12pm – 1:59pm	29
2pm – 3:59pm	36
4pm – 5:59pm	31
6pm – 7:59pm	57
8pm – 9:59pm	20
10pm – 11:59pm	14
TOTAL	253

92. Christchurch Men's Prison and Auckland Region Women's Corrections Facility had the most reported self-harm threat to life incidents, with 45 incidents and 37 incidents respectively. These numbers reflected a small number of individuals who were involved in multiple self-harm threat to life incidents. (See Appendix A, Figure 13 for more information on the numbers of self-harm threat to life incidents at different prisons).

93. Most of the 158 people (126, or 80%) were involved in only one self-harm threat to life incident. Thirty-two people (20%) were involved in more than one self-harm threat to life incident. One person was involved in 17 incidents (see Appendix A, Figure 14).

Physical and mental health

94. Ninety-eight (62%) of the 158 people involved in a self-harm threat to life incident had physical health conditions, with 18 of the 98 having neurological conditions (predominantly headaches) and 17 having respiratory issues (predominantly asthma). There were 31 people who had more than one physical health condition.
95. One-hundred-and-nineteen people (75%) had a mental health diagnosis, with 102 of these being diagnosed with anxiety and/or depression. This percentage was higher for women; 85% of the women who were involved in a self-harm threat to life incident had a documented mental health diagnosis.
96. Fifty-six people (35%) had conditions including attention-deficit hyperactivity disorder (ADHD), autism spectrum disorder, foetal alcohol syndrome, and traumatic brain injury.
97. Fifty-two people (33%) had a personality disorder/trait which included anti-social, narcissistic, and borderline personality disorders. Twelve people had more than one of these disorders/traits.

Investment in Mental Health and Addictions Services and Systems

Introduction

98. During the review period, Corrections strengthened or introduced several mental health and addictions services that aim to improve the mental health of people in prison and reduce suicide and self-harm incidents. This section provides a brief overview of this investment to give the reader context. We do not necessarily comment on effectiveness or suggest any areas for consideration for this section as some services have not yet been formally evaluated, or only initial evaluations have been completed.

Initiatives prior to 2016

99. From the mid-1990s, New Zealand prisons introduced At-Risk Units (ARU) for the safe management of prisoners with mental health needs and increased risk of self-harm. Practice in these units focused on the use of screening tools to identify risk, the maintenance of the prisoner's physical safety (for example, through close observation and removal of materials that could be used to self-harm), and referral to regional forensic mental health services to provide specialist assessment and treatment if indicated.

100. The Mental Health Screening Tool was developed in 2011 in partnership with forensic mental health services to enable Corrections staff to screen for suicide and self-harm as part of the reception process. It is completed by registered nurses as part of the Initial Health Assessment.[20]

101. In 2014 and 2015, the Columbia-Suicide Severity Rating Scale (C-SSRS) was tested for validity as a screening tool for suicide risk in New Zealand prisons (Wilson, 2017). In 2015, the C-SSRS was included in the Reception Risk Assessment which is completed by custodial staff and recorded in IOMS.

2016 – 2021: Key investment

The Developing Mental Health and Reintegration Services Programme

102. In 2016, Corrections received $13.8 million over two years through the Justice Sector Fund to increase access to mental health and reintegration services for prisoners and community-based offenders. This work was known as the Mental Health and Reintegration Services Programme. The programme contained four pilot initiatives that would be delivered over a two-year period (Frame-Reid & Thurston, 2016; Azuela, 2018):

    » The Improving Mental Health (IMH) Service: Aimed at increasing support for offenders with mild to moderate mental health issues. This pilot saw more clinicians working with prisoners, community-based offenders and staff. Teams of contracted mental health clinicians were working across 16 prisons and four Community Corrections sites from August 2017. Referrals for an assessment by an IMH clinician can be made by any Corrections staff member.

    » Support for women: Four trauma counsellors and four social workers were introduced to the three women's prisons to address women's specific needs around trauma, victimhood, and family/whānau. These services

[20] The Initial Health Assessment is a comprehensive health assessment conducted by a registered nurse with every prisoner.

were evaluated in 2018 and found to be "operating successfully at all three women's prisons" (Bowman, 2018).

- Supported Living: This contracted service enables up to 10 offenders with mental health needs or cognitive impairment to live temporarily in supported accommodation upon release from prison and to receive wrap-around reintegrative support. There are two services, one in Auckland (six residential beds) and one in Hamilton (four beds). Between 1 April 2017 and 30 June 2021, 97 people used this service.
- Wrap-around family/whānau support: This service, offered by contracted service providers, supports the family/whānau of offenders who are engaged in mental health services during their imprisonment or while serving a sentence or order in the community. The initiative connects family/whānau of prisoners with community services. Family/whānau are supported to reunite or stay united with offenders.

103. An implementation update for the Mental Health and Reintegration Services Programme was published in 2018. This update indicated that there would be an evaluation of the four initiatives, with a "strong focus on outcomes" (Azuela, 2018).

104. In the same year, an initial evaluation of the Improving Mental Health Service examined the programme's operational processes, including fidelity to service design, uptake of referrals, and successes and challenges of the programme's delivery. The initial evaluation found the service was contributing to improvements in offender mental health, and increasing general staff awareness of mental health issues (Barnes, 2018).

105. We understand that a review of primary mental health service provision at Corrections is underway.[21]

The Intervention and Support Project

106. In March 2017, the Chief Ombudsman released a critical review of At-Risk Units (Chief Ombudsman, 2017). The same year, Corrections reviewed prison suicides from the previous six years to look for patterns or trends that might inform work to mitigate suicide and self-harm (Jones, 2017).

107. The findings from this review, and a literature review and summary of how to transform support for at-risk prisoners (Alleyne, 2017) informed a budget bid in 2017 to set up the Intervention and Support Project. The project would "develop and pilot a new Model of Care (MoC) at three prison sites, to better identify prisoners who are vulnerable to self-harm or suicide, and to transform intervention and support for them" (Love & Rogers, 2018). The intention was to test a service that could be delivered to additional sites as more funding became available.

108. A key component of the new model of care was a site-based clinical multi-disciplinary team for each of the three pilot sites: Auckland Prison, Auckland Region Women's Corrections Facility, and Christchurch Men's Prison. These Intervention and Support Practice Teams (ISPTs) would include such roles as clinical managers, psychologists, occupational therapists, clinical nurse specialists (mental health), social workers, and cultural support workers. They would work with people vulnerable to suicide or self-harm across the prison as well as in a specialist unit and would focus on delivering interventions and support. At-Risk Units nationwide were renamed 'Intervention and Support Units' (ISUs) to signal this change of approach.

109. A Corrections intranet article published in 2019 and entitled 'Launch of pilot to reduce suicide and self-harm of people in prison' set out that the first Intervention and Support Practice Team (ISPT) began work at Christchurch Men's Prison in 2019, and that recruitment for the teams for the other two pilot sites (Auckland Region Women's Corrections Facility and Auckland Prison) was underway at that time.

[21] Information from an email to the Office of the Inspectorate from Corrections Director Mental Health and Addictions, received 4 May 2022.

110. Corrections reviewed the implementation of the Christchurch team at the end of 2019 (Rogers, Reet & Love, 2021). The review highlighted some issues that had impaired the team's ability to deliver care as envisaged. Key recommendations included:

» the need to acquire additional space within the site for meetings and consultations

» an increase in the number of ISPT members to meet the level of demand

» the need to adopt a wider range of assessment tools

» increased levels of cultural support needed to support the wider site

» generally broadening the scope of the model of care to encompass mental health needs beyond suicide and self-harm.

111. By April 2020, ISPTs were operating at the two Auckland pilot sites with the recommendations from the Christchurch review incorporated into practice. Additional funding allocated through Budget 2019 allowed Corrections to establish, in 2021, three additional ISPTs and services at Rimutaka Prison, Mount Eden Corrections Facility and Spring Hill Corrections Facility.

112. In April 2022 Corrections finalised ISPT guidelines to combine cultural and clinical practice. These guidelines would be used to guide practice at all prisons where there was an ISPT.

113. We were told that, early in the lifetime of the Intervention and Support Project, the scope was expanded to include some improvements to those ISUs that were not resourced for ISPTs as part of the first pilot. Multi-disciplinary team guidelines were developed for these ISUs to assist staff (e.g. health and custodial) to work more closely together, and a Supported Decision Framework was developed for ISU custodial staff to support them in making sound decisions in challenging situations.

114. The Intervention and Support Project team developed a therapeutic physical environment guideline to give guidance to staff on making ISU physical environments more therapeutic. Some enhancements to ISU physical environments, including new paint in soft colours and murals of natural scenery, were made to soften the look and feel of the units. Evidence suggests this kind of improvement can lessen distress in mental health settings.

115. The Intervention and Support Project also introduced some 'sensory' items, such as stress balls and weighted blankets, to all ISUs nationwide, along with brief training and guidelines for custodial staff about how to use such items safely with people in distress (Love & Rogers, 2018). Sensory modulation therapy can lessen distress and reduce the need for seclusion and restraint by encouraging people to modulate their emotions by using their senses, for example through music or aromatherapy.[22] While sensory modulation therapy proper could only be delivered by the trained therapists who were part of the Intervention and Support Practice Teams, it was felt that people in all ISUs nationwide might benefit from these sensory items.

116. Corrections reviewed ISUs and Management Units in 2018[23] and followed up with a further evaluation of ISUs in 2020.[24] The 2020 evaluation found, amongst other things, that the multi-disciplinary team approach was well embedded, and that there were some good examples of sites using an individualised approach for prisoners. However, practice differed between sites and custodial staff were not always being given specific training to work in ISUs and to manage people with deteriorating mental health or complex or challenging behaviours. The evaluation also found that staff in the ISUs were being offered "limited support" for managing their own wellbeing.

22 https://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/sensory-modulation

23 Department of Corrections, 2018, Intervention and Support Unit (ISU) and Management Unit (MU) Follow-up Review, internal report by Quality and Performance Team, Department of Corrections.

24 Department of Corrections, March 2020, Intervention and Support Unit Second Follow-up Review, internal report by Integrated Quality Improvement Team, Department of Corrections.

2016 – 2021: Other investment

Other investment: 2016 – 2017

117. In 2016, Corrections launched *Breaking the cycle: Our drug and alcohol strategy through to 2020* (Department of Corrections, 2016). Aligned to this strategy, Corrections offered a suite of programmes to help prisoners deal with alcohol and other drug (AOD) issues. As reported in the Corrections Annual Report for 2016/17, the suite ranged from a brief motivational programme, to an AOD Intermediate Support Programme (20 hours of treatment for prisoners serving short sentences) through to an Intensive Treatment Programme (eight weeks of treatment) and Drug Treatment Programmes (treatment for prisoners with a moderate to high AOD need comprising three or six months of treatment, sometimes in a specialist Drug Treatment Unit) (Department of Corrections, 2017a). Corrections continues to provide AOD programmes, reporting, for example, in its 2019/20 Annual Report that 153 people completed the Intensive Treatment Programme that year, and 748 people completed a Drug Treatment Programme in the same period (Department of Corrections, 2020).

118. In 2017, Corrections contracted service providers nationwide to work with prisoners with mild to moderate mental health needs, and to provide them with primary mental health 'Packages of Care'. This support is still available in 15 prisons.[25]

119. Also in 2017, Corrections launched *Wāhine: E Rere Ana Ki te Pae Hou Women's Strategy 2017 – 2021* (Department of Corrections, 2017b). This strategy reflected the recognition that the correctional system had largely been built for men, but that research showed that women had different paths to offending, different needs, and different responses to treatment and management. The Women's Strategy was not focused on reducing suicide or self-harm, but aimed to introduce approaches based on evidence of what works to reduce women's offending. Several programmes and initiatives for women were introduced as a result of the strategy, including a trauma-informed approach to custodial practice.

Other investment: 2019

120. In August 2019, Corrections launched *Hōkai Rangi: Ara Poutama Aotearoa Strategy 2019 – 2024* (Department of Corrections, 2019a), which expressed Corrections' commitment to delivering outcomes with and for Māori, and which focused on humanising and healing, involvement of whānau, and whakapapa amongst other priorities. *Hōkai Rangi* aimed to introduce new ways of working, and build upon work already being done, such as Māori Pathways programmes in Hawkes Bay. Since August 2019, all Corrections initiatives or projects have had to align to the principles of *Hōkai Rangi*.

121. Also in 2019, Corrections began development of the Waikeria Mental Health and Addiction Service, to be housed in a dedicated part of Waikeria Prison which is under construction. The Waikeria Mental Health and Addiction Service was later re-named Hikitia.[26] It will be available for men in the Corrections central region and is seen by Corrections as a critical enabler of *Hōkai Rangi*.

122. Hikitia, which will be culturally led, and clinically and custodially supported, is a partnership with iwi and the then Waikato District Health Board (since disestablished and replaced with Te Whatu Ora).[27] A foundation document (Department of Corrections & Te Arawai, 2020 – 2021) outlined the partners' vision and set out the service framework which was depicted as a three-stage journey: on Mihingia (entering the service) men and

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[25] Information retrieved from https://www.gets.govt.nz/DC/ExternalTenderDetails.htm?id=18838018 and from the Department of Corrections intranet.

[26] According to the Corrections intranet, Hikitia means "to lift up and support, raise up, carry in one's arms, and take away the troubles that overwhelm a person".

[27] District Health Boards were replaced on 1 July 2022 by Te Whatu Ora (Health New Zealand) an agency established by the New Zealand government to run the health system across the country.

their whānau will be welcomed and connected to a network of people who can help on their journey. During Whāngaihia men will be assessed and participate (with whānau if wanted) to create a plan to bring about wellness. At Manākihia men will be supported to transition out of the service while maintaining their wellness. Throughout, staff will draw on traditional Māori knowledge and western clinical interventions. Hikitia is still under development.

123. It is important to note that in 2019, Corrections formally ended the use of tie-down beds in prisons. Tie-down beds had not been used in prisons since 2016, but prior to that date had sometimes been used as a last resort to prevent people from inflicting extreme and prolific self-harm, or where their behaviour posed a threat to their life or the safety of staff and other prisoners.[28]

Other investment: 2020

124. In 2020, a Corrections review of eight recent prison suicides (2019 – 2020) made a number of recommendations, including that: "Ara Poutama Aotearoa develop a suicide prevention strategy and plan which includes policy and referral pathways for staff to access suicide pre- and postvention services. This will support affected staff and people in our care following death by suicide."[29]

125. Also in 2020, Corrections restructured its Health Service to align with Hōkai Rangi. The new structure, with the establishment of a deputy chief executive health position, aimed to support a stronger collaboration between national office and regional and site health teams. Other changes included establishing specialist heads of profession, with a strong focus on delivering a model of care that best met the needs of Māori. For example, Chief Māori Health Officer, Director Mental Health and Addictions, Chief Nurse, Chief Medical Officer and Director Health Insights and Analytics roles were established.

Other investment: 2021 onwards

126. Early in 2021, the Corrections Suicide Prevention and Postvention Advisory Group was established. The group meets bi-monthly and regular attendees include: the Chief Māori Health Officer, Director Mental Health and Addictions, Manager Mental Health Quality and Practice, Programme Manager Pacific, General Manager Integrated Practice and Innovation, Chief Probation Officer, Chief Custodial Officer (all from Corrections) and representatives from the Suicide Mortality Review Committee, and the Ministry of Health's Suicide Prevention Office.

127. The group was set up to oversee the development and implementation of suicide-related initiatives within Corrections, including those outlined in Corrections' *Suicide Prevention and Postvention Action Plan* which was released the following year (Department of Corrections, 2022). The action plan contains milestones and emphasises co-design of services with Māori. It uses a model adapted from *Every Life Matters*, New Zealand's suicide prevention strategy.

128. In 2021, Corrections released an updated alcohol and other drug strategy: *Our Alcohol and Other Drug Strategy 2021 – 2026* (Department of Corrections, 2021b).

129. Corrections updated its Women's Strategy with *Wāhine – E rere ana ki te pae hou: Women's Strategy 2021 – 2025* (Department of Corrections, 2021c). The updated strategy was aligned to Hōkai Rangi and placed oranga (wellbeing) at the centre of Corrections' work with women.

130. Clinical nurse specialist (mental health) positions were created at 11 prison sites that did not have Intervention

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[28] https://inspectorate.corrections.govt.nz/reports/investigations/summary_of_the_corrections_inspectorate_case_review_of_the_management_of_a_prisoner_at_auckland_prison_and_the_use_of_tie-down_beds

[29] Department of Corrections Health Services Internal Memorandum, dated 22 September 2020, from Senior Advisor Mental Health to Deputy Chief Executive Health, Suspected Suicide Thematic Review.

and Support Practice Teams. By 31 December 2021, 6.8 FTE clinical nurse specialists (mental health) were employed, with three vacancies.[30]

131. Figure 8 shows the growth in funded and actual numbers of additional staff employed by Corrections to provide mental health services in prisons across the review period, from 2016 (when there were no staff in these roles) to 2022. This figure shows staff numbers for the six Intervention and Support Practice Teams (ISPTs), clinical nurse specialists (mental health) (CNS-MH), and staff providing the Improving Mental Health (IMH) and Wrap-Around Whānau (WAW) support services.

Figure 8: Funded and actual additional staff providing mental health services in New Zealand prisons by service, in the review period (2016 & 2021) and for 2022

	01/07/2016		30/06/2021		30/05/2022	
	Funded	**Actual**	**Funded**	**Actual**	**Funded**	**Actual**
ISPT x6	0.0	0.0	39.0	19.0	54.8	46.4
CNS-MH	0.0	0.0	10.0	6.8	8.8	5.8
IMH/WAW	0.0	0.0	42.0	35.0	44.0	36.0
TOTAL	0.0	0.0	91.0	60.8	107.6	88.2

132. Corrections Mental Health and Addictions Team members advise that investment is planned to ensure there are no gaps or duplication of services and to assist staff on the frontline by providing processes to communicate more effectively.

133. As well as the services mentioned above, Corrections' Annual Report for the 2020/21 year sets out that Corrections employs more than 200 registered psychologists whose duties may include providing group or one-to-one offence-focused therapy to people in prison (Department of Corrections, 2021a). These psychologists address offending and rehabilitation needs rather than mental health concerns.

134. In terms of broader support, Corrections contracts Tira Tūhāhā Prison Chaplaincy Aotearoa New Zealand to provide religious and spiritual support services to all New Zealand prisons. Corrections also has a Kaiwhakamana[31] Visitor Policy that enables Māori prisoners to access kaumātua or kuia to support them with whakapapa, tikanga and whānau matters.

30 Budget 2019 Mental Wellbeing Package: Overview, as at 31 December 2021, Powerpoint slides, internal Department of Corrections document, provided by Director Mental Health & Addictions in an email 7 April 2022.

31 Kaiwhakamana are kaumātua or kuia (Māori elders or people of status) who have access to prisons to enable the wellness and well-being of their people.

Investment in Training and Workforce Development

Introduction

135. Many reviews of suspected suicide or self-harm incidents in prisons have called for more training and development for staff, particularly in recognising, assessing and managing people with mental health and addictions issues. This section provides a brief overview of relevant staff training and workforce development initiatives provided by Corrections during the review period. As with the 'investment overview' section above, we do not necessarily comment on effectiveness, nor suggest areas for consideration for this section, as some investment has not yet been formally evaluated, or only initial evaluations were completed.

Custodial staff

Ara Tika

136. Ara Tika is a five-day learning programme for new Corrections staff, including custodial staff. Ara Tika introduces staff to Corrections' purpose and role. Staff completing Ara Tika may choose to examine suicide as a research topic, and links are provided on a Corrections intranet page to some suicide awareness material.

137. Ara Tika is generally delivered at the National Learning Centre near Wellington. However, it was delivered virtually during COVID-19 restrictions. Ara Tika replaced Frontline Start (an older induction programme) in November 2019.

The Corrections Officer Development Pathway

138. The Corrections Officer Development Pathway (CODP) is the initial learning pathway for Corrections officers and offender employment instructors. It is an 11-week programme that involves both learning at the Corrections National Learning Centre, and prison-based training with the support of facilitators, 'buddies', and other colleagues. The initial 11-week phase is followed by 40 weeks continued development to reach the requirements of the New Zealand National Certificate in Offender Management Level 3. The 11-week programme covers some suicide awareness material: risk factors, signs of self-harm and vulnerability, risk assessment tools and how to perform the Reception Risk Assessment and the Review Risk Assessment, and the actions of a first responder to a suicide attempt. For indicative timings for CODP content relevant to this review see Figure 9.

Figure 9: Content and indicative timings for Corrections Officer Development Pathway content relating to suicide and self-harm

Content	Indicative timings
Suicide and first responding officer	6 hours
Death in custody exercise where the learner must demonstrate the use of a Hoffman knife[32] and duties of a first responding officer in a simulated exercise.	1.5 hours

[32] A Hoffman knife is a rescue tool that safely cuts a ligature.

139. Learners spend several weeks in prison units observing, completing tasks, and having discussions with their colleagues. During this time, it is expected they would spend around one hour learning more about suicide and self-harm, depending on their unit placement.

140. Competency during the CODP is assessed through discussion with facilitators, site champions and through a self-assessment of confidence in delivery of the Review Risk Assessment. The Review Risk Assessment is an assessment of a person's vulnerability to suicide or self-harm and should be administered whenever a person's risk may have changed (e.g. on return from court or following a distressing visit with family/whānau). Risk assessment competency has a Unit Standard which is assessed by the Corrections Government Training Establishment team during the officer's first year of employment.

Pou Whirinaki Iho

141. Due to COVID-19, since early 2020 to the end of the review period, Corrections delivered Pou Whirinaki Iho in place of CODP. Pou Whirinaki Iho is an eight-week site-based programme where learners are supported remotely by a Learning and Development facilitator. Learners are based in their prison unit throughout and receive support from site-based colleagues and a site champion. Learners cover the same suicide awareness material as with CODP, and also complete a Hostage and Suicide module.

142. Pou Whirinaki Iho learners, facilitators and site champions assess learners' knowledge through discussions, classes, observations and assessments, culminating in a Progress Assessment Log sign off by all three parties.

143. The self-harm, suicide, risk assessment and first responder learning opportunities are in the final course of Pou Whirinaki Iho. Content and indicative timings are given below, though timings are variable depending on how long it takes for the learner to achieve sign off. In addition, learners may have daily conversations with their colleagues around these topics (see Figure 10).

Figure 10: Content and indicative timings for Pou Whirinaki Iho content relating to suicide and self-harm

Content	Indicative timings
Learning platform content and activities, collegial conversations	90 mins
Live class with facilitator	60 mins
Learning module – people vulnerable to self-harm and suicide	60 mins
Safety conversations review – actions of a first responder/preserve the scene	60 mins
Risk assessment practice activity with colleague	30 mins
Progress Assessment Logs sign off discussion with site champion	30 mins

The Hostage and Suicide Refresher

144. The Hostage and Suicide Refresher is a self-directed learning programme available on the Corrections intranet. It takes approximately two to four hours to complete, depending on the learner. The programme content is split evenly between hostage situations and suicide prevention, though the learner can focus more on a specific area based on their needs. Staff can complete the refresher individually, in pairs, or as a group, as sites/teams see fit. Custodial staff should complete the refresher every two years. The Hostage and Suicide Refresher is not assessed, but qualitative information is taken from the reflection exercise to gauge whether the programme is working to raise awareness.

145. The Hostage and Suicide Refresher covers the same suicide awareness areas as the CODP and Pou Whirinaki Iho, including the Reception Risk Assessment and the Review Risk Assessment. The refresher encourages staff to reflect on practice, with questions such as, "In the suicide module, what did you find was important when conducting a review or reception risk assessment?" and "What responsibilities of a first responder during a suicide attempt did you learn about?".

146. The Hostage and Suicide Refresher replaced a regionally delivered one-day 'in-person' refresher of the same name in 2019. However, in 2022, Corrections trialled a new classroom-based version of the programme which received a positive initial evaluation by custodial staff, with 91% agreeing that the in-person refresher session helped improve their confidence in supporting vulnerable people and responding to suicide situations.[33]

147. The three programmes described (i.e. the CODP, Pou Whirinaki Iho, and the self-directed Hostage and Suicide Refresher) combine discussion based learning, learning resources accessed through a device (i.e. online), research activities, real life practice and observations, and assessments. The learning platforms used as part of CODP, Pou Whirinaki Iho and the Hostage and Suicide Refresher allow Corrections to collect quantitative data around who has completed and when. Corrections also gathers qualitative assurance through learner-specific responses to reflections and assessments.

Other training for custodial staff

148. Once they have completed initial training, corrections officers receive further informal training from more experienced colleagues. In addition, all custodial staff receive seven rostered training days a year. All prisons also have a weekly lockdown where prisoners are confined to their cells and staff are available to attend team meetings and receive training.

149. As well as the standard training offered above, custodial staff may receive occasional brief learning sessions in the form of Safety Conversations, which focus on health and safety topics. Session topics relevant to this review include Preserve Life (Death in Custody) which was introduced in 2017, Why Understanding Trauma Matters (introduced in February 2020) and Actions of a First Responder (Death in Custody) which was introduced in June 2020. These short (i.e. typically five to seven minute) sessions are run as leader-led discussions and are usually delivered at shift handovers or daily briefings. The leader of the discussion may decide to follow up with staff to ensure they have understood the intended outcome. Leaders can choose to access Safety Conversation information from the Corrections intranet.

150. Some custodial staff in the three women's prisons received trauma-informed practice training (developed as part of the first Women's Strategy which was launched in 2017). This training was positively received by staff, but the impact of these practices has not yet been evaluated. The Inspectorate's thematic report into the experiences of women in prison suggests that ongoing training is needed to embed trauma-informed practice (Office of the Inspectorate, 2021).

151. A self-directed Understanding and Responding to Trauma programme was made available on the Corrections intranet in 2019. This was mainly aimed at custodial staff though others may also choose to complete it. Understanding trauma is relevant to this review as trauma is a known risk factor for self-harm. The Understanding and Responding to Trauma programme comprises a learner workbook, video resources and a reflection exercise, which asks questions such as "What are two things you will do more of to work in a trauma-informed way?". The programme takes about one-and-a-half hours and staff can complete an optional assessment. In the review period, 1,580 staff completed the programme, with a further 60 completing the optional assessment.

[33] Hostage and Suicide refresher pilot 2022 evaluation summary, supplied by Department of Corrections Learning and Development team on 25 July 2022.

152. Included in the implementation of 'Improving Mental Health' clinicians in August 2017, was a contractual requirement that these clinicians would provide about five hours a week of informal training and support to other Corrections staff. We were told that some Improving Mental Health clinicians may be offering a certain amount of training and support to staff at some sites, but that this is not delivered at all sites.

153. In 2018/19, Corrections introduced a one-day Mental Health 101 workshop, mainly aimed at custodial staff. Delivered by a contracted provider, this training in "recognising, relating and responding" to people with mental distress was aimed at staff who had limited or no experience of working with such people. In the year the Mental Health 101 workshop was introduced, 720 staff completed it, mostly at Auckland Prison, Auckland Region Women's Corrections Facility and Christchurch Men's Prison, which were the three pilot sites for the Intervention and Support Project. The workshop was offered at other sites in 2020/21, when it was completed by 102 prison-based staff. We note that from January 2023, the Mental Health 101 workshop was added as a standard element of the Corrections Officer Development Pathway.

154. Custodial staff who work in Intervention and Support Units may receive supervision and specific training, including in understanding and effectively engaging with people with complex behaviours and personality disorders. As part of the Intervention and Support Project, a six-hour Intervention and Support Learning Programme (which included the Trauma programme) was offered to custodial staff at the three pilot sites. However, in practice, staff told us that custodial staff with no special training may be rostered to work in an Intervention and Support Unit if there are staff absences or shortages. We also heard that this training no longer occurs.

155. Between early 2021 and January 2022, 11 half-day suicide prevention training workshops named Custodians of Hope: Supporting the Suicidal Person were offered to custodial staff in ISUs, and health staff, including nurses. Each workshop was delivered to a maximum of 40 attendees. Provided by a contractor, the Custodians of Hope workshop covered topics including legal obligations, including family/whānau as part of a support team, and key principles in engaging and supporting a suicidal person. We were told that informal feedback from participants was "very positive" but at the time of writing (21 April 2022) no formal evaluation had been completed.[34]

156. Some custodial staff – primarily those working in ISUs and Management Units – have also been able to attend one of four one-day workshops entitled Skills for Working with Borderline Personality Disorder 101: An Introduction to Borderline Personality Disorder. First delivered in 2021 by a contracted clinical psychologist, this workshop is commonly known within Corrections as 'managing challenging behaviours training'. Each workshop had a limit of 30 participants. The workshop is relevant to this review as people with borderline personality disorders are over-represented in suicide and self-harm statistics.

157. While custodial staff in ISUs were the main intended audience for the Borderline Personality Disorder 101 workshop, difficulties in releasing them from their duties meant an invitation was extended to health staff, case managers, and, at one site, probation staff. We were told that feedback from the workshops was "very positive"[35], though some attendees felt it could have been more specific to ISUs, and a few felt it could have been more practical, with one commenting on an evaluation form that they would have liked:

> *"More practical on the job skills for working with prisoners with borderline personality disorder (i.e. in the moment stuff)." [Borderline Personality Disorder 101 Workshop Attendee]*[36]

158. Also of note was the internal release in April 2022 of Corrections' *Joint Action Plan on Reducing Violence and Aggression in Prisons*. This action plan outlines five initiatives, and while none are specifically focused on

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[34] Information from an email to the Office of the Inspectorate from Corrections Director Mental Health and Addictions, received 21 April 2022.

[35] Information from an email to the Office of the Inspectorate from Corrections Director Mental Health and Addictions, received 4 May 2022.

[36] Quote from a 'Summary of Feedback – Skills for Working with Borderline Personality Disorder – Christchurch Men's Prison 22 October 2021' form attached to an email to the Office of the Inspectorate from Corrections Director Mental Health and Addictions, received 4 May 2022.

preventing suicide and self-harm, two are relevant to this review as they could have a positive impact on the skill level and job focus for custodial staff. 'Initiative 2' looks to ensure that training for custodial staff is fit for purpose and delivered in an appropriate and engaging way, and 'Initiative 4' will help to ensure that sites are appropriately staffed with the aim of freeing up custodial staff time "to allow staff more opportunities to build rapport with people in prison to achieve better outcomes and create a safer working environment". We note that these initiatives, if properly realised, could also have a positive impact on suicide and self-harm rates.

Health staff

159. Corrections' Annual Report for 2020/2021 sets out that its Health Services employ approximately 250 nurses, including registered nurses, enrolled nurses, and nurse practitioners, to provide primary level healthcare services across prisons (Department of Corrections, 2021a). At 30 May 2022, 5.8 FTE clinical nurse specialists (mental health) were also employed, with three vacancies.

160. New Zealand registered nurses are comprehensively trained, which includes mental health training. Internationally qualified nurses must meet New Zealand Nursing Council competencies but do not have to have had mental health training to gain registration in New Zealand. If nurses have had no mental health training this is recognised as part of their registration process and conditions may be placed on their practice. It is not known how many registered nurses at Corrections have conditions on their practice. A senior advisor mental health told us that internationally qualified nurses may have different beliefs around suicide and self-harm. For example, they might feel shy to talk about suicide so do not ask about it or talk about it in any depth.

161. As well as any specific training it might offer to health staff, Corrections has a duty to provide all nurses with professional supervision. Professional supervision is a facilitated reflective process that supports the continued development of the professional competence of a nurse. There are numerous competency assessments available on the Corrections intranet for orienting nurses.[37] However, apart from cardio-pulmonary resuscitation (CPR) updates, there are no on-going competency assessments for nurses within Corrections.

162. Corrections' Supervision for Nurses policy recognises that individual supervision by external supervisors (e.g. during the review period from local District Health Boards) would be the ideal. Funding allowed for either individual or group supervision. However, supervision was limited at some sites due to lack of availability of supervision providers. Just before the first COVID-19 lockdown in 2020, Corrections surveyed nurses to better understand their requirements for supervision and to seek their recommendations for changes that could be made to increase uptake. It was also intended to survey the supervisors. This action had to be paused due to COVID-19, though it remains on the Corrections Health Quality and Practice Team's work-plan. Corrections considers it likely that, due to staffing issues and increased workload due to COVID-19 safety measures and restrictions, supervision for nurses has not taken place since 2020.[38]

163. Substance withdrawal management guidelines for health professionals are available online[39] and Corrections has an orientation manual for nurses on alcohol and other drugs which contains some information on withdrawal. However, we observed that during most of the review period there was no substance withdrawal training for registered nurses at Corrections.[40]

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37 For example, competency assessments for nurses to complete during their orientation period included: Receiving Office nurse role, cardiovascular risk assessment, medication management, emergency response and equipment, and standing orders.

38 Email from Corrections Manager Health Quality and Practice Team, 19 May 2022.

39 https://www.tepou.co.nz/resources/substance-withdrawal-management-guidelines-for-medical-and-nursing-practitioners

40 During an interview with Corrections Addiction Services, May 2022, the Office of the Inspectorate was advised that a one-day training course in alcohol and other drug assessment and management of withdrawal was being negotiated with the same training provider as had delivered primary mental health training. "One-off" substance withdrawal training had been available to nurses between 2014 to 2017.

164. From 1 June 2018, Corrections contracted mandatory primary mental health training for all registered nursing staff. This training consists of a three-day workshop followed by a one-day refresher workshop which is to be completed every two years. Amongst other outcomes, at the completion of the three-day workshop, nurses are expected to be able to demonstrate:

» "an ability to provide initial 'first aid' for acute mental distress and understand appropriate referral pathways (a stepped-care approach) and in particular the role of regional forensic services in line with current Department policies and procedures

» an ability to recognise and manage suicidal behaviour

» an ability to develop an appropriate care plan including practical strategies to deal with a person in distress."

165. Some nurses were able to attend one of the 11 half-day Custodians of Hope: Supporting the Suicidal Person suicide prevention training workshops.

166. Some nurses or other health staff have been able to attend the one-day workshop: Skills for Working with Borderline Personality Disorder 101: An Introduction to Borderline Personality Disorder.

167. In August 2022, Corrections Health Services developed a Mental Health Learning Module which includes information on mental health, traumatic brain injury and trauma as part of the nursing orientation package.

168. In the Health Services practice centre on the Corrections intranet there are At-Risk Assessment Guidelines to support clinical decision-making. These offer a quick reference guide that includes prompts and references to New Zealand guidelines.

169. Before nurses can work in the Receiving Office of a prison, they must complete the Receiving Office Nurse Competency Assessment. This assessment, which is available on the Corrections intranet, includes the nurse being able to describe to the assessor how a person should be managed in the Receiving Office, including at-risk assessment, alcohol and other drug withdrawal, and COVID-19 screening.

Other staff training

170. Case managers receive structured activities supported by colleagues as part of a case management learning programme called Pou Arahi Iho. However, this does not include any specific suicide or self-harm awareness material. Case managers can request access to the Hostage and Suicide Refresher Programme, and may be included in training opportunities such as the Mental Health 101 training.

171. Case managers also receive training in how to administer the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). The ASSIST screens for a range of substances and determines a risk score for each substance (i.e. low, moderate or high). It involves asking prisoners questions about their alcohol and other drug use across their lifetime and in the past three months. For prisoners, this means the most recent three-month period they had 'normal' access to substances.

Reception into prison

Introduction

172. Going to prison may be a major change in a person's life situation and it can require considerable effort to adapt (Radeloff et al, 2021). According to World Health Organisation guidelines, all prisoners should be screened on entry to prison for a range of mental health and related problems, and given psychiatric treatment if they would benefit from it (WHO, 2014b).

173. A recent UK report (Shalev & Tomczak, 2023) sets out that it may not be appropriate to transfer some people with mental health issues to prisons at all. The authors state that prisons should not be used as places of transition from the courts and police into secure healthcare facilities, and include a recommendation that "mental health assessments should be available at all times for those in police and court custody to determine the appropriateness of a transfer to a prison."

174. Risk factors for suicide and self-harm are more prevalent amongst people entering prison than in the general population. The literature suggests there are key risk factors for suicide and self-harm in prisons, that, if identified at reception, can assist staff to recognise and respond to vulnerable people. These risk factors include distress, previous suicide or self-harm attempts, mental health issues, alcohol and drug issues, physical health needs including pain, and a history of trauma (Zhong et al, 2021; Favril et al, 2020).

175. Placement in prison is, for many, the result of a life that has been impacted by multiple adverse and traumatic events, frequently from a young age. These events are further compounded by significant social stressors that include limited education, poor employment opportunities, and family/whānau separation and relationship breakdowns. Exposure to these factors has been recognised in the literature as contributing to an overwhelming feeling of hopelessness and a sense of abandonment (Moore, Siebert, Brown, Felton & Johnson, 2021).

176. The reception process aims to receive prisoners into prison in an efficient and effective manner, ensuring that they are aware of their rights and responsibilities; of the prison rules, routines and procedures; and of compliance issues. The reception process also aims to identify prisoners who may be at immediate risk of self-harm, or harm to or from others, or who may have immediate needs.

Reception process: the Receiving Office

177. All prisons have a Receiving Office, which is a single point of entry and exit for all prisoners arriving at or leaving prison. Receiving Offices typically feature holding cells for prisoners and one or more rooms where staff can interview them. Some prisons may receive only one or two people at a time, while large receiving prisons will get high numbers of people arriving together, sometimes late in the day. Receiving Offices may be stark, noisy and lack privacy.

178. At the Receiving Office, custodial staff first go through a series of reception procedures including confirming the prisoner's identity; strip searching them to ensure they are not carrying items they cannot have with them in prison;[41] a clothing check; recording property, which may be given back to the prisoner, stored, or disposed of; and taking photographs and fingerprints. If a prisoner has money with them it is deposited into their prison trust account, which they can use later to buy approved items from the prison canteen, such as snack food.

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[41] We note that Correction plans to introduce full body scanners to Receiving Offices at all three women's prisons to 'ease the experience of new arrivals and improve overall safety' and 'promote personal dignity and wellbeing' for people entering prison. Rimutaka Prison also has a body scanner. Information retrieved 7 November 2022 from the Corrections intranet story 'Women's prisons prioritised for new full body scanners'.

179. While many Receiving Office staff do their best to explain what will happen, we have heard that prisoners may remain scared or unsure of the processes.

> *"I was shocked to be sent to prison from court … pretty scared. Staff at the Receiving Office were nice. I called my nan. They explained briefly." [Prisoner][42]*

> *"Every person here expected me to have been in prison before, that I already knew stuff." [Prisoner][43]*

180. We understand from an article on the Corrections intranet, that in 2022 Corrections was trialling a package of written information to support new arrivals in prison. The package was translated into Te Reo Māori, Tongan, Samoan, Simplified Chinese, Vietnamese, and Arabic. The package included a brochure 'What happens to me now I have arrived in prison' for new prisoners on arrival at the Receiving Office, which covers such information as the procedure for strip searching. The package also contains a health brochure 'Your health in prison' which is given to prisoners when they are first seen by health staff during reception. Translated versions of forms and information about property, making a complaint, and contacting a consulate were also supplied. At the same time, Corrections was trialling an electronic 'reader pen' that reads English aloud when scanned across text. The reader pen is designed for the dyslexic reader or people with low literacy. This package could help to alleviate uncertainty.

The Reception Risk Assessment

181. In New Zealand prisons, custodial staff in the Receiving Office conduct the New Arrival Risk Assessment in which they screen prisoners for risk of suicide and self-harm using the Reception Risk Assessment. The Reception Risk Assessment must be done within four hours of reception, and, where practicable, must be undertaken in an area that offers privacy from other prisoners and staff.

182. The purpose of the Reception Risk Assessment is to identify the level of self-harm risk that each prisoner presents at reception and to minimise this risk as quickly and safely as possible. Risk assessment of this type is standard practice in many prison jurisdictions and has been linked to a lower risk of suicide (see, for example, Joshi & Billick, 2017). However, it has been acknowledged that identifying and predicting who may self-harm in prison is difficult (Borschmann, Young, Moran, Spittal & Kinner, 2018).

183. The literature highlights the importance of being aware of all risk factors for suicide and self-harm, and points out that understanding the risks that are modifiable is critical to understanding how to manage the associated distress (Zhong et al, 2021).

184. The literature suggests that risk assessments are best undertaken as a collaborative approach (with custodial, health, and administrative involvement) and linked to an overarching suicide prevention programme (Daniel, 2006).

185. A recently published evidence-based Self-harm: assessment, management and preventing recurrence guideline from the UK National Institute for Health and Care Excellence (NICE) suggests that the focus of risk assessment should be on the person's needs and how to support their immediate and long-term psychological and physical safety. The guideline sets out what information and support is recommended for people who have self-harmed and their families, and what staff should know and be able to do. The guideline includes recommendations about risk assessments. It applies to staff from all sectors who work with people who have self-harmed, though it does acknowledge that some of the recommendations may need to be tailored for criminal justice settings (NICE, 2022).

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[42] Quote from Office of the Inspectorate (2021) Thematic Report: The Lived Experience of Women in Prison. Department of Corrections, Wellington.

[43] All unattributed prisoner quotes have been taken from inspector interviews with prisoners during inspections or thematic reviews.

186. In New Zealand prisons, custodial staff take several steps to complete the Reception Risk Assessment. These include:

- » Reviewing any information from other sources if this has not yet been done.
- » Interviewing the prisoner and asking a series of 13 questions based on the validated Columbia Suicidality Scale. This includes several questions relating to mental health and suicidal ideation or plans, including "Have you wished you were dead or wished you could go to sleep and not wake up?" and "Have you actually had any thoughts of killing yourself?".
- » Observing the prisoner, including answering questions such as "Does the prisoner look / sound intoxicated or appear to be withdrawing from any substances?" and "Does the prisoner appear low in mood?".
- » Assessing the information obtained in the interview.
- » Consulting with Health staff about the person's at-risk status.

187. Custodial staff summarise any information that has been shared with them before completing the Reception Risk Assessment. We were told that at some sites, dedicated custodial staff assess this information. Generally, these staff have had extensive experience working in the Receiving Office and are skilled at sourcing and considering all relevant information.

> *"We had people who would always do the background checks. Deep dive into their files while they were on the road so we had an indication of who we might be needing to put in the At Risk Unit when they turned up." [Principal Corrections Officer]*

> *"[We got] on the job training with a very experienced officer. Staff feel confident in doing the initial assessments due to this." [Corrections Officer]*

188. However, while learning from colleagues may produce skilled staff at some sites, some custodial staff told us the lack of formal advanced training in this area may lead to variable levels of expertise and quality of assessments. When we asked a focus group of custodial staff at one prison how confident they felt about conducting the Reception Risk Assessment, some expressed their concerns:

> *"They did cover it in [staff] college, but you just do it on paper. On the job there was some role modelling, but it was limited. It was really just going through paperwork." [Corrections Officer]*

189. We found in some instances, for example in two death in custody investigations, that information in Reception Risk Assessments was copied and pasted from other Reception Risk Assessments. Copying and pasting is poor practice because it can lead to inaccuracies being introduced into a person's records, and can mean that records become generic and meaningless, with repetitive or unnecessary information.

190. We noted that while the Reception Risk Assessment is a validated screening tool, assessments were only as good as the information considered. If information was lacking or not shared, the assessment was less accurate. The Reception Risk Assessment takes the assessor's observations of the person into account, but relies heavily on self-report and officers only documented what the prisoner told them.

191. There are other factors that can impact upon the quality of the information gathered at the Reception Risk Assessment, such as if the prisoner is withdrawing from alcohol or drugs, is mentally or physically unwell, feeling anxious or afraid, lacking rapport with the assessor, or wanting to avoid being sent to a particular unit.

192. We were told by custodial staff that prisoners who have served previous prison sentences may know what, or what not, to say to get themselves to a unit quicker.

> *"Reception was a pretty positive experience ... When you've been in before you just want to be quick so you can go and get settled." [Prisoner]*

193. Some literature suggests that even when a prisoner recognises that they have significant mental health problems, they would rather "take their chances in a mainstream prison unit than disclose their problems and risk being placed in an unfurnished (stripped) cell in a special unit where more disturbed prisoners are managed" (Birmingham, Gray, Mason & Grubin, 2000).

194. We observed during prison inspections that some custodial Receiving Office staff were experienced and comprehensively completed the Reception Risk Assessment in a respectful and professional manner. However, we were told that sometimes, with many prisoners to assess within short periods of time, there was pressure, and the emphasis turned to processing prisoners quickly. For example, at one site we found that staff sometimes asked prisoners the Reception Risk Assessment questions at the same time as they were conducting the strip search.

195. In addition, at some sites the limited space, noise, and lack of privacy in the Receiving Office could impact on the quality of the assessment process. For example, at one site we observed that while risk assessments did occur in separate offices, sometimes there was so much noise in the Receiving Office concourse that it was difficult to hear what was being said.

196. One subject matter expert considered there should be more emphasis on relationship building at reception:

> *"(The focus in New Zealand prisons) is more on risk assessment, with relationship building added on. Risk assessment is very transactional ... It is close to a tick box exercise." [Principal Adviser Mental Health and Addictions]*

197. After the Reception Risk Assessment, custodial staff conduct the Immediate Needs Assessment, in which prisoners are asked if they have any issues that need to be dealt with immediately. This includes questions such as "Are there any medical problems or conditions of which we should be aware?" and "Do you need to arrange childcare for your children?".[44]

Electronic alerts in IOMS

198. During the Reception Risk Assessment (or at other times), if the prisoner is found to have a history of self-harming or is found to be at risk of suicide or self-harm, the custodial officer should create an alert in IOMS. IOMS has three alerts related to suicide and self-harm: 'at risk of suicide', 'at risk of self-harm', and 'at risk' ('at risk' is generally used to mean 'at risk of self-harm but needs further assessment to determine the level of risk'). These alerts can be active (visible to staff when they go into the person's record) or inactive (not immediately visible to staff unless they go into the historic alerts tab. This tab can have several pages that staff may need to click through to find relevant alerts).

199. The Prison Operation Manual sets out that the custodial officer must ensure the 'risk of suicide' alert is placed on IOMS for any prisoner who "has a history of self-harming behaviour and/or attempted suicide". This alert should remain active up to the prisoner's release date. We note that a number of people who died by suspected suicide had historical alerts for suicide or self-harm, but when they came into custody on a new occasion these alerts remained inactive so staff had less visibility of this history.

200. In our review of the 29 people who were involved in a suspected suicide in the review period, we found that 19 (65%) were noted to have previous suicidal ideation, suicide attempts or self-harming behaviours such as cutting, attempted hanging, or overdoses. However, only 16 people (55%) had a current IOMS alerts for 'risk of suicide' and/or 'risk of self-harm'. A further eight people (27%) had inactive (or historical) alerts.

[44] Prison Operations Manual: I.04.Form.02 Immediate needs checklist

201. In our review of the 158 people involved in a self-harm threat to life incident, we found that 71 (45%) had an active IOMS alert (either 'at risk of suicide', 'at risk of self-harm', or 'at risk') at the time of the incident. Thirty-seven people (23%) had an inactive/historical alert.

The Reception Health Screen

202. Following the Reception Risk Assessment and the Immediate Needs Assessment, a registered nurse completes a Reception Health Screen. The Reception Health Screen aims to identify and prioritise the prisoner's immediate health and mental health needs and to determine the timing of the Initial Health Assessment, which is a more in-depth assessment.[45] The Reception Health Screen is a series of set questions. It is required to be completed on the day the person arrives in prison.

203. The Corrections Health Services Health Care Pathway 2019 policy (Department of Corrections, 2019b) sets out that during the Reception Health Screen the nurse will undertake an at risk of self-harm or suicide assessment. One of the questions in the Reception Health Screen is "have you tried self-harm/suicide in the last year?" The form provides a 'yes', 'no', or 'unknown' drop down box to complete and has a text box in which the nurse can add more detail.

204. Site inspection observations found that many of these assessments were brief, with only a few questions asked about a person's support networks, future plans, and by asking the question "do you have any thoughts of self-harm?" The nurse conducting this assessment will also consider the prisoner's clinical presentation, level of engagement, mood, and behaviours, such as if a person is tearful.

205. If the person is found to be at risk of suicide or self-harm, the nurse should create an alert in the electronic patient health record. Available alerts include 'acute mental health,' and 'self-harm history.' As with IOMS records, these alerts can be active (visible when staff go into the person's record) or inactive (not visible to staff).

206. As mentioned above, in our review of the 29 people who were involved in a suspected suicide, we found that 19 (65%) were noted to have previous suicidal ideation, suicide attempts or self-harming behaviours. Of these 19 people, only ten had an alert on their electronic patient health record to notify health staff of the self-harming history.

207. Nurses may experience the same challenges as their custodial colleagues, with pressure to process high volumes of people in a short time. Depending on the design of the Receiving Office there may not be appropriate space, meaning health interviews sometimes took place in an environment that lacked privacy.

208. When a person has been prescribed medication in the community, the nurse must establish who the community health provider is and take steps to ensure the prisoner receives the medication they need. Some health teams have access to regional electronic clinical information sharing services[46] which share information such as recently dispensed medications, investigation results (e.g. blood tests and x-rays), hospital specialist letters and any scheduled specialist appointments. This aids continuity of health care.

209. When health staff request paper-based information from community providers, they may receive limited information consisting of only currently prescribed medications and classifications (diagnoses) rather than a more comprehensive medical history. At times there are delays in the community providers sending the requested information.

210. Some of our death in custody investigations found that prisoners did not always fully engage with health staff at reception and did not always share important aspects of their mental or physical health history. This finding was

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[45] The Initial Health Assessment should occur within 30 days of entry into prison, or sooner depending on the person's need.

[46] TestSafe was provided by northern region District Health Boards during the review period. HealthOne was used for parts of the South Island.

echoed in a study from the UK which found that a considerable number of prisoners reported that they did not volunteer, and often deliberately withheld, information during prison screening assessments (Birmingham, Gray, Mason & Grubin, 2000).

211. For this reason, it is important for nurses to review information such as the person's electronic health file (if they have been in prison before) or information from community providers. However, nurses told us that even if a person had previously been in custody, they did not always have time to review that person's electronic health file to gain a better understanding of their needs and risks.

212. Our interviews with nurses and observations during inspections found that due to time pressures the Reception Health Screen was often task driven, and inexperienced nurses did not always ask further important exploratory questions during assessments, and did not always display critical clinical thinking and decision-making when planning follow up care. One nurse told us they would call in sick if rostered in the Receiving Office due to the pressures of the environment and their fears that they may miss something of clinical significance.

> *"The whole receiving process needs improving. It's a tick-box based process. Task oriented rather than based on the need." [Former Chief Medical Officer]*

213. Despite these issues, during our prison inspections we also observed examples of good health reception practice. For example, at a smaller site, an experienced nurse spent time with a newly arrived woman. She sat with the woman without a desk separating them which supported engagement. The nurse gathered the required information in a conversational way, making further enquiries about issues that were raised and answering questions about being in prison. Throughout, the nurse had an empathetic and respectful approach.

214. At the Receiving Office of a large prison, we observed a nurse who welcomed a prisoner to the site. The nurse was friendly, thorough, and did not rush the prisoner with the forms that needed to be completed. She read information to the man (who did not have his glasses with him) and ensured that he understood everything.

215. At the same large site, we observed that before prisoners arrived, health staff reviewed patient records to see if there was any significant information which needed to be considered. At this site, all nursing staff had been credentialled in the Receiving Office role.

216. At the conclusion of the Reception Health Screen, a triage priority score is given that determines when a nurse will see the person to conduct the Initial Health Assessment, which is a more comprehensive and in-depth assessment of health needs.[47] The priority score determines if the person must be seen urgently (within 24 hours), semi-urgently (within 10 days) or routinely (within 30 days). The prisoner signs an Advice of General Health and Dental Services form to acknowledge that they have received information about the delivery of healthcare services, and the storage and sharing of their health information. The nurse also gives the prisoner the 'Your Health in Prison' pamphlet, which gives information about how to access healthcare services while in prison.

217. Following the Reception Health Screen, the nurse is responsible for entering any necessary alerts in IOMS. There is some guidance on when health staff should record an alert on IOMS, however it has been noted that most alerts for suicide or self-harm risk are entered by custodial staff.

218. Best practice is for the nurse to also apply alerts in the person's electronic health file in relation to self-harm and substance use so that other clinicians who access the person's file are aware of these issues. For example, prescribers are alerted when they are considering the appropriateness of medications. In practice, these alerts are not applied consistently across all sites. We note that there is no practice guidance for health staff about when and what type of alerts should be created on a person's electronic health file.

[47] An alternative Update Health Assessment (UHA) is completed if a person is returning to prison within 12 months of being released.

219. The following case study demonstrates how the Reception Health Screen can enable staff to identify issues early and ensure people are placed in the appropriate unit (e.g. an Intervention and Support Unit). This case study also highlights the importance of putting alerts in IOMS to inform custodial staff of the person's risk. Lastly, this case study shows how with the necessary support, a person's mental health can improve:

Case study 1 – Mr A

Mr A was a man in his forties who was placed in the Intervention and Support Unit (ISU) from the Receiving Office due to his history of self-harm, anxiety and depression, which he openly discussed during his Reception Health Screen. He had also previously spent time in a community mental health residence.

Mr A remained in the ISU for several weeks and appeared to settle. The multi-disciplinary team who was providing his care decided he could be moved to a voluntary segregation unit where he could associate with others. However, there were no active alerts on IOMS to inform custodial staff that he might be at risk of self-harm, only a historical alert.

Over the next month, staff noted that Mr A was becoming increasingly agitated and distressed. He said he heard voices. Three months after entering prison, Mr A attempted to hang himself in his cell. He was found and resuscitated before being taken to hospital.

Mr A was diagnosed with severe depression and received specialist treatment.

Mr A remains in prison, where he is receiving regular, ongoing support from a Corrections 'Improving Mental Health' clinician. No further self-harm incidents have been documented for Mr A. At the time of our review of the incident, Mr A still did not have any alerts for self-harm or risk of suicide on IOMS.[48]

Custodial consultation with health staff

220. Following the Reception Risk Assessment and the Reception Health Screen, custodial and health staff must consult about the outcomes of their assessments to determine whether the person is at risk of self-harm and the most appropriate unit placement for them.

221. We have observed that the quality of the consultation between health and custodial staff varies across the prison network and sometimes there is no face-to-face discussion between staff about their assessments.

222. During prison inspections, we observed health and custodial staff giving a 'thumbs up' to each other if they each determined that the person was not at risk, rather than having a conversation about their assessments. We also found that at some sites health staff would email an Advice of Prisoner Health Status form[49] to custodial staff advising whether someone was at risk of self-harm or not. No in-person discussion took place. However, these in-person discussions are crucial as prisoners can give different information to the different staff members during their assessments. If in-person discussions do take place, they may change the outcome of a prisoner's at-risk status through sharing of the information.

223. In two of our death in custody investigations we found that consultations had not taken place at all between health and custodial staff about a person's at-risk status.

224. If health and custodial staff disagree about the person's at-risk status, the matter is escalated to the principal corrections officer or senior manager on duty who must reassess the case with the clinical team leader or health

[48] The site was contacted by the Inspectorate review team and the alerts have now been created.

[49] In August 2022 this form had been reviewed, updated, and renamed the Notification of Health Status Form.

centre manager. This should occur within 24 hours of the prisoner's initial reception. In the meantime, the person is placed in the ISU and reassessed the following day.

Information sharing with the Receiving Office

225. Other agencies may share information about prisoners ahead of them arriving at the Receiving Office. For example, information may be shared by Police or court forensic nurses. Probation officers may also share information. This information assists health and custodial Receiving Office staff to assess prisoners' risk of suicide or self-harm.

226. During a focus group, custodial staff pointed out the value and importance of this information sharing.

> *"Receiving Office staff are normally able to take some time to prepare for new arrivals. [We check] IOMS file notes, previous at-risk assessments, psych info, probation info. Good information flow from Courts, Probation, Police." [Corrections Officer]*

227. However, information was not always shared with or between custodial and health Receiving Office staff. This could impact on the quality and outcome of reception assessments. For example, in one death in custody investigation, we found that information from Police about a self-harm incident in a Police holding cell was given to custodial staff, but not passed on to the Receiving Office nurse.

Alcohol and other drug screening at reception

228. Many people in prison have a history of alcohol and other drug misuse, and substance dependence/substance use disorder has been identified as a risk factor for suicide and self-harm in prison (Cain & Ellison, 2022; Favril et al, 2020). Drug withdrawal has also been identified in the literature as one of the biggest concerns identified by prisoners on admission to prison (Olubokun, 2019).

229. In New Zealand, a significant number of prisoners are known to use alcohol and other drugs, with a 2016 study finding that 47% of all prisoners had a substance use disorder over the previous 12 months, and 87% of prisoners had a substance use disorder over their lifetime (Indig et al, 2016). This suggests that a number of prisoners in the Receiving Office may be either under the influence of alcohol or drugs or experiencing withdrawal symptoms.

230. Our review of the 29 suspected suicides in the review period identified 19 people (66%) who had an identified substance use disorder, with four people noted to be withdrawing from drugs and/or alcohol at the time of their death.

231. Our review of 158 people involved in self-harm threat to life incidents found that 121 people (76%) told staff at reception that they had a history of alcohol or drug use prior to prison. Fifty of those people were noted to have a significant substance misuse disorder. However, it was not possible to tell from the data if any of those people were actively withdrawing from alcohol or drugs as this information was not collected.

232. There is one question about alcohol and other drug use in the Reception Health Screen ("Are you using/withdrawing from drugs/alcohol?"). During inspections and investigations, we have found evidence that nurses take action (such as conducting an alcohol or drug withdrawal assessment) when a prisoner volunteers information about heavy substance use, or is obviously experiencing symptoms of withdrawal. There was less evidence of any action being taken if the nurse considered the level of substance use was low or moderate, and generally nurses would rely on prisoners to self-manage or self-report using a health request form should they start to experience withdrawal symptoms.

233. If a person has been using substances before arriving in prison, they may not yet be experiencing withdrawal symptoms when assessed in the Receiving Office. Little information is provided to people arriving in prison about symptoms of withdrawal (such as irritability, anxiety, agitation, disturbed sleep, sweating, muscle aches,

poor concentration, nausea, and increased sensitivity to sound, light and tactile sensations) and how these can be managed.

234. Tobacco has been prohibited in prisons since 2011. The Reception Health Screen includes a question about a person's smoking status. Corrections issues four weeks' supply of nicotine replacement therapy (NRT) lozenges to help prisoners stop smoking. Information is also provided about telephoning Quitline. While research shows that smoking can cause anxiety symptoms or make them worse[50] many prisoners told us smoking helps them manage their stress and anxiety. They struggle with not being able to smoke in prison and with the length of time NRT is available. This issue is demonstrated by the number of complaints received by the Inspectorate.

> *"It is hard when you have been a smoker on the outside. I'm having headaches, sweating, cramps, nausea, trouble sleeping, anxiety and depression." [From a complaint by a prisoner made to the Office of the Inspectorate]*

Alternative Reception Models

Alternatives from subject matter experts

235. We were told by some subject matter experts that doing things differently for people entering prison may have an impact on suicide and self-harm incidents:

> *"Do we want to provide a new approach into prison? … to be more holistic … have more of a therapeutic community … and provide a more therapeutic approach to those new arrivals into prison? There needs to be further thought about the screening. How do we identify those at risk? There will still be a big number and then we have to ask: do we have a workforce to manage that volume of people?" [Consultant Psychiatrist]*

236. One subject matter expert suggested a focus on "welcoming people into prison instead of just processing them". He went on to say that:

> *"The physical environment would need to change to allow prisoners to adjust on entering … there is evidence which states that the initial phase of coming into prison is a very hard adjustment, especially for those in remand and that's why they're so vulnerable. The shock of coming into prison, be it new to prison or not, requires a more sensitive approach than just processing them and putting them into mainstream units which are very harsh environments." [Principal Regional Mental Health Advisor]*

237. One subject matter expert acknowledged the need to gather the history and context of the person to prevent further self-harm, but asked how Corrections could uphold the mana of the person from the beginning by humanising them. This subject matter expert felt that Corrections might be placing too much priority on factors such as criminal behaviours and gang connections instead of "focusing on whānau visits and the connection back to whakapapa":

> *"If we flipped it and thought 'how do we enhance the mana of the person and their whānau' we would humanise the person and put them at the centre. The criminal aspects are the behaviours that led them to be in prison, but these things shouldn't define them and shouldn't be the focus … the primary focus is that that person is part of a whānau and uplifting that is so important." [Chief Māori Health Officer]*

238. Another subject matter expert spoke about the potential value of a cultural approach to receiving new prisoners into custody, though he acknowledged that additional resources and a suitable space would be required to enable such an approach:

> *"(We) had great discussions … such as conceptualising a pōwhiri process for people who identify as Māori and come to the Receiving Office. One of the things that restricted that was never having the resources. I am only*

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50 https://smokefree.gov/challenges-when-quitting/cravings-triggers/anxiety-smoking

one person. The Receiving Office received people from 12 to 6pm. There was physically not enough space ... So that never really happened. It was parked up." [Cultural Support Worker, Intervention and Support Practice Team]

Reception nurse based at court custodial suite

239. An alternative approach to reception health screening in a prison Receiving Office has already been trialled in New Zealand. In March 2020, in response to COVID-19 pandemic restrictions, Corrections, the Ministry of Justice and Police trialled the completion of reception health screening assessments in the 'custodial suite' at Te Omeka Justice and Emergency Services Precinct in Christchurch.[51]

240. An experienced registered nurse was based at the custodial suite every Monday to Friday, between 9am and 5pm. The nurse completed reception health assessments (including COVID-19 screening) of people who had been to court and received a custodial sentence or who been remanded into custody.

241. This model meant the nurse was able to assess people throughout the day, rather than as they arrived at a prison in groups later in the day. Additionally, the nurse was able to obtain background information, such as health records, before the person arrived at a prison. The nurse would provide handovers to prison staff.

242. Staff working in the custodial suite reported that the initiative was "hugely valuable", and that the health assessments had been "thoroughly professional" and had identified some health issues which may have been otherwise missed.[52]

243. However, further review by senior health leaders found the nurse was mainly managing acute trauma and injury for people in Police custody. There was limited value from a reception to prison perspective.

Melbourne Assessment Prison

244. In Victoria, Australia, the Melbourne Assessment Prison (MAP) is a maximum-security facility that provides the primary state-wide reception assessment and orientation for male prisoners received into the prison system.

245. At MAP, all prisoners receive a general health assessment conducted by a medical practitioner, and a detailed mental health assessment. Particular attention is given to prisoners who have a history of mental illness or suicidal behaviour/intent in the past two years, or who have recent self-harm behaviour or suicidal ideation (all known risk factors for suicide/self-harm).

246. Victoria Department of Justice has an alert system, which is linked to its offender management system, with codes for placement, violence, and security classification. It also has codes for medical, suicide/self-harm, and psychiatric needs. These codes are managed by health staff and are all visible on the prisoner dashboard so that all staff, including custodial, are alerted to prisoners' needs. For example:

    » Medical: M1 = serious, M2 = ongoing treatment, M3 = requires assessment

    » Suicide/self-harm: S1 = immediate, S2 = significant, S3 = potential, S4 = history

    » Psychiatric: P1 = serious, P2 = significant, P3 = stable, P4 = suspected.

247. In 2018, during a visit to MAP by members of the Inspectorate review team, health staff in the Receiving Office spoke about being able to spend time in a room out of sight of other prisoners with each of the people they were assessing. In addition, people with medical needs had these attended to on the day of their arrival (such as having medications prescribed).

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51 Te Omeka Justice and Emergency Services Precinct brings together all justice sector agencies and emergency services in Christchurch into one site. The 'custodial suite' holds people in custody, including those who are waiting for court hearings or who have had their court appearance and been remanded into custody.

52 Operational Performance – Southern Memorandum, 'Provision of health screening assessments in the Custodial Suite at Te Omeka', dated 2 April 2020.

248. While we do not have any suicide or self-harm figures from MAP, we were told that few people were managed in their At-Risk Unit. Custodial staff we spoke to acknowledged that the coding system was visible on their offender management system. They valued this coding system to alert them to the presence and seriousness of prisoners' health and psychiatric needs.

Summary

249. Going to prison may be a major change in a person's life and can require considerable effort to adapt. It is crucial to identify people who are at risk of suicide or self-harm when they enter prison and to provide them with support.

250. While many prisoners had their initial needs met by reception screening, Receiving Offices provide a stark environment that may lack privacy, and staff, when busy, may focus on processing prisoners rather than meaningful engagement.

251. Screening for risk of suicide and self-harm may be more effective if Receiving Offices provide privacy, and practices are person-centred, trauma-informed, and culturally responsive.

252. Screening for risk of suicide and self-harm may be more effective when custodial and health staff engage in consultation. However, this does not always occur.

253. Information sharing between external agencies and Corrections staff is vital for assessment of risk. However, critical information is sometimes not shared or only partially shared.

254. A significant number of prisoners are known to use substances, and withdrawal symptoms can exacerbate risk of suicide or self-harm. Current reception processes may not adequately identify people who use substances, and, if they are identified, there may be insufficient support available.

255. There are alternative reception models that may have benefits for the effective reception and screening of people at risk of suicide and self-harm.

Areas for consideration: Reception

1. Corrections should consider how to improve the Receiving Office environment, including:
   - ensuring there are safe and private areas to conduct all assessments
   - adopting the Intervention and Support Unit therapeutic physical guidelines, or similar (as appropriate) to soften the environment.
2. Corrections should consider how to improve the quality of Receiving Office processes to ensure they are culturally responsive, person-centred and trauma-informed, including:
   - staff have time to engage and build rapport with the people they are assessing
   - staff have time to actively identify risk factors from all information available to them
   - staff have time to assess distress and other risk factors for suicide and self-harm
   - there are robust information-sharing processes so that staff have the time to share information with colleagues
   - appropriately trained and experienced clinical mental health staff are available to assist in determining the risk of suicide or self-harm.
3. Corrections should consider the recently published evidence-based guideline (2022) from the UK National Institute for Health and Care Excellence (NICE) that provides standards for best practice in the assessment, management and prevention of self-harm.
4. Corrections should consider credentialling all staff who work in the Receiving Office to ensure they have

had relevant training, including in using alcohol and other drug withdrawal tools, assessing distress, and checking IOMS alerts for self-harming behaviour.

5. Corrections should consider reviewing existing guidance for all staff about alerts for suicide and self-harm in IOMS. This should be done to ensure staff know when to create these alerts, how to check them, and when to remove them. Corrections should also consider creating new alerts that provide early warning signs to staff that a person may self-harm again.
6. Corrections should consider updating IOMS so that alerts (i.e. risk of suicide, risk of self-harm, at risk, and substance use alerts) are created automatically where appropriate, alerts are easily visible to staff, and alert definitions are available so that staff know when to apply them.
7. Corrections should consider the resourcing of Receiving Offices, particularly in high-volume receiving prisons.
8. Corrections should consider enhancing all mechanisms to share information between prisons and courts, probation, police, health, and other agencies.
9. Corrections should consider strengthening practice around the early assessment and treatment of substance withdrawal, including providing supportive information to newly received prisoners.
10. Corrections should consider alternative reception models, or aspects of the models.

Early days in prison

Introduction

256. The risk of suicide and self-harm is heightened during the early days and weeks a person is in prison. Contributing factors described in the literature include a restrictive regime, disconnection from families and society, exposure to violence in prison and overcrowding (Liebling, 1992; Stoliker, 2018; Forrester & Slade, 2014). These factors may be especially relevant for remand prisoners who are awaiting conviction or sentencing and who are therefore also dealing with uncertainty over what will happen to them (Tartaro, 2019). Some prisoners may have had little or no time to prepare for their incarceration.

257. There is some evidence to suggest that early days in prison may be a particularly high-risk time for women. Women in prison are more likely to self-harm than men, and more likely to report a lifetime history of suicidal ideation and attempts (Stijelja & Mishara, 2022). An Australian suicide prevention framework sets out that: "Women prisoners experience incarceration differently to men, with particular risk factors relating to issues of family stress and their outside relationships. This may include separation from dependent children, their children going into care or the women's imprisonment ending their ability to care for older family members." (Department of Justice & Regulation – Justice Health, 2015). Another Australian study found "that a gender analysis shows that women entering prison are generally more distressed than men" (Australian Institute of Health and Welfare, 2012).

258. Aside from these social and systems-based risk factors, people entering prison may also have individual risk factors. For example, the likelihood of self-harm increases in people with mood disorders, personality disorders, and major mental illnesses such as schizophrenia. As Corrections' reception risk assessments are based on self-report and people do not always share such information with staff, there is a risk that these individual risk factors are not fully understood in the early days, weeks or months a person is in prison (Rhodes, 2022).

Unit induction

259. Having completed the reception process, prisoners are escorted to their new unit where a custodial officer conducts an induction interview.[53] Prisoners are informed of the unit routines and daily life in prison, such as how to make telephone calls and receive visitors. During prison inspections we generally found that custody staff did complete the induction interview. However, prisoners sometimes told us that they were not inducted properly and were unaware of how to do things such as getting telephone numbers approved so they could make calls. This may be due to information overload within the first few days in prison or there may be other reasons.

> *"I didn't know the ins and outs of prison [telephone] cards – wasn't explained to me how to make phone calls or how to get stuff sent in. I guess if you don't ask, you don't get told." [Prisoner]*

260. We found that some units provided written induction booklets. However, as prisoners may have low levels of literacy, with approximately a third having only primary school/intermediate school levels of literacy, written booklets may be difficult for some to understand.[54] Current data also estimates that 50-61% of prisoners are dyslexic.[55] Further, a growing number of prisoners are from other countries, and may have English as a second language. Therefore, induction information may not be being delivered in a way that meets all prisoners' needs. This may contribute to uncertainty and anxiety.

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53 Prison Operations Manual: I.07.Form.01 Unit Induction interview

54 Data extracted from the 2019 Literacy and Numeracy Assessment tool data and sent to the Inspectorate review team by Corrections Principal Advisor Custody via email on 5 September 2022.

55 Information provided by the Corrections Education Team and sent to the Inspectorate review team by Corrections Principal Advisor Custody Dr Bronwyn McGovern via email sent 5 September 2022.

261. An effective unit induction is important as it can contribute towards reducing prisoner anxiety and assisting prisoners to maintain social connections through visits and telephone calls. We consider a well-conducted unit induction to be a vital part of a prison-wide approach to improving prisoner wellbeing.

Initial telephone call

262. Prisoners are supported by staff to make an initial free telephone call. This usually occurs on the day of arrival but may be delayed if the prisoner arrives late or attempts at calls are unsuccessful. We note that one person who was involved in a suspected suicide did not have an initial call as they did not know any telephone numbers. It is not uncommon for new prisoners to be unable to remember any telephone numbers.

> *"Got locked up on the spot so didn't have any numbers with me. It would have helped to be able to call someone. Staff eventually helped by calling probation who got my numbers off family and I've been in touch now." [Prisoner]*

Cell sharing

263. The local and international literature highlights that single occupancy cells are a risk factor for prison suicides (Rhodes, 2022; Zhong et al, 2021). However, a recent international meta-analysis of risk factors for self-harm in prisons found no clear association between self-harm and single cell occupancy (Favril et al, 2020).

264. In a study of 39 suicides in New Zealand prisons from 1 July 2010 to 30 June 2016, all except one occurred in a single occupancy cell (Jones, 2017). The study found that those who died in single occupancy cells were over-represented compared to the total number of prisoners who occupy those cells.

265. Cell sharing may therefore be a protective factor for suicide. However, the association between single occupancy cells and suicide is sometimes complex. Single cells mean prisoners have increased opportunity to attempt suicide because they have more privacy. Single cells also mean less opportunity for association, which may increase a sense of social isolation. On the other hand, less association may be positive if someone is concerned about bullying or intimidation.

266. In our analysis of the 29 suspected suicides in the review period, we found that 24 people (83%) were in a single occupancy cell at the time of their death and five (17%) were in a shared cell.

267. Of the 158 people who were involved in a self-harm threat to life incident during the review period, 111 (70%) were in a single occupancy cell at the time they self-harmed.

268. In situations where prisoners are required to share a cell, custodial staff in New Zealand prisons complete a Shared Accommodation Cell Risk Assessment (SACRA) to consider prisoner compatibility.[56] SACRA guidelines set out that prisoners who have been identified as at risk of self-harm are to be "placed in a single cell". The guidelines add that "there may be situations where the prisoner will benefit from having a suitable cell mate" and advise staff to consult with health staff before making this decision.

269. Over the review period, the requirement for cell sharing decreased due to the prison population decreasing. However, at the time of writing (October 2022) we observed that cell sharing was once again on the increase as prisoners were being moved for consolidation purposes due to custodial staff shortages.

270. We observed that the Shared Accommodation Cell Risk Assessment may be conducted by an officer who is unfamiliar with the prisoners, especially if the prisoners are new. However, we have also observed that custodial staff generally consult with prisoners as well as completing the assessment, to ensure the prisoners also feel they are compatible.

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56 Prison Operations Manual: I.08.Form.01 Shared accommodation cell risk assessment

Induction or First Nights units

271. In the first few days or weeks of imprisonment, the risk of suicide and self-harm is known to be heightened. A UK study identified that up to 30% of prisoners who died by suicide did so within the first month of their incarceration (UK Prison and Probation Ombudsman, 2016).

> *"A prison should provide everything a woman needs within 24 hours of her arrival. She shouldn't be sitting in a cell not knowing or understanding what she is entitled to. If she doesn't know what she can ask for then she is not going to ask for it and she will continue to go without which will have some kind of impact on her health, hygiene, mental and wellbeing." [Prisoner]*[57]

272. Our review of 29 suspected suicides showed that nine (31%) people died within the first 28 days of coming into prison, including three people who died within three days of arriving.

273. Our review of 158 people involved in self-harm threat to life incidents found that 70 people (44%) self-harmed within 28 days of coming into prison. Moreover, we found that 27 (17%) people self-harmed within the first week of being in prison, with 20 (12%) self-harming within the first three days.

274. Some prisons attempt to make the transition to prison life easier by putting new prisoners into Induction or First Nights units. These units aim to provide additional support and information. Prior to COVID-19, some prisons in New Zealand were observed to be using some elements of an Induction unit approach, though this was never standard across the prison network.

275. One subject matter expert felt that such units could be beneficial, but that they may not be practical to implement at all prisons:

> *'We have no formal first night unit. I think we should have, but physically we would struggle to do that. We don't have enough space and the prison isn't designed to support that." [Prison Director]*

276. There is currently little published literature regarding Induction or First Nights units. One preliminary report examining the Maltese prison population acknowledged the "extreme stress" that the transition from freedom to imprisonment can cause and recommended that "more information should be provided to prisoners, especially during their induction period". The author suggests this could take the form of one-to-one information sessions (which prison staff in New Zealand already conduct in the form of the unit induction) or through a practice akin to an induction unit. In the Maltese study, it is suggested that an induction unit would provide information from two sources: official information provided by prison staff, and peer support (Scalpello, 2021).

277. We note that Hikitia, the new mental health and addictions service that Corrections has planned for the central region, has an induction model demonstrated by the Mihingia (on entering the service) part of its "journey overview". This includes a pōwhiri/whakatau to welcome new prisoners and their whānau. The Hikitia Mana Whenua – Ahi Kā Foundation Document (Department of Corrections & Te Arawai, 2020 – 2021) also sets out that, "In the early stages of mihingia, understanding each tāne and their wholistic whānau needs is pivotal in ensuring their needs are met". While Hikitia is still under development, this induction model seems a promising move towards discovering and meeting people's needs in the early days.

278. At one prison, we observed that prior to COVID-19, a multi-disciplinary team worked together in a First Nights unit to offer a more individualised approach with supportive cultural practices.

> *"You can see the wairua is all over the place when women come in. Presentation isn't good. They always have underlying issues. The small things, but for them it could be a huge thing. Their houses might be open, their car on the road, their children at school not sure who'll pick them up ... Us being able to provide a karakia for them, sitting there and having a yarn ... Breaking down all those barriers ... I was seeing all the women when*

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[57] Quote from Office of the Inspectorate (2021). Thematic Report: The Lived Experience of Women in Prison. Wellington.

they first came out of the Receiving Office. A group of us had a briefing in the morning to see who needs to be seen by social workers, cultural support, ISPT, etc. That's normal practice to provide support in that space." [Cultural Support Worker, Intervention and Support Practice Team]

279. We are aware that Auckland Region Women's Corrections Facility's First Nights Centre Te Waharoa Whakatautangata restarted operations in November 2022. Te Waharoa Whakatautangata is a receiving unit dedicated to identifying the immediate needs of women at the earliest opportunity so that appropriate support can be put in place to meet those needs. We understand that Corrections is also piloting an updated Immediate Needs Assessment in this unit.[58]

Prison environment – general

280. One of the first things a new prisoner will notice is the prison environment. In New Zealand, prisons have been built with a security focus, rather than as therapeutic spaces. Some experts suggest prison architecture can be triggering for people who have experienced trauma at an early age. They argue that it is futile to "introduce trauma-sensitive services in establishments that are replete with hostile architecture, overt security paraphernalia and dilapidated fittings" (Jewkes, Jordan, Wright & Bendelow, 2019).

281. Successive inspection reports from the Office of the Inspectorate and the Office of the Ombudsman have noted the lack of therapeutic spaces and the stark environments in New Zealand prisons, particularly in high security units and those used for remand prisoners.[59]

282. There is strong evidence that being in nature is supportive of wellbeing (William, 2017). For Māori, being on home whenua may also be important. One subject matter expert told us:

"The lack of access to the outdoors and gardens is culturally offensive. The women should be able to feel the earth under their feet as the land is so much part of who they are." [Trauma Counsellor]

283. The literature supports the role of green spaces in prison in supporting wellbeing. A recent study in England and Wales found increased volumes of green space in prisons were associated with lower rates of self-harm and violence. This relationship persisted when controlled for prison size, types, age and level of crowding (Moran, Jones, Jordaan & Porter, 2021).

Prison environment – removal of ligature points

284. The most common means of suspected suicide and self-harm in New Zealand prisons is hanging, with a range of objects used as ligatures and ligature points. These results are consistent with other international and national studies on the means of prison suicides (Jones, 2017).[60]

285. Of the 29 people who died by suspected suicide during the review period, 24 (83%) used a ligature.

286. Of the 253 self-harm threat to life incidents, 161 (64%) involved use of a ligature.

287. The need to create safe environments, free of elements such as possible ligature points, has been re-iterated in many reviews (for examples, see Jones, 2017). Though, as noted by Jones, there are limits to what can be achieved in this regard and broader actions are required. Jones also recommended that Corrections develop a work programme to identify and remove potential ligature points across the prison network where practicable.

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[58] Source: Auckland Region Women's Corrections Facility First Nights Centre – Te Waharoa Whakatautangata operating guidelines Version.02, received 3 February 2023 by email from Clinical Manager Mental Health ISPT (Registered Clinical Psychologist), Auckland Region Women's Corrections Facility.

[59] See for example, Office of the Inspectorate (2021). Thematic Report: The Lived Experience of Women in Prison. Wellington.

[60] See also Department of Corrections Health Services Internal Memorandum dated 22 September 2020 from Senior Advisor Mental Health to Deputy Chief Executive Health, Suspected Suicide Thematic Review

288. Following this recommendation, Corrections reviewed the physical aspects of cells across the prison network, aiming to minimise fittings or fixtures that could assist with suicide. During 2020, Corrections undertook a Non-Ligature Cell Review to evaluate cells using a standardised template and to upgrade them if necessary. Corrections has advised they have an on-going programme of work to address any ligature points.[61]

Remand management

289. During the review period, remand and new prisoners were generally managed as high security prisoners, meaning they were housed in more secure units with a higher staff to prisoner ratio[62] and a regime that was more restrictive than in units for people managed as lower security. Prisoners managed as higher security generally got less time out of their cells and had little or no access to rehabilitation programmes or employment opportunities. High security classification and associated regimes are associated with increased risk of self-harm (Rhodes, 2022).

290. Corrections has an online assessment tool called the Remand Management Tool that custodial staff can use to ascertain the risks the remand prisoner presents to the good order and discipline of the prison, and to assess the level of custodial supervision they require. The tool can be completed once the prisoner arrives in a remand unit. It assesses the prisoner as either Level 1 (high supervision) or Level 2 (low supervision). Low supervision prisoners might be able to spend more time out of their cells and have greater access to work or educational opportunities. Each site developed their own supervision strategies for each level, based on factors including staff resources, activities available, and the lay-out of the site/unit.

291. We observed that during early stages of the review period custodial staff seldom used the Remand Management Tool. We were told by some staff that they had been directed not to use it, because staff supervision levels had to remain the same (i.e. one custodial staff member to 15 prisoners) even if prisoners were assessed as 'low supervision' as staffing levels could not change.

292. We have observed that this practice has now changed, and that custodial staff at several sites are now using the Remand Management Tool to assess the level of custodial supervision that remand prisoners require. We have observed that if a remand prisoner is assessed as requiring low supervision, they may be given the opportunity of moving to a low security sentenced unit instead of remaining in a remand unit. The increased use of the Remand Management Tool at these sites is likely to be due to the increasing remand population and ongoing staffing issues. However, there are still limited activities for remand prisoners at most sites.

Being on remand

293. Prisoners who have not yet been sentenced are placed on remand (either remand accused or remand convicted) and, for security reasons, are generally managed on a high security regime, which is restrictive.

294. As previously mentioned, while the overall prison population decreased over the review period, the remand population decreased more slowly. The Justice Sector Projections 2021 – 2031 (Ministry of Justice, 2022) predict that without changes to the current system, the remand population is set to increase to more than 4,000 by June 2031, meaning almost 50% of the prison population could then be categorised as remand. This prediction seems likely to be accurate considering that on 14 February 2023, 45% of the prison population was on remand.[63]

295. We note that the remand population in the New Zealand's women's prison population represents a greater proportion than the men's population. In June 2022, 50% of women in prison were on remand. Māori women represented a significant proportion of this remand population at about 72% at 30 June 2022.

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[61] Information received 27 December 2020 from the Corrections Suicide Prevention Working Group Non-ligature Cell Assessment programme of work to remove known ligature points.

[62] Staff to prisoner ratios are generally one custodial staff member to 15 prisoners in high security environments, and one custodial staff member to 20 prisoners in low security.

[63] Information sourced from COBRA: Of a total of 8,630 prisoners, 3,885 were on remand.

296. An international meta-analysis of risk factors for suicide in prisons found that remand status was one of the strongest criminological factors for suicide (Zhong et al, 2021). Remand prisoners may experience many of the known risk factors for suicide and self-harm, including social isolation from support networks, restricted regimes, uncertainty around court processes or outcomes, substance withdrawal and lack of purposeful activity (see, for example, Tartaro, 2019).

297. A UK report into improving prisoner death investigations and promoting change in prisons sets out that "a very significant systemic hazard is the large number of seriously mentally unwell people warehoused in prisons when a least-restrictive therapeutic environment would be more appropriate" and adds that this hazard is likely to be at its "most acute" for those on remand (Shalev & Tomczak, 2023).

298. A New Zealand study which compared groups of sentenced prisoners held in certain units (Intervention and Support Units, Separates Units, and Management Units) with remand prisoners held in the same units found that remand prisoners had more acute mental health needs, a higher risk of self-harm and a higher risk of harming others (Wilson, Lane, Sullivan, O'Neill-Murchison & Polle, 2020).

299. However, a recent international meta-analysis of risk factors for self-harm in prisons found no clear association between self-harm and remand status. The authors suggested that this disparity might reflect differences in risk factors for self-harm as opposed to suicide (Favril et al, 2020).

300. Our review of suspected suicides showed that 22 (76%) of the 29 people were on remand at the time of their deaths, 17 of whom were remand accused. The remaining five were remand convicted.

301. Our review of 158 prisoners who were involved in a self-harm threat to life incident showed 117 (74%) were on remand at the time of the incident.

302. The following case study illustrates the impact of an unfavourable court outcome on a recently received remand prisoner, Ms B, who was being housed in an Intervention and Support Unit because she had been assessed as at risk of self-harm.

Case study 2 - Ms B

Ms B was on remand and being housed in the Intervention and Support Unit at the time of her self-harm threat to life incident.

She had to attend court and told a staff member that if she did not get bail, she would hang herself.

Ms B did not get bail and custodial staff recorded that she appeared "agitated and upset but stated she was OK". However, on return to the ISU, Ms B refused to engage with custodial staff and screamed at them to get out of her cell, so they did.

Later, Ms B again informed staff that she was going to hang herself. Staff went into the cell and removed her mattress and blankets and anything else they thought she might use to hurt herself.

The moment they left, she pulled a ligature from beneath her anti-ligature gown,[64] put it around her neck and pulled it tight. The offender notes do not describe the ligature nor explain how Ms B was able to get it.

Staff returned to Ms B's cell and removed the ligature. Ms B was strip searched again, put into a new anti-ligature gown, and all remaining items were taken from her cell.

At the time of our review, she had been seen by almost all the mental health clinicians available, including members of the regional forensic mental health team.

[64] Anti-ligature gowns are made of material that is difficult to tear and convert into a ligature.

Time out of cell for remand prisoners

303. Generally, in New Zealand prisons, remand prisoners can watch television in their cells, exercise in a yard or gym, and access the prison library. They may be able to participate in unit-based work, such as cleaning, or access some education materials. However, the length of time remand prisoners spend out of their cells varies by prison and depends on a variety of factors including the design of the prison, the security risk level of the prisoner and staffing levels.

304. Long hours spent alone in a cell is sometimes known as restrictive housing and may be defined as "the practice of isolating individuals who are incarcerated in small cells for 22 to 24 hours a day" (Brinkley-Rubinstein, Sivaraman, Rosen et al, 2019). People housed in this way are exposed to social isolation, sensory deprivation, and physical idleness. Social isolation is well-known to be a risk factor for suicide and self-harm in prison.

305. A recent review of 14 international studies examined the impact of time out of cell and time spent in purposeful activity on a range of adverse outcomes, including mental health and suicidal ideation. The review found "limited but consistent evidence" of links between both low levels of time out of cell and restricted time in purposeful activity and a higher risk of suicide (Stephenson et al, 2021).

306. The Corrections Act 2004 requires that prisoners have a minimum entitlement of one hour of exercise each day,[65] a requirement that is echoed by the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), which set out that "Every prisoner who is not employed in outdoor work shall have at least one hour of suitable exercise in the open air daily if the weather permits" (United Nations, 2015). For some prisoners, this entitlement would have been the extent of their time out of their cell. In fact, during the review period, some remand prisoners would likely have experienced solitary confinement as that term is defined in the Mandela Rules as more than 22 hours a day without "meaningful human interaction" (Office of the Inspectorate, 2023).

307. For those remand prisoners required to isolate due to COVID-19 (discussed later) time out of their cell was further restricted and they may also have been denied association with other prisoners during the isolation period.

308. Prisoners who are remand accused are not eligible for offence-related rehabilitation programmes because they have not been convicted of a crime. For remand convicted prisoners (who are waiting to be sentenced) the length of their sentence is still unknown. Since prisoners are only accepted onto programmes if they will be in prison long enough to complete them, this means remand convicted prisoners are also ineligible for programmes. This includes drug and alcohol rehabilitation programmes.[66]

> *"Remand accused … are not entitled to or receive any programmes … there is no help for them at all … Alcohol and drugs could be addressed … no one is giving us the tools and support for release … there is no activities for motivation" [Prisoner]*
>
> *"While on remand I am not entitled to anything … counselling, education or release planning … they sell you the dream but give you the nightmare." [Prisoner][67]*

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65 Corrections Act 2004, section 70.

66 An exception is Te Ira Wāhine, a kaupapa Māori intensive alcohol and drug programme, which has been available to remand convicted (and sentenced) women at Auckland Region Women's Corrections Facility since 2018.

67 Quotes from Office of the Inspectorate (2021). Thematic Report: The Lived Experience of Women in Prison. Department of Corrections, Wellington

309. Prisoners themselves typically express concern about themselves or others who are on remand and have little to do. For example, one woman we interviewed for a thematic review expressed her concerns about a few young women who had been in prison on remand for two years and received no programmes. Another prisoner interviewed for an inspection stated:

> *"No courses, no jobs … two hours out (of cells) a day … there are limited opportunities for remand." [Prisoner]*

310. Past reviews of prison suicide have recommended that Corrections provide more meaningful activities for people on remand (Māori Suicide Review Group, 1996; Jones, 2017). In line with these, a review of eight suspected suicides in New Zealand prisons during the 2019/20 financial year included the following recommendation:

> *"Specific to remand, Ara Poutama [Aotearoa] should invest significantly to increase meaningful activities. These could include education and group work, arts and crafts, drama, music and horticulture (to name but a few). All these activities provide distraction and can allow hope to flourish at the bleakest points in people's lives."*[68]

311. During the review period we observed efforts to provide activities to remand prisoners at some prisons. For example, at one prison, remand accused prisoners could participate in Alcohol and Other Drug Brief and Intermediate programmes (though these ceased in 2018) and Brainwave Trust educational parenting programmes. We also observed prisoners on remand being offered a range of activities provided by volunteers. However, such activities remained limited, and during the COVID-19 pandemic response most volunteer activities were halted.

Peer support programmes

312. Overseas research suggests that some prisoners may benefit from peer support programmes. Peer support is included in Corrections' *Suicide Prevention and Postvention Action Plan* in 'Strategic focus area 7: Responding to Suicidal Behaviour' as an additional form of support Corrections intends to introduce.

313. Peer support programmes have been used in prisons in the United Kingdom for many years. A review by HM Inspectorate of Prisons found that peer support programmes can help prisoners adjust to prison life, reduce isolation, provide positive role-modelling, promote healthy lifestyles and decrease drug use. Such programmes may also have positive effects for the peer supporter by enhancing their self-esteem and confidence, generating a positive self-image, improving communication and organisational skills, increasing levels of independence and gaining trust (HM Inspectorate of Prisons, 2016).

314. The UK Listener Scheme[69] was introduced to reduce the incidence of suicide by training prisoners to become 'Listeners', providing confidential emotional support to their peers who were struggling or feeling suicidal. The Listener Scheme was introduced in 1991 and is now available in almost every UK prison as well as prisons in Ireland. The programme provides a safe space in which prisoners can vent their frustrations, diffusing sometimes tense and potentially volatile situations. The Listeners can also relieve pressure on health staff (Jaffe, 2012; Blagden & Perrin, 2014). The scheme is built on the policies and values of the Samaritans, which emphasise privacy and confidentiality. The training provided to Listeners is similar to that given to Samaritans volunteers, and, on completion, participants receive certification. Research has shown that peer education interventions and support programmes like the Listener Scheme are effective at reducing risky behaviours and have a positive impact on recipients, practically and emotionally (Bagnall, South, Hulme et al, 2015). Typically, in UK prisons, 1,500 Listeners respond to over 50,000 requests for support every year.

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[68] Department of Corrections Health Services Internal Memorandum dated 22 September 2020 from Senior Advisor Mental Health to Deputy Chief Executive Health, Suspected Suicide Thematic Review.

[69] https://www.samaritans.org/how-we-can-help/prisons/listener-scheme/

Summary

315. Risk of suicide and self-harm is heightened during the early days and weeks in prison. Contributing factors include restrictive regimes, disconnection from family/whānau, exposure to prison violence, and hostile physical environments. These factors may have particular impact on remand prisoners who are also dealing with uncertainty over court and sentencing outcomes.

316. Corrections has processes such as unit induction and provision of an initial telephone call that aim to introduce people to prison life, reduce anxiety, and meet immediate needs. However, current practices are not always effective, and early days in prison remain a high-risk time for suicide and self-harm.

317. Cell sharing may be a protective factor against prison suicide, and custodial staff generally consult with prisoners as well as completing the Shared Accommodation Cell Risk Assessment.

318. Before the COVID-19 pandemic, some prison sites had been trialling an Induction or First Nights unit approach in an attempt to ease the transition to prison life for new arrivals. While there is little published literature on the benefits of such units, this approach could lead to a more individualised induction which may help to reduce prisoner distress and identify those at risk of suicide and self-harm.

319. Prison environments in New Zealand tend to be stark and to lack therapeutic spaces. Lack of access to green spaces may be culturally inappropriate and may impact on prisoners' wellbeing.

320. Corrections acknowledges the need to create safe environments and has a programme of work underway to mitigate against possible ligature points.

321. Prisoners on remand have limited access to meaningful activity and may receive limited time outside of their cells. This may contribute to boredom and stress.

322. Peer support programmes may be a useful additional form of support for prisoners, particularly new prisoners. Corrections intends to introduce peer support as an additional mitigation against suicide and self-harm.

Areas for consideration: Early days in prison

11. Corrections should continue to upskill custodial staff as set out in Focus Area 3 of its *Suicide Prevention and Postvention Action Plan*.

12. Corrections should consider offering more learning opportunities to custodial staff to enable them to recognise possible withdrawal symptoms from alcohol and other drugs, and understand the impact of withdrawal on behaviour.

13. Corrections should continue to consider how to better support people coming into prison who have English as a second language or others who have diverse cultural needs.

14. Corrections should consider establishing dedicated First Nights units that better support the induction process for people who are newly received in prison.

15. Corrections should consider reviewing the Shared Accommodation Cell Risk Assessment (SACRA) to ensure consideration is given to the protective factor that cell sharing may offer some people.

16. Corrections should consider how to better support and manage people on remand, including:

    » encouraging the consistent application of the Remand Management Tool to ensure prisoners are managed appropriately in the least restrictive regime possible

    » providing more meaningful activities for people on remand, particularly brief AOD interventions and

programmes that teach psychological self-management tools

» providing more time out of cell for people on remand to mitigate the isolation and provide more opportunity for meaningful human interaction.

17. Corrections should continue to explore whether adopting peer support models, particularly in remand units, could be a beneficial form of support for newly received prisoners.

Healthcare in prison

Introduction

323. Corrections Health Services deliver primary health care to prisoners. This includes initial and ongoing health assessments, treatment of illness or injuries, health education and promotion, screening, immunisations, risk assessment, emergency responses and some disability support services. Health Services should be reasonably comparable to what a person could access from a community-based primary health care provider (i.e. a general practice), although in the case of Corrections, the Health Service is nurse-led.[70]

324. We acknowledge the value that nurses offer in supporting people in prison who are experiencing distress or mental illness. It is often the generalist nurse who is the first health contact a person has when they are distressed. It is the generalist nurse who attends to a clinical emergency when a person self-harms, who completes daily wellbeing checks when a person is transferred to an Intervention and Support Unit (ISU), and who completes post-ISU checks when the person transitions back to a mainstream unit.

325. Specialist mental health services are contracted or employed at all prisons to provide care to people with mild to moderate mental health issues. As mentioned earlier, by the end of the review period, six prisons had an Intervention and Support Practice Team which could offer mental health assessment and treatment to prisoners with higher needs. Clinical nurse specialists (mental health) were employed to offer mental health assessment and treatment to prisoners with higher needs in those prisons that did not have an Intervention and Support Practice Team.

326. Regional specialist forensic mental health services provide assessment and treatment to people whose "mental health needs intersect with offending behaviours". The people served by forensic services have "high and complex social needs; often have multiple mental health and addiction diagnoses; come from backgrounds often characterised by high levels of deprivation and the experience of trauma; and have committed, or are at risk of committing, offences resulting in high levels of harm to others" (Ministry of Health, 2021).

327. In our review of death in custody reports, two recommendations were made in relation to the management of nurse clinics, with some prisoners having their appointments rescheduled multiple times or missing clinic appointments altogether. This was a common theme in prison inspections, prisoner complaints to the Inspectorate and prisoner interviews, with the demand for nurse clinics exceeding supply or challenges in getting custodial support for clinics.

328. Many nurse clinics were significantly impacted by lack of available custodial staff, which means appointments were delayed for safety and security reasons. People housed in more restrictive or high security units could experience further delays in receiving health care as they required more custodial staff to escort them to the clinic or to be present when they were being seen by health staff.

329. In our review of the 29 suspected suicides in the review period, 18 people (62%) had been seen by health staff within two weeks of their death. These encounters varied. For example:

» Two people's last encounter before their suspected suicide was with a nurse for a post At-Risk Unit check.

» One person's last encounter was with a nurse for a post Use of Force assessment.

» One person was seen for mental distress.

» One person was seen in the Intervention and Support Unit because he was stating he was actively suicidal.

[70] The minimum standard for the medical treatment and standard of health care of prisoners is set out under section 75 of the Corrections Act (2004). Section 75 provides that (1) a prisoner is entitled to receive medical treatment that is reasonably necessary and (2) the standard of healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.

330. As previously noted in the 'Investment in training and workforce development' section, from June 2018, Corrections introduced mandatory primary mental health training for all registered nursing staff. This training consists of a three-day workshop followed by a one-day refresher workshop which is to be completed every two years. However, given the high rates of mental health and addictions issues experienced by people in prison, and based on our observations of nursing practice across the prison network, the Inspectorate review team considers that more training for nurses in understanding and responding to mental health and addictions issues would be beneficial.

331. The Primary Health Care Nurse Mental Health and Addiction Credentialling Programme[71] is an existing six-day programme that enhances nurses' responsiveness to people experiencing mental health and addictions challenges. It is suitable for nurses working within prisons, and could offer a broader scope of training than the existing three-day workshop.

332. We have observed that asking for help when experiencing a deterioration in mental health takes strength and resolve, and some people may delay asking due to stigma. For example, in one of the suspected suicides, the person had put in a health request form the day before his death, asking to see the doctor. It is, therefore, essential that staff do not minimise requests for help and that they act promptly when they receive these requests.

333. With the introduction of *Hōkai Rangi*, one of Corrections' short-to medium-term actions is to: "co-design a kaupapa Māori health service, including resourcing the services of rongoā Māori[72] practitioners". The transformational journey to develop the new service has been named Te Matatiki o te Oranga (the Spring of Wellbeing) and will be underpinned by kaupapa Māori and Te Tiriti o Waitangi principles. Corrections intranet sets out that the transformation "reflects the aspirations of whānau, delivers equitable health outcomes for Māori and helps achieve pae ora, healthy futures for Māori".

Initial Health Assessment

334. The Initial Health Assessment (IHA) is a comprehensive assessment conducted by a registered nurse. It uses a guided standard assessment and documentation tool in the Corrections electronic patient management system and includes questions on a person's family/whānau health history, medical conditions, prescribed medications, and needs to support tinana (physical health) and wairua (spiritual health). The IHA includes a mental health screening tool.

335. The timing of the Initial Health Assessment is based on triaging at the Reception Health Screen (which is completed on arrival into a prison). The IHA is an opportunity to check on a person who is newly arrived in prison, to gain more detailed information about their health and wellbeing, and to provide any interventions or referrals to address their identified health needs. The IHA also enables further discussions about mental health, substance use, and any withdrawal symptoms they may be experiencing.

336. People with urgent or complex health needs are required to be assessed within 24 hours, people with a semi-urgent or medium need within 10 days, and those with routine or low health needs within 30 days (Department of Corrections, 2019b). We have observed nurses completing the IHA in the Receiving Office (which should not occur because the IHA should be done in an environment that is conducive to discussion and where there is less time pressure), or not completing an IHA at all. We have also observed inconsistencies in the application of the triaging scores. For example, there have been times when nurses entered an incorrect triage score so people were not seen for their IHA within the correct timeframe for their health needs.

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71 https://www.tepou.co.nz/initiatives/primary-health-care-nurse-credentialing-programme

72 Natural or traditional Māori healing which encompasses herbal remedies, physical therapy and spiritual healing.

337. Of the 29 suspected suicides during the review period, 10 (34%) did not have an IHA completed within the allocated triage time. Nine prisoners (31%) had the IHA completed at the same time as their Reception Health Screen.

338. There is evidence to suggest that health services are more effective if they focus on early intervention, rather than being primarily reactive to health issues (National Health Committee, 2010). Ensuring all prisoners receive a quality IHA within the allocated triage time and according to departmental policy presents a good opportunity for Corrections to improve health outcomes for all prisoners, including those who may be vulnerable to suicide or self-harm.

339. As 73% of remand prisoners are in prison for three months or less (based on 2020 data)[73] the high demand for health services, and the short duration of their sentences, means some remand prisoners may be released before any meaningful health interventions take place. This may be especially true for mental health interventions, where the establishment of the therapeutic relationship takes time.

The Mental Health Screening Tool

340. The Mental Health Screening Tool is used by registered nurses to explore a person's previous history of self-harm and contact with mental health services. The tool has value in identifying risk factors for suicide and self-harm. It is completed at the same time as the IHA or when mental health concerns arise.

341. The Corrections Health Care Pathway policy sets out that all prisoners who give a positive response to one or more questions of the Mental Health Screening Tool will be referred to forensic mental health services for triage and further assessment. Corrections has received feedback from both health and forensic services nationally that this means the Mental Health Screening Tool automatically refers people to forensic services who would otherwise not have met the criteria. This created significant demand on forensic services.

342. While information entered into the Mental Health Screening Tool populates into the notes of the person's electronic health record, and an alert of 'at risk of self-harm' shows at the time of closing the tool, there is no automatic alert that stays visible to clinicians within the health file. If a nurse wanted there to be an immediately visible alert in IOMS or the patient health record, they would be required to enter it manually. We note that At the time of writing (May 2023) Corrections had chosen a preferred vendor for replacing and upgrading its existing patient management system. The Inspectorate review team considers that the upgrade of this new system could be a good opportunity for Corrections to review how alerts function, including alerts for suicide and self-harm risk.

343. In some prisons, we observed all Mental Health Screening Tool forensic referrals were first being triaged by either the ISPT or clinical nurse specialist (mental health) which supports coordination of care with people being referred to the most appropriate service for their level of mental health need.

344. We understand that the future of the Mental Health Screening Tool is under discussion, with forensic mental health services looking at alternative procedures which may be used in addition to the Mental Health Screening Tool.

> *"The (Mental Health Screening) tool was introduced about 12 years ago, and from the outset it was made clear that considerable uplifting of resources were required to do so. The reason for this is that the tool has a very high false positive rate to avoid false negatives. This is very common in all screening tools." [Forensic Psychiatrist]*

[73] Duration of remands in prison in New Zealand, year ending June 2020, accessed from: https://figure.nz/chart/S4YKcrbIOWnKJW6M

Alcohol and other drugs

345. According to the Corrections' *Alcohol and Other Drug Strategy 2021 – 2026*, there are 11 Drug Treatment Units (DTU) across nine prisons in New Zealand which offer an intensive alcohol and other drug treatment programme in a therapeutic community environment. The same strategy notes that Corrections also provides an "eight-week, recovery-focused Intensive Treatment Programme at five prisons". However, prisoners may have to wait for treatment, and those on remand are not eligible for either programme which are aimed at people who are closer to release or their parole eligibility date, and which treat criminogenic need, not health need.

> *"There are no short-term alcohol or other drug interventions available for those on remand." [Senior Adviser, Addictions Services Team]*

346. Health practitioners use substance withdrawal management guidelines to provide support for people who are planning or undergoing substance withdrawal. Corrections uses substance withdrawal management guidelines, and we observed some use by health staff of these, particularly for alcohol, opioids and methamphetamines (Te Pou, 2021).

347. We observed limited use of alerts in IOMS and electronic patient health records regarding substance use or withdrawal from substances. There is no specific withdrawal alert available in the electronic patient health record, but this could be recorded on a miscellaneous alert with a note attached with the details. In IOMS there are alerts for 'alcohol problems' and 'withdrawing from drugs.' While there are means to record that a person has a known history of substance use, in practice this is not consistently recorded in either system. These alerts should be used to facilitate safe prescribing of medications, as some medications may be unsuitable for people with a history of drug dependence.

348. We note that Corrections' *Alcohol and Other Drug Strategy 2021 – 2026* includes in its Action Plan the short-term outcome of delivering "more timely and brief interventions, including in … all levels within prisons, including maximum security, remand, and in the women's network." The strategy also expresses Corrections' intention to provide "programmes and interventions in the remand space".

349. We were told that Corrections is planning primary mental health training for nurses, and that alcohol and other drug assessment and management of withdrawal will be integrated into this. This will include training on substance withdrawal management guidelines and the Clinical Opiate Withdrawal Scale. This training had previously been on offer to Registered Nurses at Corrections but has not been on offer since about 2017.

350. This review supports all health staff, including clinical nurse specialists (mental health), being required to undertake alcohol and other drug assessment and management training.

> *"This is especially important given the single point of entry discussions, induction units and the high numbers of people coming into prison with a dual diagnosis (co-existing mental health and substance abuse issues)." [Alcohol and Other Drug Principal Advisor]*

The Alcohol, Smoking and other Substance Involvement Screening Test (ASSIST)

351. Corrections staff may use the Alcohol, Smoking and other Substance Involvement Screening Tool (ASSIST) to screen people for substance use and determine a risk score for each substance (low, moderate or high). The ASSIST was developed by the World Health Organisation (WHO) and provides standardised assessments of people in primary health, including prisons. The ASSIST involves asking prisoners questions about their alcohol and other drug use across their lifetime and in the past three months. The person's ASSIST score helps determine the level of intervention that they should receive. People can decline to participate in ASSIST screening.

352. The ASSIST may have been completed by a probation officer prior to the person coming into prison. However, if the ASSIST has not been completed, Corrections' health policy sets out that it should be done by a nurse during the IHA. Case managers must also check whether prisoners on their caseload have had the ASSIST completed and administer it if this has not been done.

353. Corrections staff who administer the ASSIST are required to be suitably trained to administer, interpret and respond to the outcome of the tool. Corrections created an online learning module on completing the ASSIST in 2018 and nurses, probation officers and case managers were directed to complete it. This module remains available on the Corrections Learning Management System section of the intranet. Disappointingly, in March 2022, just over 20% of registered nurses at Corrections had completed this training.

354. It is site dependant whether health staff completed an ASSIST during the IHA process. We have been told by health centre managers that if health staff do not complete an ASSIST, this is often due to there not being enough staff, or because nurses have not received the required training on administering the screening tool.

> *"The ASSIST is not currently done [by nurses] as it's not able to be completed within the given time that an IHA takes to complete. Some prison Health Services have just refused to do them." [Senior Adviser, Addiction Services]*

355. We understand that there may be an intention to shift responsibility for completing the ASSIST from the nurse to the case manager.

> *"The plan is to move the responsibility for doing the ASSIST from health to case management. Reason for this is that [if case managers do it] the result does trigger access to programmes." [Senior Adviser, Addiction Services]*

356. Of the 29 people who died by suspected suicide during the review period, we found that 13 (45%) had had an ASSIST completed (one was found to be low risk, seven were moderate risk, and five high risk).

357. Of the 158 people involved in a self-harm threat to life incident, 131 (83%) had had an ASSIST undertaken by Corrections staff (17 were recorded as low risk, 64 were moderate risk and 50 high risk).

358. Depending on the result of the ASSIST, the person can be offered an educational discussion about the risks of substance use, drug use information handouts, and the telephone number of a free alcohol and drug support line. When the person has been sentenced, they can be offered more intensive AOD treatment programmes. They will need to wait for availability of a suitable programme and may need to be transferred to another site.

Access to medication

359. People who have been prescribed medication in the community should be prioritised for a consultation with a prescriber to ensure continuity of care. Some people arrive at a prison with medication. This can sometimes be used until prescribed by the Medical Officer.[74] If it cannot be used, it will remain in the person's property in the Receiving Office. Some people arrive at a prison needing prescription medication they do not have with them. All prisoners should have access to medication when this is clinically required.

360. In practice, health staff wait to receive confirmation about prescription medicine from community health providers prior to prescribing. Some health staff can access this information electronically from community clinical information sharing services, while others are dependent on community health providers to respond to requests for health records in a timely manner.

361. Prescribers may only be on site for a few hours a day, or for a few days a week, so a prisoner may sometimes have to wait several days to see them. In addition, a medical officer may change a person's medication without a face-to-face consultation. This can cause distress to the person because they were not involved in the decision-making and may not understand why a medication has been changed.

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[74] In prison, a person's prescribed or 'over the counter' medications can be used until prescribed medications have been supplied if:
• the pharmacy label is intact and legible
• the medicine was dispensed within the last three months and has not passed its expiry date
• the medicine is in the packaging it was dispensed in, or, for 'over the counter' medicines, is in the original manufacturer's packaging.

362. Overall, we observed that there was wide variation in timeframes for people receiving their medication when arriving in prison. Sometimes there were delays which could negatively impact prisoners' wellbeing. For example, prisoners may have experienced withdrawal symptoms, or been without medications they were used to taking which could be distressing.

> *"There are frequent delays in establishing meds on arrival ... My view on this is that there is a real opportunity to strengthen the safer prescribing guidelines. Delays happen through custom and practice, and institutionalised thinking in Corrections ... If someone comes in with a bottle [of pills] with a name on it, we doubt them. So, we reach out to their community GP to get the evidence first and therefore there are delays ... and that causes a lot of distress." [Former Chief Medical Officer]*

363. Custodial staff also highlighted access to medications as an issue that impacted upon the good order of the prison:

> *"It can take weeks and weeks for a prisoner's medication to be sorted when they are received into prison ... Custodial feel that prisoners know what meds they are on, but instead are told they are drug seeking. Custody are then having to try and manage unmedicated prisoners." [Corrections Officer]*

364. From our review of electronic patient health records, we found that 25 of the 29 people who were involved in a suspected suicide in the review period were taking prescribed medication for either physical or mental health conditions, with eight of these people taking medication for both physical and mental health conditions.

365. Our review of 158 people who were involved in a self-harm threat to life incident found that 94 people (59%) were prescribed medication for a range of conditions. Twenty-six of them were declining their prescribed medication.

366. Six of the 29 prisoners who died of suspected suicide had a diagnosis of attention deficit hyperactivity disorder (ADHD), with three people having been prescribed medication in the community for this. Of concern, we noted that two of the three had current special authority numbers[75] for this medication, however, it had not been prescribed while they were in prison because they were waiting for confirmation from the medical officer. Research has shown a significant association between ADHD and suicide attempts, suicidal ideation and completed suicide (Septier, Stordeur, Zhang, Delorme & Cortese, 2019).

367. In 10 deaths by suspected suicide, medical history from community providers was not requested, was delayed, or was not received. In some cases, medical history was only received from one source (GP) and, despite the person having had recent contact with community mental health services, this information was not requested. There was also one case where the information had been received, but then could not be located.

368. While sites generally have robust processes for requesting and receiving information from community health providers, the volume of new arrivals, size of the site, staffing competency and capacity, and response from community providers all have an impact on this process. This highlights the importance of adequate training and guidance for staff, sufficient resourcing and clear procedures so that there can be continuity of care with safe prescribing of medication.

Requesting access to health services

369. When a prisoner has a health concern, they complete a paper-based health request form and post it in a secure health mailbox in their unit. Health request forms are collected daily by nurses and triaged so prisoners with the most urgent or acute health needs are seen first. Health Services receive many health requests from people expressing symptoms such as anxiety, stress, low mood, sleeplessness, and pain.

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[75] If there is a 'special authority number' in a person's medical records, this means the medication has been recommended by a specialist and approved by Pharmac for this person.

370. Nurses review and assess prisoners' health concerns prior to providing an intervention or treatment, or they may refer to another health provider such as a medical officer, dentist, physiotherapist, or mental health service.

371. We have found in other reviews, investigations and inspections that due to the high volume of health requests there can be frequent delays in prisoners receiving an appointment or follow-up care. Of the health complaints received by the Inspectorate, the most common sub-category (18%) is 'access to care'.

372. Four recommendations in our review of death in custody reports related to the lack of appropriate responses to health request forms, or lack of appropriate interactions by health staff with prisoners prior to their deaths.

373. For example, when reviewing a prisoner's health file, we found that the documentation reflected that he did not feel as if he was being listened to when expressing feelings of anxiety, hopelessness and sadness. We found another example of issues in accessing care in the following excerpt from a different prisoner's health request form:

> *"I am six days into being in custody. I have not been assessed by medical for my issues. I am on medication ... and the medication isn't meant to stop. I can't sleep properly. I'm too anxious to even leave my cell." [From a health request form from a prisoner]*

374. We also have concerns about nurses triaging directly from health request forms, given that many prisoners have low levels of literacy and health literacy. This may mean the written information provided by prisoners may lack sufficient clarity for nurses to triage appropriately.

Access to a medical officer/nurse practitioner

375. Medical officers in prisons are contracted registered general practitioners or urgent care physicians. They are essential to providing healthcare to people in prison. As mentioned above, their hours vary depending on the size and type of the site.[76] Smaller sites may only have a medical officer visiting one morning a week. Given the complexity of the health needs of people in prison, demand for medical services exceeds supply at most prisons, resulting in significant waiting lists at some sites. We have observed that some people may wait several weeks to see a medical officer.

376. Corrections has integrated the role of nurse practitioners into its health team. Nurse practitioners have advanced clinical training and an extended scope of practice sanctioned by the New Zealand Nursing Council. They can provide care for people with complex conditions and are able to prescribe medications. However, none are employed at the time of writing (January 2023) due to difficulties recruiting to this role.

377. Medical officer clinic lists are mostly determined by nursing staff who first assess the patient and decide whether they require a consultation with the medical officer or if they can be managed with alternative interventions.

378. Of the 29 suspected suicides during the review period there were nine people (31%) whose mental health had deteriorated, but who had not been referred to a medical officer, or who had been referred but whose scheduled medical officer appointments had not taken place. These included:

- » A person who had asked to see the medical officer on more than one occasion as he was feeling depressed and anxious.
- » A person who had been expressing that his levels of anxiety were increasing.
- » A person who was experiencing alcohol withdrawal and had changes made to his medications without a discussion with him.
- » A person who missed a planned review of his anxiety levels.

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[76] Medical officers work between Monday and Friday during business hours. They are on-call after hours by telephone for nurse consultation advice.

Access to mental health services

379. At the time of their suspected suicide, eight (28%) of the 29 people were already under the care of mental health services, including internal services provided by Corrections (such as an Intervention and Support Practice Team (ISPT) or Improving Mental Health clinician) and external services (such as a regional forensic mental health service). A further two people (7%) of the 29 who died by suspected suicide were being seen by other mental health providers (i.e. Packages of Care and Accident Compensation Corporation (ACC) counsellors).

380. Four people (14%) had been referred to a mental health service prior to their death but had not yet been seen by the service.

381. At the time of their self-harm threat to life incident, 35 people (22%) were already under the care of mental health services, including internal services provided by Corrections (such as the ISPTs) and external services (such as forensic mental health services).

382. We observed significant variability across prisons in what specialist mental health services people in prison were able to access. This variability was partly because Corrections introduced new mental health services at various times and at various prisons across the review period. For example, ISPTs were introduced at some sites and clinical nurse specialists (mental health) at others, while trauma counsellors were introduced only at women's prisons at first. In addition, there can be variability within a service. For example, an ISPT at one site may provide a slightly different service to an ISPT at another site (e.g. there may be different waiting times to be seen).

383. The variability in services could sometimes be attributed to the geographical location of some prison sites and the availability of forensic services. For example, we observed that one rural prison (Tongariro Prison) has no ISU and that the forensic mental health services team visits less often than at an urban prison.

384. Sometimes we observed variability of services within a single prison which may be due to demand on that site and people having to be waitlisted. Some prisons, however, were observed to have a high level of integration across their health services. This integration was observed in the documentation of multi-disciplinary planning and timely referrals to various available services following a self-harm threat to life incident.

385. We observed that referrals to Intervention and Support Practice Teams (ISPTs) could be made by any Corrections staff member, and that a person may also self-refer. Referrals could be made verbally to an ISPT member or written, such as in an email.

386. Referrals to Improving Mental Health clinicians could also be made by any Corrections staff member (via an online process) if the person consented to a referral being made. The referrals were then approved by the health centre manager prior to being sent to the contracted provider of the service.

387. The Inspectorate raised concerns about the referral process for the Improving Mental Health Service in at least two death in custody reviews of suspected suicides during the review period. Ensuring that all Corrections staff, including custodial officers and education staff, are aware that they can refer people to this service, and know how to navigate the online referral process, may be an opportunity for Corrections to improve practice for people vulnerable to suicide and self-harm.

388. We were told by one subject matter expert about a system at one smaller site which involved a clinical nurse specialist (mental health) acting as a single point of entry to mental health services. The subject matter expert said this single point of entry model "works well" but that there were "downsides":

> *"[In our prison] the mental health nurse undertakes a triage based on the needs of the women. This initial triage does not utilise any formal assessment model but is effective in referring the person to the right practitioner. The nurse has an excellent relationship with forensics and is a very good conduit when we really need to get people in … The nurse set up systems for us and organised a single point of entry, but only works four days a week. The downside to this is there is no one in the evenings/at nights or at the weekends; new*

arrivals arrive and are put in the ISU. Why would you not have someone in overnight to work alongside custodial teams and be there to help and advise?" [Prison Director]

Sleep

389. Insomnia and poor sleep quality are highly prevalent in prisoners and are a risk factor for poor mental well-being, aggression, depression, and suicidality. One international study of the general population found that nocturnal wakefulness increased the risk for suicidal behaviours. It noted the reduced support available at night and found that insufficient sleep facilitated the downward spiral of negative thinking, depression, suicidal ideation and behaviour (Littlewood, Gooding, Kyle, Simon, Pratt & Peters, 2016). Poor sleep can be a consequence of a mental health condition, but it can also be a causative factor in mental health issues (Scott, Webb & Rowse, 2017).

390. Another international study found that around a third of the general population in England had experienced insomnia at some point in their lives, with prisoners at least twice as likely to have insomnia, and the majority of prisoners having poor sleep quality (Dewa, Hassan, Shaw & Senior, 2018).

391. The reasons prisoners have trouble sleeping can include the separation from family/whānau, having to share living and sleeping space, safety concerns, limited physical activity, limited access to sunlight, and environmental factors (e.g. noise, light, temperature, mattress and bedding) (Randall, Nowakowski & Ellis, 2018).

392. In New Zealand, around 25% of adults in the general population suffer from a chronic sleep problem; this is higher for Māori than non-Māori.[77]

393. We observed that poor sleep quality is common for people in prison, particularly those who are newly arrived. In our review, 15 (52%) of the 29 people who died by suspected suicide had documented concerns about sleep issues prior to their death. For example, one person had asked for sleeping tablets, one person asked for help with his sleep, saying "I can't sleep [due to] stress" and a third person stated "I need to see the doctor because I need to get something to help me sleep … I'm having bad anxiety attacks … I'm crying a lot".

394. One subject matter expert raised the issue of insomnia as a possible symptom of withdrawal from substances:

    "Insomnia is an important symptom. This is an issue that we don't have consistent or quality assessments at the time." [Former Chief Medical Officer]

395. In our review of the 158 people involved in a self-harm threat to life incident, 60 (38%) had documented sleep issues.

396. Sleep is also a common issue mentioned in prisoner health request forms, with requests such as:

    "Want to see a doctor for insomnia." [Prisoner]

    "Having problems sleeping and can't think properly." [Prisoner]

397. When health staff receive a health request form from a person who is having difficulty sleeping, they make an appointment to complete an assessment. At this assessment, the person may be asked to complete a sleep diary which records general patterns of sleep and wake times, and day-to-day variability. People may also be provided with a sleep hygiene information pamphlet. This provides a range of tips for improving sleep, such as bedtime routines and the importance of regular exercise.

398. Corrections' Safer Prescribing Guideline (2021) has a section on managing acute insomnia and states "where possible, treatments should be based on behaviour modification, karakia, mōteatea[78], sleep hygiene, relaxation

[77] Canterbury Health Pathways About Sleep and Insomnia.

[78] Te Aka Māori Dictionary defines mōteatea as "a general term for songs sung in traditional mode".

therapy, meditation, yoga, exercise and cognitive behavioural therapy where these are available, recognizing the constraints within the prison environment".

399. We observed that some sites provided simple interventions to assist people who were having difficulty sleeping, such as offering ear plugs to reduce noise, chamomile tea to aid sleep, or information on meditation. Some people were also referred to a mental health clinician for support regarding any underlying distress which may be contributing to sleep disturbance. There are no national Corrections guidelines around sleep disturbance/insomnia, but we heard from the Manager Mental Health Quality and Practice that most mental health clinicians at Corrections have the ability to offer sleep hygiene support as part of a wider mental health assessment and plan.

400. The Best Practice Advocacy Centre New Zealand recognizes that the assessment and management of insomnia in general practice can be difficult, especially in relation to managing patient's expectations about pharmacological treatments.[79]

401. We observed that it was common for prisoners who struggled with sleep to ask for sleeping tablets. Some of these requests were justified and a short course of medication was given. For example, to assist during withdrawal of drugs, after a bereavement, or to help restore sleep patterns following some specific stressor. However, best practice guidelines recommend that sedating medications are limited to short-term, acute situations.

402. Some requests for sleeping tablets were not clinically appropriate and so medication was not prescribed. This can result in significant distress. In the community, people may have relied on substances such as drugs or alcohol to help them sleep. Alternatively, their community doctor may have prescribed a medication such an antipsychotic (e.g. quetiapine) which has sedating effects. However, this may not have been prescribed when the person came into custody as the person did not have a psychotic illness and it was therefore not clinically indicated.

403. If a sedating medication was prescribed, we noted that it was often given early in the evening due to the timing of medication rounds. This could result in the person falling asleep early in the evening and waking up during the night when the medication had worn off. Therefore, the Inspectorate review team considers it essential that people take these medications as close as possible to their bedtime.

Pain assessment and management

404. The assessment and management of pain is challenging in any context but is especially challenging in prisons. As one study sets out: "...the experience of pain in any setting (including in correctional settings) is often multidimensional and complex. The assessment of the symptomatology should include assessing non-pain symptoms (nausea, shortness of breath or insomnia); psychosocial symptoms (anxiety and depression); social suffering (loneliness) and existential or spiritual suffering. Such symptoms are likely to be quite pronounced in the correctional setting. Social suffering, such as loneliness, can come from social isolation which is widespread as relationships in prison are usually experienced as distrustful, also because of fear of violence and ties to the outside are limited and often even lost completely. Additionally, the environment of deprivation in correctional settings can magnify fears and other emotions that can enhance the experience of pain." (Handtke, Wolff & Williams, 2016).

405. One 2020 review of suspected suicides in New Zealand prisons found that six out of the eight people who died had some type of chronic co-morbidity, including chronic or severe pain.[80]

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[79] Best Practice Advocacy Centre NZ advocates for best practice in healthcare treatments and investigations across a wide range of health service delivery areas.

[80] Department of Corrections Health Services Internal Memorandum dated 22 September 2020 from Senior Advisor Mental Health to Deputy Chief Executive Health, Suspected Suicide Thematic Review

406. A 2015 Australian study examining the general population found that 65% of people who had attempted suicide in the past 12 months had a history of chronic pain. In this study, chronic pain was independently associated with lifetime suicidality after controlling for demographics, and mental health and substance use disorders (Campbell, Darke, Bruno & Degenhardt, 2015).

407. There is a recognised predisposition to chronic pain for those in prison who have been subjected to early life adversity (abuse and neglect), coupled with poor comprehension of emotions and difficulty regulating emotions. Self-harm in this cohort is seen as a non-suicidal injury, inflicted to distract from unpleasant emotions/experiences by diverting attention to a physical pain sensation. This is seen with people diagnosed with a borderline personality disorder (Lane, Anderson & Smith, 2018).

408. Chronic pain is associated with an increased risk of suicidal ideation and suicide attempts. Psychogenic pain,[81] which is typically seen when a diagnosis is not made or treatment is considered ineffective, further increases the risk of suicide. Psychological or emotional pain presents greater risk than chronic physical pain, with the most significant risk factor being linked to those with depression (19-fold risk for women and 15-fold risk for men) (Hooley, Franklin & Nock, 2014; Lane, Anderson & Smith, 2018).

409. From our review, 11 of the 29 people (38%) involved in a suspected suicide were taking analgesic medication for mild to severe pain. Five of the 11 were in contact with Health Services about their pain issues prior to their death.

410. From our review of the 158 people who were involved in a self-harm threat to life incident in prison, 43 (27%) had a diagnosed pain-related condition, with musculoskeletal pain being most common (26 people, or 16%). Thirty-nine of the 158 people (25%) had identified pain prior to their self-harm threat to life incident.

411. For mild pain, we observed that prisoners could access paracetamol from custodial staff. However, the Inspectorate has received complaints from prisoners that there were challenges in getting paracetamol when they needed it. This could contribute to distress.

412. One of the challenges for prescribers in prisons is the potential for misuse of prescribed medications, especially those that may be used as currency within the prison. People who are prescribed pain medications may be vulnerable to threats from others. There are best practice guidelines to support safe prescribing of pain medications.

413. With further research into the management of chronic pain there is a movement to a model which sees the rationalisation of medication and the addition of non-pharmacological and educational approaches (Vanhaudenhuyse, 2018). This aligns with Corrections' safer prescribing guidelines and a global clinical approach to reduce harm associated with the long-term prescribing of opioids (Mackey, Anderson, Bourne, Chen & Peterson, 2020).

414. Supporting the literature, one subject matter expert commented:

> *"Considering risk factors for self-harm or suicide, I think it's more than the role of pain meds. We need to recognise poor symptom management. It's not just about pain, but poor symptom control of other things such as despair." [Former Chief Medical Officer]*

415. Given the possible connection between chronic pain and suicidal distress, we acknowledge the inclusion in Corrections' *Suicide Prevention and Postvention Action Plan* of the following short-term action: "Develop practice guidance for frontline health staff to guide the assessment of suicidal ideation/distress in individuals who are experiencing chronic pain difficulties" (Department of Corrections, 2022).

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[81] Psychogenic pain is caused, or made worse, by factors other than illness or injury. Factors include mental health issues and personal history.

Summary

416. Nurses offer valuable primary care to prisoners who may be at risk of suicide and self-harm, though some nurses may require additional training in supporting people with mental health and addictions issues. Ensuring all prisoners receive a quality Initial Health Assessment within the allocated triage time is a good opportunity for Corrections to improve health outcomes for all prisoners.

417. The Mental Health Screening Tool was designed to identify anyone who might require further assessment or support from forensic mental health services. This places significant demand on forensic mental health services and we understand alternatives are being considered.

418. Many people involved in a suspected suicide or self-harm threat to life incident had substance use disorders. More treatment options and programmes should be provided, including to remand prisoners.

419. Completing the Alcohol, Smoking and other Substance Involvement Screening Tool (ASSIST) has been the responsibility of nurses, however, in practice it may be done by other Corrections staff or not completed at all. There may be an intention to shift responsibility to case managers.

420. Accessing their medication, or changes to their medication, may be a considerable stressor for some prisoners.

421. Access to health staff, including medical officers and mental health clinicians, can be an issue, and prisoners may have to wait to be seen. This may be a contributing factor in some suspected suicide and self-harm threat to life incidents.

422. The diagnosis and management of insomnia requires a detailed medical, sleep, and psychiatric history to ascertain what clinical interventions will best support the person. Requests for help to sleep need to be taken seriously. Early interventions should be redirected away from medical officer services and towards improving access to sleep education, supportive non-pharmacological approaches, and psychological supports.

423. The assessment and management of pain is a difficult issue in prisons due to concerns about the addictive nature of some medications and the potential for drug seeking behaviours. However, chronic pain is associated with an increased risk of suicide and we encourage the use of practice guidance for staff in this area.

Areas for consideration: Healthcare in prison

18. Corrections should continue to upskill health staff as set out in Focus Area 3 of its *Suicide Prevention and Postvention Action Plan*. In particular, Corrections should consider incorporating the Primary Health Care Nurse Mental Health and Addiction Credentialling Programme into its mandatory training for those nurses who have not already had specialist mental health and addictions training.

19. Corrections should consider offering more learning opportunities to health staff to enable them to recognise possible withdrawal symptoms from alcohol and other drugs and provide appropriate education and intervention.

20. Corrections should continue its discussions with national and regional forensic mental health services about the effectiveness and application of the Mental Health Screening Tool.

21. Corrections should consider providing practice guidance for the use of health alerts in the electronic patient management system.

22. Corrections should consider whether responsibility for administering the ASSIST tool should be with Health Services or Case Management, and whether staff are appropriately trained and resourced to carry out this screening.

23. Corrections should consider how to ensure prisoners have more timely access to medication prescribers, including considering adopting more telehealth technology.
24. Corrections should consider how it can better support people who have acute and chronic insomnia and/or pain.

Life in prison

Introduction

423. In this section, we briefly discuss some of the aspects of prison life that may be protective factors against suicide and self-harm. We follow this with a discussion of trigger events and trauma that may overwhelm a person's ability to cope and that may lead to a suspected suicide or self-harm threat to life incident. We also examine practice around the Review Risk Assessment, which should be used by custodial staff any time they consider a prisoner's risk of suicide or self-harm may have changed.

Custodial staff

424. Custodial staff, such as corrections officers, manage prisoners day-to-day and are well-placed to notice changes in behaviour that could signal a vulnerability to suicide or self-harm. Custodial staff are often skilled at managing people with challenging behaviour, and may be supportive and observant. However, they have limited formal mental health training, and mental health knowledge is not a prerequisite for the role. There is no training for custodial staff in recognising the symptoms of substance use withdrawal.

425. Case officers are corrections officers or senior corrections officers who are assigned a number of prisoners to actively manage, for example by discussing offender plan progress and assisting with prisoners' needs. Case officers are a conduit between the prisoner and the case manager through which prisoners can raise any new needs or concerns which may be affecting their progress.

426. Corrections policy sets out that case officers should meet with the case manager and the prisoner to discuss the offender plan activities within 10 days of receiving the offender plan. They should also have regular formal or informal meetings with the offender to motivate them and to discuss any progress or issues with the offender plan. These meetings should be file noted. In practice, we observed that such meetings, even if they occurred, were seldom file noted.

427. Case officers should build rapport with the prisoners on their caseload and get to know their personal circumstances and needs. This means case officers may notice subtle changes in a prisoner's behaviour, and may therefore be able to identify people who are vulnerable to suicide and self-harm.

428. It is our view that the role of the case officer is not working well across all prison sites. We did not see file notes being completed consistently by case officers during our review of the 158 people who were involved in a self-harm threat to life incident in the review period. Case officers should at least be meeting regularly with their assigned prisoners and recording the outcomes of those meetings in file notes.

Case management

429. There is evidence to suggest that having a plan for the future may help people become more future-focused, which can be a protective factor against suicide and self-harm. An individualised plan can also assist with the management of risk and ensure the prisoner has access to necessary supports during their time in prison (Biddle, Dyer, Hand & Strinati, 2018).

430. In New Zealand prisons, a case manager acts as a conduit between the prisoner and access to purposeful activity and rehabilitation programmes. All people in prison should meet with a case manager who assesses their needs and works with them to create a remand plan or an offender plan, depending on their status as a prisoner (these plans are the same document, but the offender plan has an 'offending needs' section).

431. According to the Case Manager Practice Centre on the Corrections intranet, case managers should meet with every new person on their caseload within ten working days of allocation for an initial contact visit. The practice

centre also sets out that they have 20 working days from the site reception date to complete an initial contact visit, though they may see some people sooner. An initial remand/offender plan should then be finalised within 40 working days of a person's arrival in custody.

432. We observed that while initial contact visits in the earlier part of our review period were always face-to-face, at the beginning of the COVID-19 pandemic, case managers were directed to meet prisoners virtually. Initially, this was a sensible precaution to stop the spread of COVID-19, but we observed that the practice has continued. This does not appear to be in line with the case management practice guidance available on the Corrections intranet which states "I will undertake face-to-face contact with each person based on their individual assessed risk, need, and responsivity barriers."

433. In our review of 29 suspected suicides, 11 people (38%) had no remand or offender plan at the time of death. However, 10 of the 11 were remand accused, which may suggest that they were new to prison and that their case manager had not yet had time to create a remand plan.[82]

434. The remand plan is usually created first (for those on remand) because it focuses on the person's immediate needs in case they are released, such as whether they have a suitable release address. Recidivist offenders who come in and out of prison frequently require a new remand plan each time. Case managers can view previous plans, but we observed that this demand may place pressure on them.

435. If a person is sentenced, the case manager creates an offender plan. The offender plan should "clearly detail requirements for addressing identified risks and needs". The offender plan should include all the main activities planned for the person, such as rehabilitation programmes or training opportunities. Some activities may not take place for months or years. We observed that prisoners became frustrated if they were unable to complete the activities on their offender plan, for example due to waiting lists for some programmes. Not having completed programmes may make it more difficult for prisoners to demonstrate progress in any application for parole.

436. The offender plan is "a living document – constantly reflecting the person's journey". In practice we observed that many plans are updated around every six months or when a transfer to another prison occurs.

437. In addition, we observed that while offender plans were generally created taking the prisoner's views into account, some plans were more reflective of the activities the case manager believed were appropriate, and the prisoner seemed to feel little ownership of the plan.

438. Generally, case managers aimed to build rapport with the people on their caseloads and some may have been in a position to identify issues regarding the wellbeing of the person they were interviewing. However, case managers do not have day-to-day contact with the people on their caseloads. At some smaller sites, a case manager may meet with people around once a month. At larger sites, they may meet them around every six months. This means that most case managers were not well placed to notice day-to-day differences in a person's behaviour or demeanour that might have indicated that their risk of suicide or self-harm was increasing.

439. We note that if a case manager does have concerns about a person's wellbeing, they can refer them to an Improving Mental Health clinician or a trauma counsellor. Case managers may also alert health and custodial staff (e.g. the person's case officer) and ask them to consider doing wellbeing checks or a Review Risk Assessment.

Connections with family/whānau

440. As highlighted already, social connectedness and support are key drivers of wellbeing and resilience and are regarded as a protective factor against suicide and self-harm. Socially well-connected people are more likely to

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82 Data for remand/offender plans was not obtained for the 158 people who were involved in a self-harm threat to life incident.

be happier, healthier, and better able to take charge of their lives and find solutions to any problems they are facing (Frieling, Peach & Cording, 2018).

441. While strong relationships are a protective factor against suicide, social isolation or relationship breakdowns are factors in many explanations of suicide and are recognised as a potential trigger for suicide (WHO, 2014a; Durkheim, 2007; Schneidman, 1993).

442. We observed that prisoners have a range of mechanisms to maintain social connections. These include sending and receiving mail, accessing telephones to make calls, and receiving visits. In some prisons, virtual visits via audio-visual link (AVL) were also possible.

443. However, being removed from social supports is a challenge for many prisoners and a large body of evidence suggests that maintaining social connections helps prisoners cope with their experience and successfully transition back into society on release (see, for example, Cochran, 2014; De Claire & Dixon, 2017; Lord Farmer, 2017). Internationally, having no social visits is a risk factor for suicide (Zhong et al, 2021).

444. Fostering social connection for social support, belonging and identity feature in important suicide prevention strategies including *Every Life Matters* and the Corrections *Suicide Prevention and Postvention Action Plan*. In addition, *Hōkai Rangi* sets out Corrections' intention to enact "policies and practices that focus on placing and keeping people who are in the care and management of Ara Poutama Aotearoa as close as possible to their whānau".

445. Whānau is central to te ao Māori, and one of the *Hōkai Rangi* pou is Whānau. Whānau is also an integral part of other *Hōkai Rangi* pou (e.g. Humanising and Healing, Incorporating a te ao Māori worldview, and Whakapapa). However, the foundations of New Zealand's justice system, including the corrections system and the legislation supporting it, are not well aligned to te ao Māori. Some subject matter experts raised the following points with the Inspectorate review team:

> *"One thing that's very not Māori is that we are all individuals. Within the legislation it is an individual's right, which overrides the basic Māori rule that you belong to a whānau and a hapū, so the collective needs to be involved in your healing, and whānau could be victims as well of the offending. But we disconnect people from the support that they really need and that will help them while they're in our care."*
> *[Cultural Support Worker, Intervention and Support Practice Team]*

> *"I'm a big advocate that whānau need to have the right to have a choice to be involved. They'll decide whether they want to, but I think it should be a right for them to be invited to be engaged. They can tell us so much more; they've known their whānau member for a lot longer than us. They understand their patterns and stressors, exposure in childhood, what contributed to the person being in our care. There are opportunities for us to understand how we can engage with and do things differently for them. Biggest changes [will come from] groupings of people: whānau, hapū and iwi, as well as individuals." [Chief Māori Health Officer]*

446. During our review of the 29 suspected suicides in the review period, we found some data on social connectedness by reviewing people's health records and information on IOMS. From this data, it appeared that fifteen people (52%) were in a relationship, either married or de facto. Six people (21%) were single, and relationship status was unknown for eight people. Thirteen people (45%) were parents, eight (27%) were not parents and a further eight had unknown parental status.

447. From the same available information (i.e. health records and IOMS) for the 158 people who had been involved in a self-harm threat to life incident, we found that 75 people (47%) appeared to be in relationships, while 37 people (23%) did not share relationship information.

448. It is important, however, to note that even with strong social support, some prisoners may still attempt suicide when distressed, as the following case study illustrates:

Case study 3 – Mr C

Mr C was in his thirties at the time of his self-harm threat to life incident. He had a supportive partner, a young child, and other support within the prison. He also got on well with the man he shared a cell with. It was Mr C's first time in prison.

Mr C displayed aggressive behaviour towards staff due to an issue with a meal and was pepper-sprayed. He was decontaminated from the pepper spray and assessed for self-harm risk afterwards (as is standard practice) and found not to be at risk.

However, Mr C continued to experience the effects of the pepper spray on his eyes. He got angrier, yelling and kicking his cell door, then told staff via the cell intercom that he was going to kill himself. He was found unresponsive on the floor in his cell by custodial staff who provided emergency first aid.

Later, Mr C told staff that he had not meant to go that far and had not wanted to die. He said he had been feeling angry, his eyes hurt and he had felt no one was listening to him.

Following the incident, Mr C was well-supported by the custodial and health teams.

Telephone calls

449. After a prisoner's initial telephone call, they must make a written application to have telephone numbers approved by the unit PCO and entered on the Corrections Prisoner Telephone System. We observed there can be a delay in having telephone numbers entered on the system, sometimes up to several weeks. This may be because staff are unable to contact people to ensure they consent to receive calls. Prisoners must also be issued a PIN number to enable them to use the telephones, and a phone card, which, during the review period, they had to pay for.[83]

450. As noted above, the quality of unit induction varies from unit to unit, and, during interviews with inspectors, some prisoners said they were unaware of the process to have telephone numbers approved, even though staff had completed induction interviews.

451. Our analysis of 29 suspected suicides showed that 12 people (41%) had no approved telephone numbers. One person had applied for telephone numbers to be approved but this had not yet occurred when they died.

452. For the 158 people involved in a self-harm threat to life incident, we found that 86 people (54%) had no approved telephone numbers.

453. In most prisons, telephones are situated in a shared area in the unit or in the exercise yards. This means around 30 to 50 people may be sharing one or two telephones, and since prisoners are only allowed access to these areas for certain periods, they may need to wait to use the telephone. In addition, prisoners only have access to these areas at certain times of day, making it difficult for them to connect to family/whānau and others who are not available to take calls during those times. For example, we observed that it may be difficult for some prisoners to talk to their children because they can only use the telephone when the children are at school.

454. The minimum entitlement for telephone calls is one five-minute call a week, though many prisoners will receive more than this. However, in units with more restrictive regimes, such as Management Units, and depending on their management plan, this five-minute telephone call may be all some people get.

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83 From 11 October 2022, Corrections began transitioning prison sites onto a new telephone system and covering the costs of calls.

455. One subject matter expert felt telephone calls should be more freely available:

> *"Women need to be able to talk with their whānau without people standing over them, waiting in line. In the wings there is only one phone. The cost of calls is very expensive, and some women can't afford phone cards … Phone calls should be free; they should have three numbers that can be free." [Prison Director]*

456. During the review period, local telephone calls from prisons were charged at a flat rate of $1 for up to 15 minutes, which was the maximum call time allowed. National calls were charged at $0.25 a minute, calls to cell phones at $0.35 a minute, and international calls cost $0.90 a minute.[84] These costs may have been prohibitive for some prisoners, particularly if they had no financial support from outside the prison. We note that when the COVID-19 pandemic began, Corrections attempted to mitigate the effects of social isolation by giving prisoners one free $5 phone card a week.

457. Moreover, Corrections' intranet sets out that from 11 October 2022, Corrections began transitioning prison sites onto a new telephone system that did not require telephone cards. Corrections is now covering the costs of national calls and providing 30 minutes of free international call time a week. Free calling to friends and family/whānau aims to improve prisoner welfare, and the Inspectorate review team welcomes this innovation.

Visits

458. Under the Corrections Act, 2005, section 73, a prisoner is entitled to receive at least one private visit a week for a minimum duration of 30 minutes. This is in addition to visits from legal advisors and external agencies.

459. Prisoners must complete a form to apply for visits and setting up visits can take time. During the review period, the Office of the Inspectorate recommended in one death in custody investigation that Corrections review the visitor application process to ensure these applications are processed in a timely manner.

460. Our analysis of suspected suicides found that 22 of 29 people (76%) had no visits at all, or none within one year if they'd been in prison for a longer period.

461. In our review of the 158 people involved in a self-harm threat to life incident, 144 (91%) had no visits. There was evidence that 10 (6%) had visits prior to the incident.

462. We observed that many prisoners did not receive visits for a variety of reasons, including: families and friends were victims of the person's offending and did not want to visit; the prisoner did not want people to see them in prison; the prisoner did not want people to have to travel. Sometimes, the prison was too far away for family/whānau to visit, or the cost of travelling was prohibitive.

> *"A lot of the men I've met don't have the ability to have their whānau there. Not just Māori men. [The whānau is not] able to sit with them and have that face-to-face contact with their whānau member." [Cultural Support Worker, Intervention and Support Practice Team]*

463. Since 2020, the lack of visits was due to the impacts of COVID-19, as visits were cancelled to prevent the spread of the pandemic. To mitigate the effects of cancelling face-to-face visits, Corrections introduced a national initiative to enable people to have virtual visits with their family/whānau. We acknowledge the usefulness of this approach for maintaining social connectedness, however, we observed that there were challenges in accessing this for the majority of prisoners.

464. Visits in some prisons recommenced in October 2022, but we note that, generally, regimes in most New Zealand prisons remain more restrictive than they were pre-COVID-19. While the reasons for this are outside the scope of this report, staff shortages and the continuing presence of COVID-19 in our communities are contributing factors.

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[84] From the Prison Operations Manual C.02.Sch.02 Schedule of phone card rates retrieved 11 July 2022.

Time out of cell and purposeful activities

465. A recent international literature review by Stephenson et al examined the impacts of time out of cell and time spent in purposeful activity on a range of adverse outcomes for prisoners (Stephenson et al, 2021). Stephenson et al found "limited but consistent evidence" of links between both low levels of time out of cell and restricted time in purposeful activity and a higher risk of suicide. These findings were consistent with the Harris Review (Lord Harris, 2015) which found a lack of time out of cells and few purposeful activities were associated with poor mental health which in turn increased the risk of suicide among young men in English and Welsh prisons. Stephenson et al suggest more research is required and note that their findings were inconsistent with a previous meta-analysis which found that work in prison was not protective of suicide. They suggest this may be because time in purposeful activity encompasses a broad range of activities which may be protective when a single activity is not.

466. One Australian study found that an Aboriginal Art Programme was associated with lower rates of suicide and self-harm when a history of these incidents was controlled for (Rasmussen, Donoghue & Sheehan, 2018).

467. In an English review of prison suicide (Bennett, 2020) that sought the perspectives of former prisoners, work and education were seen as important in helping to keep prisoners occupied, and, if activities stopped, wellbeing was felt to worsen:

> *"You are stuck in your cell. You can't go to work, you can't go to education … Without work, education or nothing you are going to go mental … You are going to go mentally ill, aren't you…" [Former Prisoner]*

468. Of the 29 people who died by suspected suicide during our review period, five (17%) were being held in units with restrictive regimes, such as ISUs or Management Units, at the time. Prisoners who are subject to directed segregation may also experience restrictive regimes and receive limited time out of their cells.[85]

469. In terms of work, we found that five (17%) of the 29 people were employed in jobs such as grounds worker, cleaner or painter. Two (7%) of the 29 had a recent history of attending programmes, and one person (3%) had been listed to start a carpentry course.[86]

470. Of the 158 people who were involved in a self-harm threat to life incident, 76 (48%) were housed in a unit with a restrictive regime, including ISUs, Special Needs Units or Management Units, at the time of the incident.

471. Of the 158 people who were involved in self-harm threat to life incidents, we found that ten (6%) were attending programmes. The rest were not engaged in programmes or did not have this information recorded. For many, this would have been due to being on remand and therefore not eligible for programmes: 117 (74%) of the 158 people were on remand at the time of the incident.

472. We note that most (177 or 70%) of the 253 self-harm threat to life incidents occurred between 10am and 8pm. This is contrary to what occurs in the community, where most self-harm presentations to hospital emergency departments occur outside normal working hours (the most common timeframe being between 8pm and 3am) (Evoy, Clarke & Joyce, 2023). While we acknowledge that the hospital presentations were for all self-harm incidents (i.e. not necessarily only self-harm incidents where there was a threat to life) and so the comparison is not exact, it is possible that this difference reflects the fact that many prisoners have little to occupy them during the day and that this may lead to them being more at risk of self-harm.

473. Social connections with other prisoners during unlock periods may be protective for some prisoners, but may be an additional stressor for others, therefore a personalised approach to activities in a prison is important.

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[85] Under section 58-60 of the Corrections Act, Prison Directors have the power to make segregation directions so that a prisoner's opportunity to associate with other prisoners is restricted. Prisoners may be put on directed segregation if the safety of a person, or security or good order of the prison would otherwise be endangered or prejudiced; a prisoner requests segregation; a prisoner has been put at risk by another person and there is no reasonable way to ensure that prisoner's safety; or a health centre manager recommends that segregation is desirable to assess/ensure physical or mental health.

[86] Data about employment and education were not collated in our review of the 158 people involved in a self-harm threat to life incident.

474. We note that the Corrections *Suicide Prevention and Postvention Action Plan* includes a long-term action (to be completed in 2023 – 2025), stating that Corrections will: "Work with relevant partners to identify current whānau, hapū, iwi and community-based wellbeing initiatives that could be introduced to prison and community probation sites in order to add to activities that promote oranga. Ensure that any initiatives that are introduced meet the needs of Māori, in line with *Hōkai Rangi*."

Trigger events

475. Certain events or circumstances may overwhelm a person's ability to cope with distress which may increase their risk of suicide or self-harm. In prison, these trigger events can include imprisonment itself, relationship or family/whānau stresses, court appearances and decisions, inter-prison transfers, and bullying from other prisoners.

476. In a review of community-based offenders in New Zealand (a population with many similarities to prisoners), Corrections probation service found that an accumulation of issues over time could mean that a seemingly innocuous event became a trigger:

> *"Predating the use of the Columbia Suicide Severity Rating Scale (C-SSRS), the probation service undertook a review of 11 people serving community-based sentences who had committed suicide. What was found was that there wasn't a single thing that stood out. No particular event that seemed to be the trigger. There was, however, what appeared to be an innocuous event – a straw that broke the camel's back. And an accumulation of issues over time ... It made us think that if you see someone who has gone through an accumulation of events over time that they may be at risk. We tend to think that people who have suffered grief or loss are more at risk. But this is not necessarily the case. This highlights that 'if you are worried about something, do the [C-SSRS] tool'." [General Manager Probation and Case Management / Chief Probation Officer]*

477. A 2020 review of prison suicides in New Zealand noted stressors such as relationship breakdowns and loss in the sample of eight suspected suicides.[87]

478. In our review of suspected suicides, we found that 11 (38%) of 29 people had experienced court-related incidents around the time of their death, including appearing in court or being due to appear in court, having their appeals dismissed, receiving an unexpected sentence indication, or entering a plea.

479. Three people (separate to the 11 above) were coming up for release, and one was frustrated about a stalled reintegrative pathway. Two more people had received distressing telephone calls or visits. Another two had not had any contact with families as telephone numbers or visitor applications had not been approved.

480. In our review of the 158 people involved in a self-harm threat to life incident, 46 (29%) had identified relationship issues prior to their self-harm event, and 59 (37%) had court attendances. Twenty-five (16%) of the 158 people had told staff about a recent bereavement. Nineteen of these 25 bereavements were due to a suspected suicide. These are all events that may have triggered thoughts of suicide or self-harm (Clinical Advisory Services Aotearoa, 2017).

481. We observed that some staff did attempt to identify events or circumstances that may have caused a person to self-harm, however it is difficult to know how a person will respond to a particular event and even more difficult if staff are unaware an event has taken place.

482. The following case study illustrates that triggers for self-harm threat to life incidents may not be obvious and can include a series of smaller events. This case study also demonstrates that self-harm threat to life incidents can occur even if people appear well-supported by staff.

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[87] Department of Corrections Health Services Internal Memorandum dated 22 September 2020 from Senior Advisor Mental Health to Deputy Chief Executive Health, Suspected Suicide Thematic Review.

Case study 4 – Mr D

Mr D was in his twenties when he was involved in the self-harm threat to life incident we reviewed. Due to Mr D's mental health diagnoses, he got angry easily and did not cope well with change. He also had physical health issues and was taking pain medication. He had a known history of trauma and self-harm.

Mr D was in regular contact with the occupational therapist and cultural support worker from his prison's ISPT. Their trauma-informed approach appeared to be helping him manage his behaviour and anxiety. Custodial staff had good relationships with him and gave him a structured routine and jobs to keep him occupied. The residential manager arranged for him to receive his medications at a fixed time every day as this helped Mr D feel calmer.

Despite this support, one day when custodial staff arrived to escort him to the Health Unit to get his medications, Mr D would not engage with them and refused all instructions. Staff decided he was at risk of harming himself because he was displaying irrational thinking. He was taken to the Intervention and Support Unit where he self-harmed and had to be taken to hospital.

Afterwards, he would not talk about the incident. However, ISPT members spoke to custodial staff who acknowledged, with hindsight, that there may have been a series of escalating triggers before the self-harm incident, including an appearance before the NZ Parole Board, a change in his case manager, and a recent court appearance.

Trauma

483. Trauma results from an event, series of events, or set of circumstances that an individual experiences as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing (Substance Abuse and Mental Health Services Administration, 2014). Trauma that is unaddressed can significantly increase the risk of mental and substance use disorders and chronic physical diseases.

484. The impact of trauma can be "subtle, insidious, or outright destructive" with many sufferers stuck in a constant state of extreme stress and self-protection. In real terms, trauma can have the following impacts (McGlue, 2016):

- Difficulty trusting, making it hard to establish close relationships.
- Negatively affected cognitive abilities.
- Undermined sense of safety causing counterproductive behaviour in an effort to regain control over their environment. Such behaviour could include self-harm, defiance and aggression.
- Hypervigilance and fearfulness.
- Physical pain or illness symptomology.
- Emotional numbing, feeling nothing most of the time.
- Freezing when there is a present or perceived danger.

485. Both internationally and in New Zealand, trauma is understood to contribute to suicide in the general population. For example, a review examining the link between child maltreatment and attempted suicide found all types of child abuse were associated with suicide attempts. From strongest to weakest these associations were for sexual abuse, physical abuse, emotional abuse, emotional neglect and physical neglect. Combined abuse showed the strongest association (Angelakis, Austin & Gooding, 2020).

486. New Zealand research on the prison population has found high rates of trauma, with over three-quarters of prisoners experiencing some type of violence in their lives before imprisonment. Women in prison had

experienced a higher concentration of family and sexual violence than men, were more likely to have experienced violence from a young age, and to have been exposed to more types of family and sexual violence. Women were also more likely to be affected by post-traumatic stress disorder than men in the previous 12 months (40% of women vs 15% of men) (Bevan, 2017).

487. The effects of trauma can have adverse impacts on people's behaviour in prison, causing self-harm, defiance, extreme emotional reactions and difficulty engaging positively with staff (Miller & Najavits, 2012). However, these behaviours are often not recognised as trauma related.

488. In a prison environment, the impacts of trauma can be amplified because many day-to-day occurrences can be perceived as threatening. Loud noises, banging doors, shouting, confined spaces, control and restraint techniques, lack of privacy and body searches can all trigger responses for trauma sufferers, or profoundly retraumatise them (Benedict, n.d.). Regardless of pre-existing trauma history, people may also experience traumatic events while in prison.

489. In our review of 29 people who died by suspected suicide, nine (31%) had told staff about a history of trauma. The trauma history for the remaining people is unknown as there was no information in their health records regarding this.

490. In addition, 10 (34%) of the 29 people had documented experience of loss, including loss of relationships, or having a close contact who had also died by suicide. One person had lost four people to suicide.

491. Eighty-one (51%) of the 158 people involved in a self-harm threat to life incident in the review period had told staff about adverse childhood events, of which 59 had a mixture of emotional, physical and/or sexual adverse events.

492. Fifty-two (33%) of the 158 people involved in a self-harm threat to life incident had a diagnosis of post-traumatic stress disorder. In line with the literature, this figure was higher for women, with 54% of them having a documented history of post-traumatic stress disorder.

493. In 2016, Corrections introduced trauma counsellors and social workers to the three women's prisons to help address the high rates of trauma amongst the women. Corrections' intention was that by helping the women to address these needs, they would be better able to participate in rehabilitation and other programmes and would therefore have improved skills to support reintegration to their families and communities post release.

494. We have heard positive feedback from women in prison about the trauma counsellors and social workers. During one prison inspection, a woman told us:

> *"If it wasn't for (the trauma counsellor), I wouldn't be here now." [Prisoner]*

495. Corrections also introduced a Trauma-Informed Practice Training Package for custodial staff at the women's prisons. The package aimed to assist staff to identify the ongoing effects of trauma and to learn practical strategies they could employ to manage people who had suffered trauma (Dempster-Rivett, 2018).

496. As part of Budget 2019, eight permanent trauma-focused positions were established at some men's prisons. At the time of writing (August 2023) it appeared that three of these positions were filled.

497. Prisoners who have suffered trauma may be able to get therapy via the Accident Compensation Corporation sensitive claims service (for example, if they have been sexually abused), but we have observed that this service can have long wait times due to limited providers.

498. While trauma-informed practice training was not offered to custodial staff at the men's prisons, we have observed some practice by staff in men's prisons that could be considered trauma-informed. For example, at one prison we observed a corrections officer doing rub-down searches of a group of prisoners. Before touching intimate parts of the prisoners' bodies (which is necessary during such searches), the officer provided warning that he was about to touch them. This was a respectful and trauma-informed approach.

Hopelessness

499. It is important to note that hopelessness is considered a significant risk factor for suicide and self-harm in prisons (Gooding, Tarrier, Dunn, Awenat, Shaw, Ulph & Pratt, 2017) and is one of the concepts targeted by influential theories and treatments for suicide (Beck, Kovaks & Weisman, 1974). It also features in New Zealand's suicide prevention strategies (see Lawson-Te Aho, 2016).

500. Many of the subject matter experts we interviewed for this review spoke about the hopelessness experienced by some people in prison, and the importance of hope for the future as a protective factor against suicide and self-harm.

> *"[We need to] try to understand the hopelessness someone feels before engaging in self-harming behaviour … They feel there aren't any other options available to them." [Operations Manager Mental Health and Addictions]*

> *"[In the] recovery from addictions space … How do we help people to grow their recovery capital, maintain recovery? Main thing is connectedness. Move away from bad connections but hook up with those who are able to help change. Give people hope that things could be different … Giving people a sense of identity so they're not a druggie. They become a mother or father. Identity becomes a positive space." [Senior Adviser Māori Addiction and Mental Health]*

> *"How do we create hope in ISUs? People come into prison, some suffering immense distress, so how do we give people hope? There's been research done about that, and one way is through creativity." [Senior Adviser Mental Health]*

The Review Risk Assessment

501. In New Zealand prisons, custodial staff use the Review Risk Assessment at specific times or after specific events that could cause a prisoner's risk of suicide or self-harm to change. There are 21 events that trigger the Review Risk Assessment, including: a prisoner returns from court, after a court appearance via AVL, if further charges are laid, the person's custodial status changes, upon reception following an inter-prison transfer, and following an increase in security classification.[88] Unlike Reception Risk Assessments, there is no policy requirement for custodial staff to involve health staff in Review Risk Assessments unless they have any concerns regarding the prisoner's medical history.

502. As noted earlier, a recently published Self-harm: assessment, management and preventing recurrence guideline from the UK NICE suggests that the focus of risk assessment should be on the person's needs and how to support their immediate and long-term psychological and physical safety (NICE, 2022).

503. In our review of 29 suspected suicides, we found that 15 people (52%) had a Review Risk Assessment completed in the two weeks prior to their death, with all but one assessed as not at risk. It should be noted that these assessments are dynamic in nature and levels of risk often change.

504. However, we observed variability with the quality and timeliness of Review Risk Assessments. Following an in-depth review of seven people who were involved in a self-harm threat to life incident (and six of whom feature in our case studies), we noted that effective Review Risk Assessments:

» showed evidence of including others in decision-making

» showed evidence that the assessing officer had talked to a nurse about any health risk alerts (e.g. drug use, previous self-harm attempts)

» included a good summary of secondary sources of information and showed evidence that the assessor had

[88] Prison Operations Manual: M.05.02 Review risk assessment.

sought out secondary sources if these were lacking

- included evidence based on the assessor's observations
- told a story, written so an independent person could understand why the assessor had decided the prisoner was, or was not, at risk
- were documented in IOMS, with the assessor clearly explaining why they had decided that the prisoner was, or was not, at risk.

505. At one prison, staff told us that other staff in mainstream units sometimes wrongly assessed prisoners as being at risk of self-harm to get them placed in an ISU because the prisoner was challenging to manage.

> *"At-risk assessments done by unit staff vary in quality. Some are stock standard answers and that's how you can see it is a placement issue." [Custodial Officer, Intervention and Support Unit]*
>
> *"Placement issues take time away from those prisoners who really need to be there [in the ISU]. 50% of prisoners are needing to be there, 50% are placement issues." [Custodial Officer, Intervention and Support Unit]*

506. There is evidence in the international literature that some prison staff (health and custodial) believe that threats of self-harm may be a strategy used by some prisoners to manipulate outcomes such as cell placement or contact with particular groups. This may impact on the quality and timeliness of risk assessments (Short, Cooper, Shaw, Jenning, Abel & Chew-Graham, 2009). Our review of 158 people involved in a self-harm threat to life incident found occasional examples (in electronic health records) that indicated that health staff believed a prisoner had self-harmed as a way of manipulating placement.

507. The Inspectorate review team also observed some cases where the Review Risk Assessment should have been done but was not. For example, we observed one case where a prisoner's court appearance occurred by AVL, but because the person had not left the prison, custodial staff seemed unaware they should be conducting a Review Risk Assessment. We observed some cases where health staff were not involved in the Review Risk Assessment but should have been given the person's deteriorating mental or physical health. In other cases, we observed a nurse's name had been put on the Review Risk Assessment even though the nurse had not actually assessed the person.

508. Further, we observed that risk assessments result in a binary outcome (at risk or not at risk). Some people may benefit from an alternative outcome that allows them to remain in their usual mainstream cell with additional supportive measures in place. This would mean they would not need to be assessed as at risk and therefore placed in a restrictive regime, including being strip searched, placed in anti-ligature clothing, and denied association with other prisoners. We note that welfare monitoring checks can provide an alternative approach, and consider that further alternatives, including appropriate cell sharing, peer support, and additional services or interventions could also be considered.

Summary

509. There are on-going challenges associated with being in prison, including feelings of hopelessness and other known risk factors for suicide and self-harm. However, there are also factors that may be protective against suicide and self-harm risk in prisons.

510. Case officers may be well placed to build rapport with the prisoners on their caseloads and take active roles in assisting prisoners to plan for the future and overcome any issues. We also observed that case officers are not consistently file noting their interactions with their assigned prisoners, which may suggest that these meetings are not taking place.

511. Case managers meet with prisoners to create an offender plan that connects prisoners to purposeful activity and rehabilitation programmes. Case managers attempt to build rapport with the people on their caseloads but do

not have day-to-day contact with them. We observed that prisoners may become frustrated if they are unable to complete activities on their offender plan.

512. Connections with family/whānau may be protective of suicide and self-harm, and enabling prisoners to maintain these connections in a variety of ways should be expedited. We noted that significant numbers of people who were involved in a self-harm threat to life incident or a suspected suicide had no approved telephone numbers, and even greater numbers had had no visits.

513. Too much time spent alone in a cell with little to do is a known risk factor for suicide and self-harm. Activities such as education, employment, programmes and recreation are protective factors as they relieve boredom and create opportunities for meaningful interaction with others.

514. Access to protective factors in prisons was variable, and certain circumstances or events may overwhelm a person's ability to cope and trigger thoughts or acts of suicide and self-harm.

515. A history of trauma is known to be a risk factor for suicide and self-harm, and the majority of people in prison have experienced traumatic events, including violence. We observed that trauma counsellors seem to be working well in women's prisons but that there were limited trauma-focused roles in the men's prisons.

516. Some possible trigger events are well-known and the Review Risk Assessment is generally used at specific times or after specific events that could cause a prisoner's risk of suicide or self-harm to change. However, it is sometimes difficult for staff to predict what these trigger events may be for any individual, and there may be no main trigger event but a series of 'smaller' events.

517. Custodial staff were generally conducting Review Risk Assessments at the appropriate times, but sometimes failed to consult with health staff when this would have been appropriate. We had concerns about the binary nature of Review Risk Assessment results (i.e. 'at risk' or 'not at risk') and note that alternative approaches could support the prisoner without significantly restricting their regime.

Areas for consideration: Life in prison

25. Corrections should consider how it can ensure that case officers are actively managing prisoners and documenting their interactions.

26. Corrections should consider offering prisoners more educational opportunities to support them in managing day-to-day stressors, including sessions for learning meditation, mindfulness, managing distress, managing anxiety, managing a traumatic brain injury, hearing voices, and dialectical behaviour therapy skills for those with borderline personality disorders or traits.

27. Corrections should consider expediting the approval processes for visits/telephone calls.

28. Corrections should consider offering greater access to family/whānau, including via telephones, visits and audio-visual options (for example, in-cell technology).

29. Corrections should consider ways to strengthen opportunities for family/whānau input and family/whānau-centred care, in particular for people with high and complex needs.

30. Corrections should consider expanding trauma counsellor roles across all prisons to align with demand.

31. Corrections should consider providing early intervention to support those at risk of suicide or self-harm, or those otherwise vulnerable, to remain in mainstream units.

32. Corrections should consider reviewing its process so that all Review Risk Assessments are completed according to best practice and in collaboration with health where necessary.

33. Corrections should consider the National Institute for Health and Care Excellence (UK) guidelines when reviewing its risk assessments, with a focus on psychosocial assessments, risk formulations and safety plans.

Going to an Intervention and Support Unit

Introduction

518. Intervention and Support Units (ISUs) are specialist units that are intended as safer environments where prisoners who are assessed as being at risk of suicide or self-harm can stay for a limited time. It is intended that prisoners in ISUs will be closely monitored and receive specialised care to support them to return to their mainstream unit. Some prisoners in ISUs are provided with care while they await transfer to an in-patient mental health facility. There are 13 ISUs in prisons nationwide and four prisons do not have an ISU (see Appendix B for ISU locations and capacities).

519. ISUs may also house people who are not at risk of self-harm but who have been identified as particularly vulnerable or who have a physical health condition that requires closer monitoring by health staff. These people may be neurodiverse or have cognitive or intellectual conditions which make them vulnerable or complex to manage in a mainstream unit. These prisoners tend to spend longer in the ISU as there is no other suitable unit they can be safely transferred to. During previous inspections we observed that the mental health of these vulnerable people can decline while in the ISU.

520. The literature is clear that prolonged periods of time spent with restricted access to others is detrimental to prisoners' wellbeing, and in fact can increase risk of self-harm (Favril et al, 2020; Brown, 2020). While temporarily moving at-risk prisoners to different units for oversight and management has been a typical response both in New Zealand and internationally, the practice has mixed results. Some researchers argue that rather than creating specific units, resources should go into developing interventions that can be deployed in units across the prison, with the use of multi-disciplinary teams key to these efforts (Power, Smith & Trestman, 2016).

521. Our review of 29 suspected suicides found that 13 people (45%) had spent time in an ISU before their deaths. Two of the 13 died while in the ISU, and four of the 13 had been in the ISU within the last month. There was an additional suspected suicide of a person from a prison with no ISU who died one day after leaving a 'safe cell'.

522. Our analysis of the 253 self-harm threat to life incidents during the review period showed that it was standard practice for people who self-harmed in their units to be transferred to the ISU. We also found that 94 (37%) of the 253 self-harm threat to life incidents occurred within an ISU.

Intervention and Support Practice Teams

523. Of the thirteen ISUs nationwide, by the end of the review period, six were being supported by an Intervention and Support Practice Team (ISPT) (see Appendix B for ISPT locations), and we understand that Corrections intends to introduce more ISPTs. As mentioned earlier, ISPTs are site-based clinical multi-disciplinary teams. ISPTs are supported by administration and custodial staff who have been allocated to them. ISPTs assess people, develop individualised care plans for them, and provide therapeutic interventions. ISPTs work with people vulnerable to suicide or self-harm across the prison as well as those within an ISU. Referrals to ISPTs can be made by any Corrections staff member, and a person may also self-refer.

524. Sites with ISPTs are able to offer a more comprehensive multi-disciplinary approach for people who are at risk of suicide or self-harm.

> *"ISPT is a site-wide resource. Very accessible. We can ring them and get advice on a prisoner, even one who isn't on their books." [Custodial Officer]*

525. At prisons without ISPTs, clinical nurse specialists (mental health) provide clinical support to people with moderate to high mental health needs. Clinical nurse specialists (mental health) also triage referrals and help to coordinate the care that people receive. They work in ISUs and across all units within a prison. On 30 June 2021 there were 10 funded clinical nurse specialist (mental health) positions nationwide, though this had been reduced to 8.8 funded positions at 30 May 2022.

526. We acknowledge that as more ISPTs are introduced, clinical nurse specialists (mental health) may gain additional support, and services for people at risk of suicide and self-harm may further improve. We were told by one prison director:

> *"Having access to a multi-disciplinary team is important. It doesn't need to be on site full time all the time." [Prison Director]*

Regional forensic mental health services

527. During the review period, regional forensic mental health services were supplied by District Health Boards[89] to prisons nationwide. These services provided specialist assessment and treatment for people with major mental health diagnoses or who required acute mental health care.

528. Section 45 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 provides that prison directors may make an application for a prisoner to be assessed and treated in an in-patient mental health facility. These facilities have specialist mental health staff, and are able to operate in a more therapeutic environment with more treatment options available than in prisons (Ministry of Health, 2000).

529. Historically, there was an understanding between forensic mental health services and Corrections that Corrections would not make an application until a bed in an in-patient mental health facility had become available, which could take weeks or months. Corrections' current expectation is that these applications should be made when appropriate, and not delayed due to bed availability. However, we have observed that this practice is not always followed.

530. Due to the shortage of forensic in-patient beds, we have observed mentally ill people in ISUs waiting for weeks or months for beds to become available. This appears to be evidence of "systemic hazards" which the literature suggests may be a key contributor in some suspected suicides (Shalev & Tomczak, 2023).

531. Forensic services do not routinely treat people with a diagnosis of personality disorder, even if those people are seriously self-harming and extremely challenging to manage. Despite this, we observed that many forensic services staff did provide some guidance to staff who were managing people with personality disorders if their needs were very complex.

532. One forensic model we noted to work well was where forensic staff were permanently based in a prison health unit and integrated into the wider health team that included nurses, clinical nurse specialists (mental health) and the Improving Mental Health clinicians. The health centre manager at the prison where this model is in place told us this had significantly improved care for prisoners as it was a true multi-disciplinary team, with forensic staff readily accessible every day to provide support and to see prisoners who needed urgent review.

Custodial staff in ISUs

533. Custodial staff who work in an ISU manage people day-to-day who are vulnerable to suicide and self-harm,

[89] District Health Boards were replaced on 1 July 2022 by Te Whatu Ora (Health New Zealand) an agency established by the New Zealand government to run the health system across the country.

and who are more likely to have a mental illness or personality disorder than those in the general prisoner population. As custodial staff remarked in a focus group:

> *"Prisoners need consistency, and the ISU staff know the triggers of the prisoners as well as the officers' strengths." [Corrections Officer]*

> *"Prisoners believe that ISU officers are different to normal unit officers. Rapport is built differently in ISU. They talk to them better and tell them more." [Corrections Officer]*

534. According to the Ara Poutama Practice Centre on the Corrections intranet: "Custodial staff working in an ISU report to the Principal Corrections Officer (PCO), with day-to-day tasks managed by the ISPT Clinical Manager. They are placed on the ISU roster and staff rotate through that role. This allows custodial staff a break from the unit routine on the week they are working with the ISPT. This benefits the whole team as it gives these staff variety and the opportunity to learn new skills while working with the ISPT that they can bring back to the non-ISUs."

535. We were told that some sites have custodial staff permanently based in the ISU who had gone through a selection process to work there. The process included consideration of temperament and attitude.

536. In the 'Investment in training and workforce development' section of this report we set out the training Corrections has made available to custodial staff who are selected to work in ISUs. The Intervention and Support Unit (ISU) and Management Unit (MU) Follow-up Review conducted by the Corrections Quality and Performance Team in 2018 noted that: "Overall, there is a selection process for staff to work in the ISU. This selection process provides some basic assurance that staff who have the skills and are genuinely interested in working with people in the ISU are selected." However, the same review set out that: "...ISU and MU [Management Unit] staff are often resourced from other areas due to multiple factors such as unplanned leave, sick leave, staff shortages, and site long-term vacancies."

537. Custodial staffing issues were also noted by our subject matter experts:

> *"[Custodial] staff get moved around, so in the ISU any mental health training with custody just moves on and then we need to build up staffing experience again." [Senior Adviser Mental Health]*

> *"The ... ISU is a busy unit, and it is not particularly unusual for the prisoner muster to reach capacity. We only have the one operational model, so we must run the unit the same way every day, no matter if we have three prisoners in our care or thirteen. When the muster gets high, there is a high potential for staff to be run off their feet attempting to complete even the compulsory basics of our duties. Having little to no down-time of any kind can cause stress in the short term and burn-out in the long term. Incidents of all kinds always tend to crop up when staff are under extreme pressure." [Corrections Officer, Intervention and Support Unit]*

538. Despite these issues, we observed examples of good custodial practice in ISUs. For example, during a visit to one prison, we observed that a prisoner who was known to have a history of self-harm was admitted to the ISU in the afternoon following a self-harm incident. Staff in the ISU knew him and understood that when he was distressed it took time for him to stabilise. He did not want to be in his cell and wanted to stay in the yard, so staff sat with him in the yard and talked with him. The prison director approved overtime to increase the staff numbers in the unit so that an officer could remain with him at all times overnight and by the morning he had returned to a more settled state that enabled staff to move him into a cell.

539. Staff working with prisoners in distress can become traumatised themselves and develop attitudes that may not be helpful. For example, believing some prisoners self-harm to manipulate placement or management may decrease staff motivation to take self-harm seriously or comply with protocols (Power, Smith & Trestman, 2016).

540. Included as part of the original Intervention and Support model was an intention to provide 'reflective supervision' sessions to custodial staff working in ISUs. These sessions were intended to assist staff to reflect on and improve their practice, including practices relevant to the prevention of suicide and self-harm. Sessions were also intended to help staff manage their own mental wellbeing.

541. We were told that supervision is being provided at eight out of the 13 sites with Intervention and Support Units. However, supervision is not available to everyone and may not be considered useful by all custodial staff:

> *"Clinical supervision is available to officers, but it depends on shifts. The staff do not find it very valuable. Staff have to remain in the unit to keep running it, so it's not available to everyone." [Corrections Officer, Intervention and Support Unit]*

> *"Distress of individuals in ISUs is mirrored in the staff … It's recommended that staff get clinical supervision … and that principal corrections officers and senior corrections officers have separate supervision. People thought supervision was helpful … and everyone wanted it … [though it] seems to have taken a back seat at some sites." [Senior Adviser Mental Health]*

542. At one ISU, we were told that a psychologist comes in once a week for supervision sessions with custody staff. Officers are invited to raise topics of their choosing and the psychologist will speak with them about these. This service had been provided for the last two years and custodial staff were positive about these sessions:

> *"I find it quite good, a good forum to bring up things that are annoying me, and I don't know how to handle them. He gives us ideas of how to cope with it. Nice to offload a few things. Good to have someone from the outside." [Corrections Officer, Intervention and Support Unit]*

> *"Definitely benefits us – [it] helped me a lot. A lot of staff burn out with the volume of high needs and complex prisoners." [Corrections Officer, Intervention and Support Unit]*

543. We were told that ongoing efforts are being made to recruit supervisors for the remaining sites with Intervention and Support Units, including sites where supervision was in place but supervisors moved into other roles. There have been challenges with recruitment due to low unemployment and workforce shortages.

544. The Corrections *Suicide Prevention and Postvention Action Plan* sets out initiatives that support an increase in capability for custodial staff working in ISUs:

- » A short-term action is piloting a range of workshops to upskill custodial staff, particularly custodial staff working in Intervention and Support Units, to understand and effectively manage mental health, including suicide risk. This action has now been completed, with 11 workshops on suicide prevention and five workshops on managing complex and challenging behaviours delivered by the end of 2021.
- » A long-term action describes developing a more sustainable mental health learning programme for custodial staff which is mandatory, ongoing (i.e. begins at initial induction and continues throughout the career of a custodial officer) and includes suicide prevention as a key topic.

Placement in the ISU

545. Entry to an ISU generally requires a person to be assessed as being at risk of suicide or self-harm following a Reception Risk Assessment or a Review Risk Assessment.[90] These assessments are usually done by custodial staff. However, there are no standard guidelines for practice around ISU placement, and we observed that decisions about placement varied from site to site. At some sites, all people found to be at risk were immediately placed in an ISU with no consideration given to any other options. At other sites, staff sometimes made a professional decision to allow an at-risk person to remain in their mainstream unit with additional support such as extra welfare checks.

546. Our analysis of the 253 self-harm threat to life incidents in the review period showed that 94 (37%) of the incidents occurred when the person was already in an ISU. If people had self-harmed in other units, it was standard practice for them to be transferred to the ISU following a Review Risk Assessment.

[90] Prison Operations Manual: M.05.02 Review risk assessment.

547. For 79 (31%) of the 253 self-harm threat to life incidents (which occurred either in the ISU or another unit), the person required transfer to hospital. Most people who went to hospital were able to be returned to the ISU following treatment in an emergency department. Only a small number of people required hospitalisation for further treatment such as blood transfusions or surgery.

548. We observed some people's behaviour had deteriorated over a number of days, but they did not receive any interventions. By the time a decision was made to transfer the person to the ISU, the person needed to be taken with the support of the Site Emergency Response Team, who sometimes had to employ a 'use of force' procedure to transfer the person.

549. We observed that custodial staff considered that some people who were involved in a self-harm threat to life incident required mechanical restraints (e.g. handcuffs) for safe escort to the ISU.

550. However, we also observed that some people who were experiencing distress in their unit requested to go to the ISU. For example, a nurse told us about a prisoner who had been withdrawing from methamphetamine without medication, who became tearful and requested to go to the ISU.

551. Conversely, one subject matter expert considered that sometimes people who should be placed in an ISU were placed in other units instead due to their mental health issues being misdiagnosed as behavioural issues:

> *"There are a number [of people] who are actively suicidal and wouldn't go to ISU; they'd be sent to directed segregation or a Management Unit. There are some very unwell people in those spaces ... [but] it's seen more as a behavioural issue. This group is misunderstood in terms of their risk of suicide. They're normally seen as violent or predatory men. They don't want to be in the ISU, and staff don't want them there. The danger is that when they are back in their units ... they turn violence on themselves ... This is partly due to differences in how depression and risk are expressed in men. Women have a different expression. Men are more likely to show anger, violence, irritation. But it's often mis-diagnosed as a behavioural thing." [Principal Psychologist]*

Arrival in the ISU

552. On arrival at the ISU, standard practice was for custodial staff to strip search the prisoner to ensure they were not concealing anything they could use to hurt themselves or others. While strip searching in this situation is a legal requirement that aims to mitigate harm, we recognise that it can be embarrassing and dehumanising. Many people in prison have histories of trauma or are neurodiverse and strip searches may be especially traumatic for them.

553. Prisoners were sometimes allowed to continue wearing their own clothes (inclusive of underwear), but they were more frequently given an anti-ligature gown (sometimes called a 'stitch gown') to wear, which aimed to minimise the risk of them self-harming using their clothing. This decision was generally made by custodial staff, though at times it was made in collaboration with health or ISPT staff.

554. We observed (especially for self-harm threat to life incidents earlier in the review period) that people were routinely placed in a dry cell[91] in the ISU to decrease the risk of further self-harm. This aligned to the fact that, historically, people who had engaged in self-harm or been assessed as at risk would be placed on the most restrictive cell/regime possible to reduce further self-harm. Over the review period, we noted improvements to practice in this regard, and by the end of the review period, dry cells were not routinely used for people at risk of self-harm.

555. We observed that generally custodial staff in ISUs were empathetic and tried to engage with the person as they

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[91] A dry cell does not have a toilet, running water, or a modesty screen. Dry cells are often used in the management of people who are suspected of concealing items (such as drugs) internally.

were processing them. If staff had not had any training to work in the ISU, we observed that they sometimes found it challenging to work with people with complex needs.

556. Once in an ISU cell, the person was placed on observations which could vary from constant observations (where a staff member remained with them at all times), to every 15, 30 or 60 minutes. Observations had to be made by custodial staff in-person (i.e. through a cell hatch or window). When people first arrived in the ISU they were mostly observed every 15 minutes, but as time passed and if their presentation of acute risk improved, staff reduced observations to every 30 and then to every 60 minutes. Decisions about the timing of observations were made collaboratively by health and custodial staff.

557. As stated earlier, if the person had injured themselves significantly or there were any health concerns, they were transferred to hospital. However, in most cases, hospitalisation was not necessary. Instead, a nurse assessed the person's physical and mental health and provided treatment or other supportive interventions. Custodial staff may have provided other interventions, such as providing the person with a telephone call, or staying with them to talk. If there was no nurse on site (for example because the incident occurred after-hours) custodial staff may have provided first aid while waiting for an on-call nurse to arrive.[92]

558. Once the person was in an ISU cell, we observed that practice was variable. If mental health clinicians were on site, they sometimes went to talk to the person and offered some intervention. However, depending on the time of day and who was available on site, the person may have had to wait until the next morning to be assessed by a clinician and offered some intervention.

559. If a person was still actively self-harming in the ISU cell, custodial staff may have put them in mechanical restraints such as handcuffs or a head protector to stop them harming themselves.[93] There are rules around the use of mechanical restraints. For example, the permission of the prison director must be given, and the person must be examined by a suitable registered health professional within three hours of the restraint being applied. Corrections' Prison Operations Manual requires that people must only be "restrained for the least time necessary to safeguard their wellbeing". When a person is put in mechanical restraints, an At-Risk Multi-Disciplinary team must meet within 24 hours to develop or review the person's At-Risk Management Plan.[94] If restraints are used for more than 24 hours, advice from a medical officer must be sought.

560. Generally, we observed that staff did remove any restraints as soon as possible. However, we noted instances where restraints remained in place even when the person's behaviour had settled.

561. We note that a person who is placed in restraints may become more distressed by this. Restraints may make it difficult for the person to use the toilet or wash. They may also make it difficult to eat and drink and the person may be reliant on staff to assist them. If a person is not able to drink, they may become dehydrated which can further impact their mental state. Restraints may also restrict movement which may inhibit any acts of self-soothing, such as meditation, exercise or yoga.

562. We observed that when a person was actively self-harming it could be upsetting for staff who were present. Staff had real concerns for the person's wellbeing and often felt that if they did not intervene with a mechanical restraint, the self-harming could become life threatening. We observed that these situations often occurred after-hours or during weekends when there were no specialist mental health clinicians on site to offer guidance to staff, or to provide therapeutic interventions to the person.

563. Increasingly, however, we noted custodial staff taking alternative measures (other than using mechanical

92 Corrections officers are trained in first aid, including CPR.

93 The use of tie-down beds as a mechanical restraint was officially discontinued at Corrections in 2019, although they had not been used since 2016.

94 The At-Risk Management Plan is developed by custodial staff and details how the at-risk person will be managed.

restraints) when a person was actively self-harming in the ISU. For example, we observed some people being put on constant observations. While this was resource intensive, it did provide a more supportive approach to managing someone who was extremely distressed. We were told by someone who regularly self-harmed in prison that having a staff member stay with them was the most effective way to help them as having someone to talk to distracted them from self-harming thoughts and behaviours.

564. Despite constant observations being a positive approach for some people who had self-harmed, we observed that it could be difficult for the staff member completing the constant observations. For example, listening to the person recount past trauma could lead to vicarious trauma for the staff member. In addition, if the person started to self-harm in front of the staff member, it could be challenging to manage.

> *"I had to sit with them doing constant obs and they talked to me about all this bad stuff that had happened to them. After my shift I went home and it's all going around in my head. Like, what am I supposed to do with that?" [Corrections Officer]*

The At-Risk Management Plan

565. All prisoners who were assessed as being at risk had an At-Risk Management Plan developed by custodial staff in consultation with appropriate support personnel, including health staff. The At-Risk Management Plan details how the person will be managed. It must be completed within 24 hours of the prisoner's at-risk assessment and confirmation of the prisoner's at-risk status. The At-Risk Management Plan ends when the prisoner is reassessed as not at risk, and they can return to a mainstream unit.

566. Inspections found that often these plans were generic with little tailoring to the individual prisoner or their circumstances. Many of these plans lacked clinical information from health teams which may have assisted custodial staff in managing that person (there are no clinical staff based in the ISUs).

567. We noted the existence of the Intervention and Support (at risk) Supported Decision Making Resource on the Corrections intranet. This resource assists staff when developing a management plan for the care and wellbeing of prisoners admitted to an ISU. The resource does provide for some flexibility in how a person can be managed in the ISU (e.g. whether they must wear an anti-ligature gown or not). During inspections we found that this resource was not widely used.

Daily welfare/wellbeing checks in ISUs

568. The health centre manager must ensure that a registered health professional (usually a nurse) conducts daily or twice daily visits to those prisoners in the ISU who are at risk of suicide or self-harm or who are being managed under medical oversight. The purpose of these visits is for a health professional to assess the person's welfare. The health centre manager may reduce the regularity of these visits if they are satisfied they are not necessary.

569. We have noted in inspections that these visits (referred to during the review period as 'welfare checks' and now known as 'wellbeing checks') were generally completed daily or twice daily by nurses, although there was variation in the quality of assessments. One of the subject matter experts we interviewed for this review also felt this was an area where more guidance could be given:

> *"We need to look at welfare checks. Nurses have no guidance on what a welfare check looks like." [Senior Adviser Mental Health]*

570. In August 2022, Corrections published on its intranet a new guidance document for nurses completing wellbeing checks. The guidance aims to enable nurses to provide a more consistent and meaningful assessment.

571. However, despite the new guidance, and depending on the site, unit routines, custodial staffing numbers and the presentation of the prisoner, we have observed that there is still variation on how these wellbeing checks are completed. A nurse should be able to complete these checks in an appropriate place such as an interview

room or other private space. We have noted during inspections and interviews with health staff that the majority of wellbeing checks were completed with the nurse standing at the prisoner's cell door and in the presence of several custodial officers. Sometimes the cell door was open and sometimes it was closed. If the door was closed, the check was done through it, or through the hatch (most cell doors are solid with a hatch that enables staff to give items to prisoners without having to open the door).

> *"Sometimes there aren't enough custodial staff to open doors in ISUs to [allow clinical staff to] carry out therapeutic interventions. [Clinical staff must] interview people with custodial staff standing with them – they're pressured with time … This can mean assessments are hurried, not safe, putting people at risk." [Senior Adviser Mental Health]*

572. Clinicians who we interviewed expressed a high degree of concern with completing their assessments this way. They told us that conducting wellbeing checks through a closed door did not allow for proper engagement because it was difficult to hear someone speaking, and more difficult to read body language. Staff also told us they had concerns about the person's privacy during assessments done in this way.

Care and support in an ISU

573. The ISU is managed by custodial staff with the support and input of clinicians, including health staff, the ISPT (if there is one at the site), clinical nurse specialists (mental health), and staff from the local forensic mental health service. An Improving Mental Health clinician may also provide support. For each prisoner, there should be a custodial lead, as well as a key clinician where appropriate.

574. Of the 158 people who were involved in a self-harm threat to life incident during the review period, 99 (63%) were afterwards referred to a mental health service (either a Corrections service or an external service) for treatment and support. Referrals to mental health services included to the ISPT (if available), to an Improving Mental Health clinician, a Packages of Care clinician, or to a forensic mental health service. Thirty-nine people (25%) were not referred to a mental health service. No information about referrals was recorded for 20 people (13%).

575. Mental health clinicians provide a variety of interventions depending on their discipline. Interventions might include talking therapies (such as cognitive behavioural therapy or acceptance and commitment therapy), or occupational therapy (such as teaching coping and self-regulation skills).

576. Some ISUs have sensory modulation rooms, and all ISUs have been provided with a basic sensory modulation tool kit. Sensory modulation therapy involves a trained therapist guiding people in using senses such as sight, sound, smell, touch, taste and movement to self-manage and change their emotional state. Tools can include music, essential oils and weighted blankets. Some custodial staff were given limited training on using sensory items. However, custodial staff in the ISUs told us that although sensory items were available, they were not confident to use them, and were concerned that prisoners may destroy them. While sensory modulation has the potential to decrease distress, the feedback from staff suggests that this potential has not yet been realised.

577. Based on our observations made during inspections to ISUs, most interactions, such as receiving medication and daily welfare checks, that prisoners had with health or mental health staff occurred in the morning. At some prisons, people were generally locked up in the afternoons without meaningful engagement or interventions.

> *"[In] our ISU … no one is engaging with them after 4pm. People have too much time on their own and they are lonely." [Prison Director]*

578. Health and mental health staff are not based in the ISU so they are not always available to give guidance to custodial staff or to provide immediate intervention to people who may benefit from this. For the same reason, health and mental health staff members' observations of people could be brief and rely on reports from

custodial staff about a person's behaviour. Many interactions were based on risk assessment and there could be limited therapeutic interventions provided.

579. If the person is in one of the ISUs with an ISPT, the ISPT meets daily to ensure the care plan and the custodial management requirements are tailored to the person's needs.

580. ISPT members complete mental health and risk assessments for people who have been placed in the ISU. They do this to establish the contributing factors that led to the person's placement in the ISU, and to understand what is happening for the person so they can mitigate identified risks. Following their assessments, the ISPT make recommendations to custodial and health staff about whether the person should remain at risk or is no longer at risk. The ISPT also make recommendations to custodial staff about the level or frequency of observations required for the person. The ISPT use skills such as motivational interviewing and crisis interventions to support people in the ISU.

581. We observed some documentation of care planning that focused on ongoing prevention strategies for people who were noted to repeatedly self-harm. This was noted for people who were more complex and where staff were involved in multi-disciplinary meetings and care plans were developed. However, not all people who were involved in a self-harm threat to life incident had this level of support.

582. One subject matter expert felt that care and support in the ISU should have more of a kaupapa Māori focus:

> *"In my opinion … [in the Intervention and Support Unit] it would be more appropriate if the kaupapa Māori service was front and centre, then add the clinical team to the side of it." [Principal Adviser Mental Health and Addictions]*

583. The Inspectorate review team heard from another subject matter expert about the increasingly complex needs of people in prison:

> *"The prison population is very complex … mental health issues are becoming even more increasingly complex. Recently, 15% of all the women at the prison were under forensics. I don't think we adequately support personality disordered/very complex/borderline people." [Prison Director]*

584. This complexity is borne out by the following case study, which also shows evidence of "systemic hazards" which the literature (Shalev & Tomczak, 2023) suggests may be a key contributor in some suspected suicides:

Case study 5 – Ms E

Ms E was in her thirties at the time of her self-harm threat to life incident in prison. Ms E was remanded into prison from court where she had been charged with serious and violent offences. Information received noted that there had been a decline in her welfare following a relationship break-up.

It was her first time in prison, but Ms E had a long history of crisis admissions to a mental health unit. She had self-harmed a great deal previously, and had also attempted suicide.

According to Ms E's court file note, the judge sent her to prison because he felt he had "no other place to put her" and Police had not recommended bail. There was no bed available in the regional forensic in-patient unit at the time.

On reception to prison, Ms E was assessed as at risk of self-harm and placed in the Intervention and Support Unit, where staff developed plans to manage her. She was seen almost daily by the clinical nurse specialist (mental health). She was also regularly assessed by the regional forensic mental health team, and seen by a trauma counsellor and case manager. Most of these interactions occurred through the cell flap as Ms E was unpredictable and prone to violence. Prison staff admitted they were struggling to manage her. They requested and received a session with a psychologist as to how best to interact with her.

As time drew near to Ms E's release, she was visited by a community mental health case manager who advised that she could be released to the local forensic mental health facility. Ms E accepted this and was released to this facility.

ISUs as therapeutic environments

585. We were told that some clinicians considered ISUs not to be conducive to recovery. Forensic clinicians sometimes recommended that people in ISUs who had self-harmed should be transferred back to their units because they were too isolated and had not enough activities available.

> *"We need to think how to 'be' with a person who is at risk ... spending time with them in spaces that are more pleasant rather than secluding them in very austere environments such as ISU or dry cells ... We really have it all back to front ... the environment is such a critical contributing factor." [Prison Director]*

> *"[In most ISUs there is a] lack of life, no nature, no animals, no pets. No ability to be creative." [Regional Principal Mental Health Advisor]*

586. One subject matter expert described the ISU as a space where very high risk and high needs prisoners were placed alongside those with lower risk or lower needs. This sometimes resulted in staff time being consumed by one or two people who were very unwell. It also created difficulties as prisoners of different security classifications are not generally allowed to be mixed, so could not, for example, have time out of their cells in the day room together.

587. Challenging behaviours could also be mirrored by others in this environment.

> *"A man came into the ISU with one issue, then developed another issue (cutting) from his cell neighbour. Well-meaning behaviours can lead to worse outcomes." [Clinical Psychologist]*

588. One ISPT member told us:

> *"The ISU is a very restrictive unit. It's meant to be a therapeutic unit but it's not – it never has been because it's a 23-hour locked regime, fully camera'd cells and people can be strip searched which can be humiliating." [Intervention and Support Practice Team member]*

Referrals to regional forensic mental health services

589. In our review of the 29 suspected suicides during the review period, 15 people (52%) had previously been on the forensic caseload, with three (10%) actively on the caseload at the time of their death.

590. Fifty-five (35%) of the 158 people involved in a self-harm threat to life incident were referred to a regional forensic mental health service after the incident.

591. Assessments by clinicians from a forensic mental health service were generally observed to be the most comprehensive mental health assessment the person had had since entering prison, especially if they had not previously been referred to the forensic team. The assessment included history of previous access to mental health or forensic services, history of alcohol and other drug use, history of sexual and physical trauma and adverse childhood events, history of previous suicide attempts and suicidal ideation, and family/whānau and relationship challenges.

592. Assessments by clinicians from a forensic mental health service frequently revealed multiple risk factors for both suicide and self-harm that had not been known by Corrections staff.

593. We observed that the regional forensic teams' comprehensive mental health assessments frequently provided a diagnosis (where indicated), recommended treatment, or made other recommendations including medication or referrals to Improving Mental Health services, Accident Compensation Corporation sensitive claims counsellors, trauma counsellors or other services. Suggestions regarding the management of ongoing distress and behaviour were also made. We also observed that regional forensic teams regularly provided ongoing assessments to people on their caseload while they were in the ISU.

594. We noted that while these assessments were available (as scanned documents) in the notes of the person's electronic health record, they were not always read by all members of the health team who were providing care for the person. As a result, opportunities to provide better treatment and support, or to consider or follow up suggested ways forward were sometimes missed.

Coordination of Care

595. Healthcare that is coordinated and that feels 'seamless' to the person receiving it may improve delivery of that care and lead to better outcomes for the person. Having a single trusted clinician or small team of clinicians increases the continuity of care, and can promote improved information sharing. However, having many different clinicians involved may be detrimental to a person's recovery or may be an inefficient use of resources. Patients experience continuity of care through receiving information, having confidence and security in the care pathway, and having a relationship with a trusted clinician (Haggerty, Roberge, Freeman & Beaulieu, 2013).

596. To ensure effective coordination and continuity of care, the roles of multi-disciplinary team members must be clearly defined.

597. Our review of the 158 people who were involved in a self-harm threat to life incident showed that some did not receive coordinated care. In some cases this was because staff did not have clearly defined roles and responsibilities.

598. At one site where a variety of mental health services were available, a prisoner was observed, over time, to have been assessed and treated by multiple providers including members of the ISPT (including the cultural support worker, occupational therapist, trauma counsellor and social worker), the health team (including the medical officer) and the Improving Mental Health clinician. There was limited evidence of a multi-disciplinary coordinated approach to the care provided to this person.

599. We were told by one subject matter expert that services could be better integrated:

> *"I think there are gaps in mental health. We need to improve access to specialist services for intellectual disability and co-morbid alcohol and drug and mental health issues. If you separate these out as much as we do it just leads to fragmentation." [Prison Director]*

600. However, across the review period we observed an overall increase in multi-disciplinary team meetings where clinicians and other Corrections staff met to coordinate care, including discussing and making decisions about treatment plans. We also note that in 2023, Corrections was reviewing its delivery of primary mental health services, developing an updated operations manual for ISPTs, and developing Service Level Agreements with Te Whatu Ora (Health New Zealand) to clarify the roles and responsibilities of forensic mental health service teams. All of these pieces of work may contribute to reducing fragmentation and improve coordination of care.

Electronic alerts after a self-harm threat to life incident

601. We observed that generally custodial staff did follow best practice in documenting self-harm threat to life incidents and applying active alerts (at risk; risk of self-harm; risk of suicide) in IOMs.

602. As mentioned in the 'Healthcare' section of this report, we observed inconsistent application of new alerts for at risk, risk of self-harm, or risk of suicide by health staff in the electronic patient health record. There are no practice guidelines for health staff in the application of health alerts in the electronic health record.

603. In addition, we observed that there were sometimes delays in health staff adding diagnostic codes into the classifications tab on the electronic patient health record. Sometimes these codes were not added at all.

Social interaction in ISUs

604. Prisoners who have been placed in an ISU as a result of a self-harm threat to life incident are likely to have poor mental health and be especially vulnerable to the negative effects of long periods spent alone.

605. If prisoners in ISUs have different security classifications, staff are not generally allowed to let them associate. In addition, a person's At-Risk Management Plan may include restrictions on their ability to associate with others. In practice, we have observed that this means prisoners in ISUs may spend a lot of time alone, even if they are allowed out of their cells.

606. Telephone calls with family/whānau give prisoners in ISUs an important opportunity for social interaction. Generally, we observed that staff in ISUs were proactive in facilitating telephone calls, but practices differed across sites. We observed that at one site, prisoners in the ISU were only able to have one telephone call a week for up to five minutes. At another site, a portable telephone was brought to each prisoner's cell and prisoners told us they could speak for up to an hour and make multiple calls. This was in addition to the prisoners' unlock time in the yard or day room where a telephone was also available (Office of the Inspectorate, 2023).

607. Given that telephone calls may be one of the few opportunities for meaningful human interaction for prisoners in ISUs, we consider that Corrections should facilitate greater access to telephone calls for these people.

608. Prisoners are also able to receive visits from their family/whānau while they are in the ISU. Again, we observed that ISU staff often facilitated these as they understood the importance of social support in a person's recovery.

The physical environment of the ISU

609. When At-Risk Units were renamed ISUs, the physical environments remained plain and tended to retain their focus on maintaining the physical safety of the prisoner. The design of ISU cells is based on standard prison cells in which risk has been mitigated by the removal of potential ligature points and having limited fittings that people may use to self-harm. For example, many ISU cells do not contain televisions or radios.

> *"Going to the ISU does not help my mental health. ISU makes you crazier – four walls and that's it." [Prisoner]*

610. Some improvement to the physical environments of all ISUs occurred in 2019, including new paint and large wall decals showing pictures of scenery. These improvements were intended to 'soften' the ISU environment and make it feel more therapeutic. However, most ISUs remained stark.

> *"Physical environments in ISUs are bleak, bland, very noisy." [Senior Adviser Mental Health]*

> *"The environment in the ISU can be damaging to a prisoner's mental health, because of the noise, especially at night, the lack of windows in some of the cells, and the reduced stimulation." [Nurse]*

611. ISUs have communal areas such as outside yards and day rooms which may (but not always) contain a television, activities such as puzzles and colouring books, and limited gym or sports equipment, such as a basketball.

612. All ISU cells have observation windows so staff can observe the person inside. Some of these windows have metal shutters which staff can close so the prisoner cannot see out. There is 24-hour camera surveillance in the cell which assists staff to monitor behaviour and confirm that the prisoner is stable and not harming themselves.

613. Some ISUs have more restrictive environments and management regimes, even though the literature shows

that isolation, boredom, and lack of purposeful activity increase the likelihood of suicide in prisoners (Favril, O'Connor, Hawton & Vander Laenen, 2020; Favril et al, 2020). During our inspections we have observed:

» Prisoners walking around the edge of the day room for want of anything better to do.

» Observation window shutters being kept shut all day to ensure the environment was quiet and to reduce stimulation (although this heightened the isolation the prisoners were experiencing).

» No windows to the outside or access to natural light.[95]

» A day room with a phone, prison kiosk[96], television and chalk board, but no chairs to sit on and the sink had been disabled due to vandalism. Staff told us the chairs had to be removed as prisoners would hide items in them. Staff said they were unable to provide activities for fear the prisoners would harm themselves. Books were not provided out of a concern that prisoners may swallow the paper.

614. Other ISUs are less restrictive, and we have observed during inspections:

» Custodial staff engaging with prisoners individually, playing board games in the day room, playing cards through the cell door hatch, or basketball in the yard.

» Staff allowing (when appropriate) prisoners to mix with others in the day room/yards.

» Gardens which prisoners can either go into or see through their cell windows.

» One ISU used to have pet rabbits which prisoners could interact with in the day room, garden or their cell.

615. The Inspection Team was advised on 13 February 2023 by the Corrections Director Mental Health and Addictions that an ISU refurbishment programme is taking place which will include safe furniture, fresh paint, and which will install television sets in all ISU cells which do not currently have them.

Moving out of the ISU

616. Suicide has been linked to transition events due to heightened stress at such times. Our literature review did not find any evidence about interventions to manage prisoners out of specialist units and back into the mainstream prison population. However, our interviews with subject matter experts indicate that transitions might be opportune times for additional intervention.

617. From our review of the 29 suspected suicides in the review period, we found that three prisoners died within ten days of transitioning out of the ISU. Three more died within 100 days of transitioning out of the ISU.

618. We know that some people in the ISU who have self-harmed (and are still assessed as being at risk) are released directly into the community, which may pose a risk to them or to others.

619. ISUs are not intended to be long-term residential units and figures provided by Corrections for the year to 30 September 2021 show that the majority of people (2,707 people (72%) out of a total of 3,767 people who spent time in an ISU) stayed for a week or less.[97] The same figures show that 81 people (2%) spent longer than two months in an ISU, with six of the 81 people remaining in an ISU for more than six months.

620. The Intervention and Support Unit notification schedule sets out that a notification process must be followed if prisoners have been in the ISU for 30 consecutive days, or if they have been placed in an ISU three times or more within the last 12 months. A further process is followed if the person has been in an ISU for longer than 60 days or has been admitted five times in the last 12 months. These processes are "intended to encourage discussion

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95 Regulation 58 sets out that natural lighting must be provided for at-risk cells.

96 Kiosks allow prisoners to submit canteen orders, request meetings, and read legislation.

97 The data includes ALL prisoners who spent time in an ISU, including at-risk prisoners and prisoners subject to a segregation direction.

and provide support to staff managing those with complex needs that result in substantial or frequent periods of time in the ISU".[98]

621. We were told that some prisoners may remain in an ISU for significant periods for a variety of reasons. For example, people may be kept in an ISU because there is no room for them in an in-patient forensic psychiatric facility. This seems to be evidence of a "systemic hazard" as highlighted in the literature (Shalev & Tomczak, 2023).

> *"The unavailability of in-patient forensic psychiatric beds to provide care for prisoners who meet criteria for the Mental Health Act, and are too unwell or not accepting of treatment in custody is a very serious issue … It may be that there will continue to be insufficient in-patient forensic beds into the foreseeable future, as has been the case for well over 10 years." [Forensic Psychiatrist]*

622. We heard that prisoners may be kept in the ISU for longer than necessary because there is no other unit in the prison that is suitable for them.

> *"I have noticed that when our muster [in the ISU] gets high, one of the most obvious contributing factors is that prisoners who have been cleared from their 'at risk' status remain with us for an extended stay as suitable placements within the prison are not available. It seems that if there were a system implemented to ensure that the prison had appropriate capacity to have cleared prisoners returned to suitable placements, the ISU would be in a better position to provide quality service to those who need us without the risk of staff burn-out or incidents." [Corrections Officer, Intervention and Support Unit]*

623. Generally, prisoners are moved back to a mainstream prison unit once their condition stabilises and they are no longer considered to be acutely at risk of suicide or self-harm. Following assessment and treatment and once the person has regained some stability, a clinician can work with the person to complete a Wellness Plan. The Wellness Plan is based on the Te Whare Tapa Wha model of health. Sections of the plan include: "What am I like when I am feeling good?", "What I need to do every day to keep myself feeling good", "These are the people that help me feel safe and well", and "These are my triggers". It also identifies early warning signs for the person, what others might see when the person is in distress, and what actions others can take to support the person. We have observed the use of the Wellness Plan on at least one site.

624. A Transition Plan will also be developed to assist the person's entry into or return to a mainstream prison unit. The Transition Plan documents any issues relating to the transition, what actions need to be taken in response, who needs to take the action, and when it needs to be done by.

625. The importance of sharing relevant information with custodial staff in mainstream units was emphasised by a subject matter expert:

> *"If they're likely to commit suicide, this needs to be passed to the unit, as well as the deterrents, [including] measures used by the prisoner to help control the thoughts. The units need to be aware. They can ask the prisoner how they're going [and will] know what to keep an eye on instead of keeping an eye on everything." [Principal Psychologist]*

626. We were told that while there are no standardised criteria for moving out of the ISU, decisions about discharge are typically made by a multi-disciplinary team. At most sites, staff discuss the transition of prisoners out of the ISU at daily or weekly multi-disciplinary team meetings. During inspections we observed good examples of staff proactively managing the transition to ensure that prisoners were able to adjust to the new environment in the mainstream unit. Some sites had a specific unit for more vulnerable prisoners, which was used to assist the transition of prisoners out of the ISU.

[98] Prison Operations Manual: M.05.03 Observing and managing at-risk prisoners.

627. During inspections we observed sites using a range of measures to assist ISU prisoners to transition back into a mainstream unit, including taking prisoners to their new unit for short visits before leaving the ISU. One site set out these steps in documented transition plans. Staff at another site told us that when planning for a prisoner to leave the ISU, you "have to slowly walk together with them, rather than [trying for a] quick transition".

628. ISPT staff members may have follow-up contact with a person to provide support once they are back in a mainstream unit, and at some sites nurses will complete 'post-ISU checks'.

629. We observed that sometimes during a person's transition from the ISU to another unit, a prison director or their authorised delegate instructed prison staff to undertake welfare monitoring checks if they believed extra vigilance would contribute to the safe and humane containment of the prisoner. These checks were sometimes done even if the prisoner had been assessed as no longer at risk. They were also sometimes done when a prisoner had not been to an ISU but staff believed the person's wellbeing needed monitoring, such as if the person had received bad news but was not considered at risk.[99]

630. However, custodial staff told us that sometimes a prisoner may receive limited support following the transition from an ISU back to a mainstream unit:

> *"When prisoners move back to mainstream unit, they are forgotten about. The staff have multiple different unlock regimes to manage, so those who have a history of at-risk behaviour are unable to be monitored or managed any differently." [Corrections Officer]*

631. We acknowledge the long-term (to be completed in 2023 – 2025) action in the Corrections *Suicide Prevention and Postvention Action Plan* that sets out that Corrections will: "investigate and implement initiatives aimed at better supporting individuals who are transferred within, between, or are released from a prison site".

632. We were told that prior to the COVID-19 pandemic, some prison sites were actively engaged in the planning of 'step-down' units to house people who had been in the ISU but were not considered to be well enough to return to their home units. We understand that this initiative ceased due to the COVID-19 pandemic.

Sites without ISUs

633. In 2022, 13 prisons nationwide had an ISU and four prisons (Tongariro Prison, Manawatū Prison, Rolleston Prison and Waikeria Prison[100]) did not (see Appendix B for ISU locations). In the review period, people at risk of self-harm at these four prisons were placed in a unit reserved for closer observation, and health and custodial staff discussed whether the person could be managed safely on site overnight (after 5pm until the next day). If the person's mental health did not stabilise or continued to deteriorate, the person was transferred to a prison with an ISU, if it was considered safe to transfer them. The health centre manager was required to be consulted when considering transferring an at-risk person to another prison.

634. This review notes concerns regarding the absence of ISUs on these sites. While at-risk prisoners at these sites are placed on observations to ensure their safety, staff may not have the same level of knowledge or experience as staff who work in designated ISUs. There can also be difficulties arranging transfers of people at risk, which can impact on the welfare of the at-risk person and place an additional burden on staff.

Summary

635. ISUs are intended as safe environments where prisoners who are at risk of suicide or self-harm can stay for a limited time to receive specialised care.

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[99] Prison Operations Manual: S.06.04 Prisoner welfare monitoring check.

[100] Waikeria Prison had an ISU until it was destroyed during the riot that began on 29 December 2020 and ended on 3 January 2021.

636. Of the 13 prisons with an ISU, six had a multi-disciplinary ISPT on site by the end of the review period. These teams can offer more comprehensive care to at-risk prisoners than those sites that do not have them.

637. Some prisoners may need to be admitted to in-patient mental health facilities which can offer more treatment options. However, admission can be delayed depending on bed availability.

638. Custodial staff who work in ISUs may have received additional training and support, but this is variable across the prison network. Deploying untrained or unsupported custodial staff to ISUs may have a detrimental effect on both the staff and prisoners.

639. Going to an ISU may mean a person is offered therapeutic interventions, however, it may be a traumatic experience as prisoners must be strip searched on arrival for safety reasons, and will experience a more restrictive regime than in mainstream units, often with little to do and little opportunity for social interaction.

640. All prisoners in an ISU should have an At-Risk Management Plan. However, we found that these may be generic and lack some clinical information that could assist custodial staff in managing the person.

641. Generally, a registered health professional visits every prisoner in the ISU at least once a day to check on their wellbeing. We found that during the review period staff had little guidance in how to conduct these welfare checks and that they were not always conducted according to best practice. Guidance for wellbeing checks was published on the Corrections intranet in August 2022. However, we have continued to observe that these checks are not always conducted according to the guidance.

642. Some attempts to improve the physical environments of ISUs occurred in 2019, however, most ISUs remain stark and many clinicians consider that they are not therapeutic environments.

643. Transitions out of ISUs may be planned and managed, but practice is variable and sometimes people receive limited or no additional support after they leave an ISU.

644. Not all prisons have an ISU and at-risk prisoners may need to be transferred to another prison with an ISU, which is concerning.

Areas for consideration: Going to an Intervention and Support Unit

34. Corrections should consider having a specialist mental health clinician leading the decision-making for people at risk of suicide and self-harm entering and leaving the ISU.

35. Corrections should consider whether ISUs should be clinically led and supported by custody to embed an evidence-based therapeutic culture, including:
    - ensuring risk assessments and care are individualised
    - learning from other models of care (e.g. Hikitia).

36. Corrections should consider having dedicated custodial and clinical staff in ISUs.

37. Corrections should consider providing more guidance to ISU staff about alternative approaches to using mechanical restraints for people who are actively self-harming.

38. Corrections should consider providing more guidance to custodial staff who are required to do constant observations, and should ensure that staff who have completed constant observations are appropriately debriefed.

39. Corrections should consider how to better support people with personality disorders, and continue to offer education and training for staff who are supporting people with complex personality traits.

40. Corrections should consider strengthening the reflective supervision model and resourcing this for custodial staff in all ISUs.

41. Corrections should consider how care plans can be better developed, reviewed and shared after a self-harm threat to life incident.
42. Corrections should consider evaluating the implementation and application of the new guidance for wellbeing checks.
43. Corrections should consider greater use of options such as telehealth, especially for situations where specialist mental health clinicians are required but are not immediately available (e.g. after hours or on weekends).
44. Corrections should consider establishing additional dedicated units that better support the assessment and care of vulnerable people (e.g. 'step-down' units from the ISU, or units for people who are new to prison, or people with a mental illness or a cognitive disability).
45. Corrections should consider, and keep under review, whether to establish ISUs in the prisons that do not currently have these.
46. Corrections should consider establishing a national formal escalation process for the care of forensically unwell people who are waiting for in-patient admission.

Postvention: After a suspected suicide

Introduction

645. The impact of suspected suicides on the deceased's family/whānau, friends, other prisoners and staff cannot be underestimated. While the number of people affected by any suspected suicide will vary, one international study in the general population found that each suicide could affect an average of 135 people, any of whom may be in need of "clinician services or support" (Cerel, Brown, Maple, Singleton, van de Venne, Moore & Flaherty, 2018). The Corrections *Suicide Prevention and Postvention Action Plan* defines postvention as "activities developed by, with or for those bereaved and affected by suicide to support recovery after suicide and to prevent subsequent suicidal behaviour". The plan sets out that "responses to suicide should be coordinated, culturally appropriate and humanising in nature".

646. Postvention is considered necessary because, as set out in *Every Life Matters*, people "bereaved by suicide, particularly those with a history of previous trauma, suicidal behaviour or depression, may be at increased risk after learning of another person's suicide". *Every Life Matters* sets out that the primary purpose of suicide postvention is "to support the recovery of the suicide bereaved and prevent contagion or imitative suicide behaviour" (Ministry of Health, 2019).

647. The literature supports a culturally appropriate approach to postvention. Postvention approaches to suicide of Māori outside of the prison context, based on interviews with whānau who have experience of suicide, suggest Māori perspectives and practices and Māori-led processes are essential for Māori (McClintock & Baker, 2019).

648. A Scottish review of families' opinions regarding the response to deaths in custody (including suicides) found that families wanted "Communication, Consistency, and Compassion" from prison staff, and went on to say that families' "experiences were not consistent, and processes and practice appeared to differ between prisons" (Families Outside, Scottish Human Rights Commission & HM Inspectorate of Prisons for Scotland, 2021).

649. We welcome Correction's strategic focus area 'Supporting after a suicide', which has the long-term actions (i.e. to be completed 2023 – 2025), as set out in its *Suicide Prevention and Postvention Action Plan* of: "Partnering with other agencies and experts who can assist Ara Poutama Aotearoa in responding effectively to suicide related events" and "Standardising the approach that we at Ara Poutama Aotearoa take to suicide postvention to ensure that all individuals and whānau affected are supported in a culturally appropriate and mana enhancing manner." Our understanding, at the time of writing (January 2023), is that this work is ongoing.

650. We observed that responses to suspected suicides were variable across the prison network and tended to focus on rudimentary postvention activities. One subject matter expert commented on this:

> *"There's a lack of suicide postvention in prisons." [Senior Adviser Mental Health]*

651. Lastly, we note that although this section of the report focuses on what happens after a suspected suicide, it is important to recognise that staff, other prisoners, and family/whānau may also require support after a self-harm threat to life incident. We have observed that while effort is rightly focused on the person involved in the self-harm threat to life incident, support for the people who witnessed or responded to the incident may be lacking.

Site response to a suspected suicide

652. Following any death in custody, including a suspected suicide, custodial staff must follow a set of instructions in the Prisons Operations Manual. These include securing the incident area pending Police investigation, posting a scene guard, and notifying Police, the Coroner, the Office of the Inspectorate, the Office of the Ombudsman, the prison chaplain, the prison cultural adviser, and the victim notification coordinator. Staff must also secure and store the deceased's personal property so it can later be released to the prisoner's contact person or next of kin.

653. Prison sites must maintain a register of cultural, religious and spiritual support volunteers who can be called upon to provide assistance to ensure processes are carried out in keeping with the known cultural, religious and spiritual needs of the deceased, their family/whānau, and others. This register must include kaiwhakamana and fautua Pasefika.[101]

Site response to family/whānau

654. If the deceased had been transferred to hospital as part of the emergency response and placed on life support, but it has been determined that they had a non-survivable injury, efforts were made to ensure partners and family/whānau members had the opportunity to say their goodbyes and be present when the person passed away.

655. Notifying family/whānau of a death is the responsibility of Police. Corrections staff liaise with the deceased's contact person to return property and any money the deceased had in their prison trust account. Staff give the contact person a booklet entitled 'Information for family and friends after a death in custody' which gives factual information about processes when a person dies in prison.

656. We observed that during the review period there were variable responses to family/whānau from prison staff. For example, in some cases we observed that staff followed the required process as outlined in the previous paragraph. However, in some cases, where senior staff felt it was appropriate, a senior member of staff spoke to the family/whānau and offered them an opportunity to visit the prison unit/cell where their family/whānau member had lived. These families/whānau were able to talk to staff, and possibly to some of the prisoners in the unit, and were able to spend time in the deceased's cell. They might also be invited to attend a blessing or other type of ceremony. Two families expressed that this was helpful to them in coming to terms with their loss.

Site response to prisoners

657. As soon as is practicable after a suspected suicide, staff will talk to all prisoners in the unit to complete a wellbeing check, and provide reassurance and support. This might be done by custody, health or chaplaincy staff, or a combination of them all.

658. During the review period, we found inconsistency in how different prisons, and even different units within those prisons, managed following a suspected suicide. Activities seem to have depended on the priorities of people on site.

659. When the undertaker removes a body from a unit, sometimes prisoners perform a haka and waiata from within their cells. After one suspected suicide in our review, prisoners who were close to the deceased were unlocked from their cells so they could farewell the deceased as they left the unit. Again, prisoners performed haka and waiata.

660. In 27 (93%) of the 29 suspected suicides, chaplaincy services were notified and attended the site to support prisoners and staff and to bless the location where the person had died.

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[101] Fautua Pasefika are Pacific Island community leaders who have been granted greater access into prisons to support Pacific Island people.

"[When there was a suicide] I went straight to that unit and spent the whole day there. I was involved in the blessing of the cell and the whole unit. The prison director, assistant prison director, residential manager, principal corrections officer and the unit staff were present. When the blessings were over, I offered myself to the PCO of the unit: 'any of your staff need me – I'm here'. I also reassured all the inmates; I went cell by cell. I know the body is removed but the pain and grief are there … The other suicide [I was involved in] – there was a kaiwhakamana, so I spoke to him and decided how we wanted to do the blessing and everything. We worked together as a team." [Prison Chaplain A]

"[After one suicide] the security manager was overridden about taking the body out of a side gate. Instead, we took the person out the front and unlocked the unit to allow farewells … One of the tāne mentioned that he had experienced a number of friends that had passed away whilst in prison and that was the first time he was able to say good-bye. Mana whenua were in the next day and a ceremony was held, which included blessing the cell. This brought some peace to the compound."
[Prison Chaplain B]

"There were two deaths in custody [from suicide] at my site in 2019. I was only informed four days later for the first one; I don't think there was much closure there. I wasn't contacted at all about the second death."
[Prison Chaplain C]

661. Some chaplains provided memorial services at a later date for prisoners and staff to attend. We were told that at one of these memorial services, blessings and prayers were given in Māori, English and Pasefika languages.

662. After nine (31%) of 29 suspected suicides there was evidence of cultural support being offered, such as kaiwhakamana being present in the unit for prisoners and staff.

663. If the deceased was sharing a cell, staff completed a Review Risk Assessment for the other prisoner, and the person was relocated to another cell; sometimes this new cell was in the ISU. In one case, the prisoner was upset at being placed in the ISU and advised that the last thing he wanted was to be on his own.

Site response to staff

664. During Inspectorate investigations, we observed the impacts of suspected suicide and self-harm threat to life incidents on both custodial and health staff. We observed, for example, nurses resigning after responding to some of these incidents. Some nurses told us that attending such incidents was traumatising and that they have reoccurring dreams about the incident. Many examples of CCTV or on-body camera footage (viewed by the Inspectorate review team as part of the investigation process) reveal the impact on custodial and health staff, with many staff tearful immediately following the incident, and reporting (when interviewed) being tearful or upset many months after the incident.

665. Corrections provides support to staff who have been involved in all serious incidents, including suspected suicides. This support includes debrief sessions, the peer support activities of Post Incident Response Team members, and confidential counselling via the Employee Assistance Programme. In addition, Corrections has eight staff welfare coordinators (two for each region) who, according to the Corrections intranet, may give extra support to staff with "more complex psychosocial needs".

666. Corrections policy sets out that post incident debrief sessions should be held following all suspected suicides and other significant incidents such as self-harm threat to life incidents.[102] Our review found evidence that 'hot' (same day as the incident) debrief sessions were held after 16 (55%) of the 29 suspected suicides, but fewer sites held a 'cold' (occurs within a month of the incident) debrief as well.

[102] Prison Operations Manual: IR.05 Post incident.

667. During our interviews with staff, many confirmed that they had attended a debrief session following a suspected suicide, although some did not attend as they were not informed the session was taking place, they were not able to be released from their duties, or they were not on site when it took place.

668. There was variation in how useful staff felt the debrief sessions were. Corrections' guidelines for these sessions set out that sessions should cover the "facts only". Some staff described the debrief sessions as valuable as everyone had an opportunity to talk about the incident and discuss what had gone well and what they could have done differently. However, some staff (earlier in the review period) described the sessions as only going through the timeline of the incident so people could record similar times in their incident reports.

669. It is important that staff involved in a suspected suicide or self-harm threat to life incident have the opportunity to deal with emotional reactions as these can be overwhelming and may lead to lasting distress. Debrief sessions in New Zealand prisons in the review period did not aim to offer personal support. Instead, the person running the session was supposed to identify or clarify the staff support opportunities that were available.

670. We found evidence of staff being offered personal support from the Post Incident Response Team and the Employee Assistance Programme after 14 (48%) of 29 of the suspected suicides in the review period. We were told by some staff that these supports were variable. For example, staff were not always available when Post Incident Response Team members were on site, and some staff felt that the Employee Assistance Programme counsellors had not understood the context and challenges of a prison environment.

671. For three (10%) of the 29 suspected suicides, sites arranged additional support for staff, including having the suicide prevention team from the District Health Board provide a group session on managing trauma for the staff involved, arranging sessions for staff on grief and loss (facilitated by Employee Assistance Programme staff) and one-to-one psychologist sessions with staff.

672. We also observed that prison directors and health centre managers may have arranged extra staff to relieve staff who were involved in the incident.

673. We note that in some other jurisdictions and services, debriefing sessions have a wider remit than at Corrections, and include support for staff to deal with their emotional reactions to potentially traumatic events. Debriefing sessions that cover emotional reactions and support are facilitated by someone who has received training to provide this.

674. A useful guide to coping with a critical incident is provided by the Victoria State Government Department of Health.[103] It recommends conducting an immediate "defusing" group to "bring the experience of the incident to a conclusion and provide immediate personal support". This is followed by a debriefing carried out three to seven days after the event. The debriefing should occur when staff have had enough time to take in the experience. It is a "structured voluntary discussion aimed at putting an abnormal event into perspective". It also assists staff to "establish a process for recovery".

675. Other debriefing guides, such as those offered by the New Zealand Nurses Organisation and New Zealand Search and Rescue, also emphasise the importance of appropriate debriefing for staff who have been involved in potentially traumatic events.[104] [105] In addition, the New Zealand Nurses Organisation recommends that debriefing should not be seen as a stand-alone intervention but should be part of a broader approach of support for staff who face complexities in the working environment.

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103 https://www.betterhealth.vic.gov.au/health/healthyliving/workplace-safety-coping-with-a-critical-incident

104 https://www.nzno.org.nz/LinkClick.aspx?fileticket=qtEMxjoFb0E%3D&tabid=109&portalid=0&mid=4918

105 https://nzsar.govt.nz/assets/Downloadable-Files/Critical-Incident-Stress-Debriefing.pdf

Role of the Office of the Inspectorate

676. As stated above, one of the responsibilities of prison staff is to notify the Office of the Inspectorate about the suspected suicide. For every unnatural death in a prison, including suspected suicides, the Inspectorate assigns two regional inspectors and one clinical inspector to investigate. The Inspectorate writes to the next of kin to advise them of the investigation and how it will happen. Inspectors do not share details of their investigation findings with the next of kin. The final report is sent to the Coroner who will determine the cause of death. The report is also sent to the Corrections national commissioner and deputy chief executive health, and to the Office of the Ombudsman. Family/whānau can then apply to Corrections to receive the Inspectorate's report.

Summary

677. The impact of suspected suicide on family/whānau of the deceased, staff and prisoners cannot be underestimated. We observed that postvention responses for these groups were variable across the prison network.

678. Responses to the family/whānau of people who have died by suspected suicide may be compassionate and culturally appropriate, but may have a transactional focus such as returning property and funds.

679. Responses to other prisoners who have shared a unit with a person who has died by suspected suicide may be compassionate and culturally appropriate, but can be variable across the prison network.

680. Responses to staff who have been involved in responding to a suspected suicide focus on operational debriefing, however some sites are now starting to engage and use additional services to support staff. Staff are offered peer support from the Post Incident Response Team and counselling via the Employee Assistance Programme. However, these options may not suit all staff members.

Areas for consideration: Postvention

47. Corrections should continue to progress the postvention workplan as set out in 'Focus Area 8' of its *Suicide Prevention and Postvention Action Plan*, and report on progress to the Suicide Prevention and Postvention Advisory Committee.

48. Corrections should consider reviewing systems and policies to better support staff after a suspected suicide including:

    » strengthening debriefing processes to ensure all staff are offered meaningful support in the short, medium and long term

    » clarifying the roles and responsibilities of managers after an incident

    » ensuring debriefing sessions are facilitated by managers trained in debriefing.

49. Corrections should consider appointing a nominated suicide prevention and postvention coordinator at each prison, whose remit could include building relationships with external agencies and experts, including iwi, Māori health services, and local regional health service suicide prevention and postvention coordinators.

Release

Introduction

681. Suspected suicide and self-harm threat to life incidents amongst people who have been released from prison are outside the scope of this review. However, Corrections' role includes managing people's transition between prison and the community, so we have examined practice in this area. This transition is seen in the literature as an important area for preventing suicide and self-harm (Borschmann et al, 2020; Forrester, Till, Simpson & Shaw, 2018).

682. The international literature consistently shows that suicide rates for people recently released from prison are much higher than for the general population (Sirdifield, Brooker & Marples, 2020; Ong & Lynch, 2016; Kinner, Spittal & Borschmann, 2018).

683. In Victoria, Australia, a Correctional Suicide Prevention Framework highlights "the first few weeks immediately following release" as "a time of high risk of suicide" (Department of Justice & Regulation – Justice Health, 2015). Another study suggests that the risk of suicide for released prisoners is highest in the first month in the community (Hopkin, Evans-Lacko, Forrester, Shaw & Thornicroft, 2018). The same study found that transition from prison to the community may be especially stressful for prisoners with mental health issues and their families.

684. Some influential models of care, for example the STAIR (Screening, Triage, Assessment, Intervention, Re-integration) model for mental health services, outline that planning for community reintegration should begin well in advance of the release date so that health and social care needs can be identified and met (Forrester et al, 2018).

685. Corrections acknowledges the importance of transitions when supporting people at risk of suicide and self-harm. One of the long-term actions (i.e. 2023 – 2025) in the Corrections *Suicide Prevention and Postvention Action Plan* sets out that Corrections will: "investigate and implement initiatives aimed at better supporting individuals who are transferred within, between, or are released from a prison site".

686. We could source no national New Zealand data on suspected suicides following release from prison. However, a 2017 review that focused on people in the community in Corrections' Southern Region found that 69 people who were either on a current community-based sentence, or who had previously been managed by Corrections, had died by suspected suicide between March 2015 and July 2016.[106] Information from the Chief Coroner's Office showed that in total, 217 people had died by suspected suicide in the South Island during that period, so the 69 people represented 32% of the total. This was an over-representation of suspected suicide deaths of people known to Corrections in the Southern Region.

687. The 2017 review outlined several risk factors for staff to be aware of, including "low risk offenders who display reckless and potentially drug fuelled offending", offenders with problematic alcohol and other drug use, those with chronic pain conditions, and those who had previously attempted suicide or been bereaved by suicide. The review also made a number of recommendations, including making the findings of the review available to all staff and providing suicide prevention training to all practice leaders.

[106] Internal Corrections Service memo dated 21 February 2017 from Lead Advisor Operational Performance to Regional Commissioner Southern and other senior Corrections staff and managers.

688. An article that analysed sudden death in patients with serious mental illness who had been under the care of the Canterbury District Health Board's Specialist Mental Health Service, found that over half (162 people, or 52%) died by suicide, and that 20% of those suicides occurred in relation to periods of imprisonment, mostly after prison release (Monasterio, McKean, Sinhalage, Frampton & Mulder, 2018). This mirrored similar findings from the Suicide Mortality Review Committee of New Zealand, which found that 27% of people who died by suicide between 2007 and 2011 had previous contact with Corrections (Suicide Mortality Review Committee, 2016).

689. During our review of the 29 people in prison who died by suspected suicide in the review period, four (14%) were nearing release. Release planning was under way for three of the four. The fourth person was expressing frustration as his reintegrative pathway had stalled and he had no progress to present to the New Zealand Parole Board.

690. We note that Corrections does not make decisions about sentence end dates and must release people from prison if they have reached the end of their custodial sentence, been granted bail, gained parole, or for any other reason as decided by the justice system. This is the case even if a person has been assessed as at risk of suicide or self-harm.

Release planning

691. Preparing for release is a core function of case managers, and the Ara Poutama Practice Centre on the Corrections intranet includes the case management standard: "I will plan the release for every allocated person on my caseload". During the review period, we observed that release planning was thorough for some people, generally including those who were due to appear before the New Zealand Parole Board. However, for many people in the general prisoner population, planning was minimal, and for people who were not appearing before the New Zealand Parole Board we observed that there were also minimal checks on release planning. We observed many people being released with no accommodation to go to.

692. In the review period, Corrections also supported release planning and reintegration through initiatives including the Release to Work programme[107], the Out of Gate reintegration navigation service for those on short sentences, and the Reintegration Support for Long Servers Navigation service. We observed that while Out of Gate and Reintegration Support for Long Servers did offer practical release support, they were not funded for accommodation, so helping with this often became the responsibility of the probation officer or staff from the Ministry of Social Development.

693. We observed that generally when people in the ISU who were assessed as being at risk of suicide or self-harm were nearing release, multi-disciplinary teams, including custodial and health staff, worked with the person, their family/whānau and community providers. This meant that support was in place to mitigate the risk of self-harm on release. We noted that in some cases, release itself may have mitigated the risk of self-harm.

694. However, as noted above, some people in the ISU who had self-harmed (and who were still assessed as being at risk) were released directly into the community, which may pose a risk to them or to others. For example, in the final year of our review period (1 July 2020 to 30 June 2021), and looking at the women's prison population alone, 14 at-risk women were released straight from the ISU into the community.

[107] Release to Work is a type of temporary release that assists prisoners in their reintegration by allowing them to leave the prison to go to work in the community.

695. We noted that in some cases, case managers encountered challenges when attempting to plan for release, especially for people with high and complex needs. For example, the case manager in the following case study was proactive in attempting to plan for Ms B's release, but was nonetheless unable to find suitable services:

Case study 6 - Ms B[108]

Ms B was on remand at the time of the self-harm threat to life incident we reviewed. Ms B had several mental health diagnoses and a history of substance use, self-harm and violence. She also had a history of being released for short periods and then being remanded back into custody.

Historically, we noted many attempts by Ms B's case manager to arrange referrals to community mental health services, accommodation, and other services for when she was released. However, many of the organisations contracted to provide reintegration services were unable to offer Ms B accommodation or support due to her history of violence and substance use.

696. Sometimes case managers raised such cases to Regional High Risk Panels. The Ara Poutama Practice Centre on the Corrections intranet sets out that these panels focus on the "level of service required for high risk and complex needs (HCN) cases, and support frontline staff to access and deliver the level of service needed to manage these risks and address the complex issues presented by these cases". We observed that these panels could be effective in supporting staff, but that they sometimes took time to review cases. In addition, we sometimes observed limited local contracts/agreements for services with other agencies. This meant that although case managers and panel members attempted to plan for people, there were no suitable services available. This seems likely to be a "systemic hazard" (Shalev & Tomczak, 2023) where more multi-agency, multi-sectoral action is required to ensure there are sufficient services for people with high and complex needs who are leaving prison.

Healthcare release planning

697. The Corrections Health Services Health Care Pathway 2019 includes the Health Care on Release Policy which sets out the requirement for there to be "a system in place so that Health Services and custodial staff share information about patients who are being released". The policy also sets out the responsibilities of the registered nurse, including to update the patient's health record before they are released and to complete the documentation needed to provide continuity of care.

698. We were told about a trial of a discharge nurse role at Auckland Prison in 2021. The discharge nurse oversaw the management of a person's release requirements before they left prison, attended multi-disciplinary release planning meetings (with case management, custodial and intelligence staff), reviewed upcoming releases, arranged discharge information from health services including medication scripts, and supported connection with a general practice in the community on release. We were told that the scope of this role became constrained during COVID-19 owing to reduced custody and health staff.

> *"Relationships, continuity of care, ending properly – as I am currently doing, saying goodbye to prisoners I have worked more closely with – these all help to humanise the experience of imprisonment and not add to the trauma they have already experienced." [Discharge Planning Portfolio Registered Nurse]*

699. We were told that Corrections intends to introduce four new regional social worker roles (i.e. one for each Corrections region) to assist with complex releases.

108 Ms B was also in 'Case study 2'.

700. We understand that since the review period, Corrections has made a number of changes to strengthen its systems and processes to ensure continuity of care when people are released. For example, in November 2022 Corrections reviewed and updated guidance for health staff about how to ensure a smooth transition of healthcare to community providers, including when a release was unplanned.

701. In addition, we were told Corrections has completed an audit at one prison to determine whether people in prison were being released with discharge summaries, health information and prescriptions. This audit is to be added to Corrections' Health Service National Audit Schedule to examine the practice across all Health Centres.

702. We also understand that Corrections has made progress on work to implement an integrated clinical record and strengthen its electronic processes. At the time of writing (May 2023) Corrections had chosen a preferred vendor for replacing and upgrading its existing patient management system. Regarding improving continuity of care on release, we were told that this new system would help to ensure that people's health information is better connected to their release information so that in future staff will not need to use multiple sources to access important details.

Community oversight by probation officers

703. People released from prison on parole or with sentence conditions will be managed in the community by a probation officer. The probation officer may use practice guidance and resources from the Probation Officer Tool Kit on the Corrections intranet to "address reintegrative and rehabilitative needs".

704. We were told by a subject matter expert that, on occasion, probation officers had knowledge of some suspected suicides in the community because they were notified about them. We were also told that more work was planned in this area:

> *"In the community we find out about a death but don't necessarily know the cause ... Sometimes we do know because the Police or family will tell us... We are wanting to understand the numbers of deaths for people under our care and are looking at a piece of work to better understand this ... We do know that we have had two suicides for people on Home Detention in the last two years." [General Manager Probation and Case Management / Chief Probation Officer]*

705. The same subject matter expert told us that the role of the Improving Mental Health practitioner at some Community Corrections sites was considered to be a valuable resource by staff. Nationally, Community Corrections sites had 12 of these practitioners who were available to advise probation officers and help them to navigate referrals to mental health services. We also heard that further development of and increased investment in this service had been 'paused' for the last two to three years while a Corrections Health Services review was underway.

Summary

706. People who have been released from prison are likely to be at greater risk of suicide and self-harm than those in the general population. Release planning can help to mitigate the risk, and we are advised that Corrections plans to investigate and implement initiatives to better support people who are released from prison.

707. We observed that release planning by Corrections case managers, health staff, and others may be proactive, but staff may encounter challenges with referrals to community-based services, especially for people with more complex needs.

708. Some probation staff consider that Improving Mental Health practitioners are a valuable source of advice and assistance to navigate mental health referrals in the community. Probation staff do not necessarily have visibility of all suspected suicides on their caseloads.

Areas for consideration: Release

50. Corrections should consider strengthening its efforts in multi-agency collaboration to address systemic issues in service provision for prisoners on release.
51. Corrections should consider reviewing the effectiveness of the discharge nurse role to decide whether it should be implemented nationwide.
52. Corrections should consider collaborating with relevant external partners to collate and review data on deaths by suspected suicide within a relevant period (to be determined) after release.

Impact of COVID-19

Introduction

709. The five-year review period 1 July 2016 to 30 June 2021 included an approximately 15-month period during which New Zealand was responding to the global COVID-19 pandemic. A state of national emergency with a countrywide lockdown was declared in New Zealand between 25 March 2020 and 13 May 2020. Restrictions and further lockdowns followed, with some areas, such as the Auckland region, enduring longer periods in lockdown.

710. The COVID-19 pandemic disrupted routines in prisons all over the world (Kim, Hughes, Cavanagh, Norris, Gao, Bondy et al, 2022). In New Zealand, prisons employed a range of strategies to reduce the risk of COVID-19 outbreaks. Having observed the impact of COVID-19 infections in prisons overseas, Corrections initially decided to adopt an elimination strategy, which aligned to the New Zealand government's approach.

711. This approach aimed to prevent illness and death from COVID-19. In some international jurisdictions, prisoners suffered high morbidity and mortality rates. For example, in England and Wales, between March 2020 and February 2021, the COVID-19 death rate among prisoners was 3.3 times higher than among people of the same age and gender in the general population (Suhomlinova et al, 2022). In New Zealand, there were no prisoner deaths due to COVID-19 during the review period, and few people required hospitalisation. The work of prison staff to achieve these results must be commended.

712. However, Corrections' elimination strategy also meant that prison regimes became more restrictive, with 14-day quarantine isolation periods for new prisoners, and with most other prisoners spending long periods of time locked in their cells. Most activities, including rehabilitation programmes, were suspended. All non-essential staff and visitors were prohibited from entering prisons. This included staff such as mental health nurses, counsellors, medical officers, chaplains, tutors, programme facilitators, case managers, kaiwhakamana, fautua Pasefika and prison volunteers. It also meant no visits from family/whānau. Clinicians from forensic mental health services were generally only permitted on site for urgent consultations when prisoners were acutely unwell or unstable.

713. As previously noted, visits in some prisons recommenced in October 2022, but we note that, generally, regimes in most New Zealand prisons remain more restrictive than they were pre-COVID-19. While the reasons for this are outside the scope of this report, staff shortages and the continuing presence of COVID-19 in our communities are contributing factors.

714. Under Section 69 of the Corrections Act 2004, prisoners must receive certain minimum entitlements, which include at least one hour of physical exercise a day, and the ability to have at least one private visitor each week. However, these minimum entitlements can be suspended in times of emergency such as the COVID-19 pandemic. Due to the length of the pandemic, there were some prisoners who did not receive their minimum entitlements for prolonged periods of time.

715. Our literature review did not specifically examine the effects of COVID-19 restrictions on suicide and self-harm rates for people in prison. However, social isolation is considered a factor in many explanations of suicide (Durkheim, 2007; Schneidman, 1993). COVID-19 restrictions significantly impacted upon the ability of prisoners to connect with others and resulted in many people experiencing prolonged periods of solitary isolation.

716. Delays to judicial processes increased the time people spent on remand in many countries, including New Zealand. Being on remand is known to be a risk factor for suicide and self-harm due to the uncertainty and anxiety about the future that many people experience (Hewson, Shepherd, Hard & Shaw, 2020).

717. In addition, fear of COVID-19 itself induced stress and anxiety in many people, including prisoners, "over the risk to themselves and those they love contracting or dying from COVID-19" (Johnson, Gutridge, Parkes, Roy & Plugge, 2021).

718. Of the 29 suspected suicides that occurred across the review period, 16 (55%) took place during the 15-month period between March 2020 (when the COVID-19 restrictions began) and the end of our review period. For the 15-month period prior to that (i.e. November 2018 to February 2020) there were five (17%) suspected suicides.

719. Of the 253 self-harm threat to life incidents in the review period, 56 (22%) took place in the 15-month period between March 2020 and the end of the review period. For the 15-month period prior to this (i.e. November 2018 to February 2020) there were 49 (19%) self-harm threat to life incidents.

Quarantine periods

720. Generally, during the COVID-19 pandemic, people arriving at prison Receiving Offices continued to experience the usual reception process, but this now included a COVID-19 assessment and screening test. New prisoners were then separated from the mainstream prison population for 14 days. This 14-day quarantine period applied to people who had come from court, had attended a court appearance, or had been transferred from another prison. This led to many prisoners spending long periods in isolation. We were told by one prison director:

> *"14 days isolation at the moment for everyone new. That is very distressing – when you are new in not seeing anyone for 14 days ... They can't have visits with their family because we don't have the technology. As a matter of urgency, we need to look at this."[109] [Prison Director]*

721. Sites attempted to reduce the risk to staff and other prisoners by limiting the time the new arrivals spent in the Receiving Office. The Inspectorate review team heard that at one site prisoners were triaged by a nurse in the van they had arrived in. If they had symptoms, they were put straight into a quarantine cell.

722. People who were already housed in mainstream prison units were also put into quarantine if they developed symptoms of COVID-19. Quarantine restrictions were managed variably across the prison network. For some prisoners, quarantine meant remaining in their cells for 24 hours a day, with minimal contact with custodial staff and no access to a telephone.

723. Due to fears of contamination, items such as books or writing paper were often not allowed in quarantine units. One subject matter expert commented that this lack of activities put some people's mental health at risk:

> *"[People in] COVID-19 isolation have nothing; maybe a couple of books. It's so restrictive, but it's difficult to give more activities. This situation is causing a lot of damage due to deprivation. [For those with mental health issues] it's worsening their conditions." [Senior Adviser, Mental Health]*

724. Custodial staff interacted with prisoners in quarantine through cell doors or hatches, for example, when they were passing food into the cell.

725. Many custodial staff were aware of the negative impacts of isolation on prisoners and attempted to mitigate the effects. For example, at one site, the principal corrections officer for the quarantine unit would sit and talk with the prisoners through the door. We were also told that staff in this unit placed a portable telephone on the floor outside prisoners' cells so they could talk to family/whānau through the hatch in the door.

726. Nurses visited COVID-19 positive quarantined prisoners daily to assess them for signs of illness. However, owing to quarantine restrictions, we observed a greater number of 'through the hatch' assessments. At many sites, we were told that if prisoners tested negative, nurses only visited when they needed to do another test.

727. During the latter period of COVID-19 restrictions, and as the national vaccination programme was established, new arrivals in prison were often grouped together into 'bubbles' for their isolation period in an attempt to reduce the impact of social isolation. This meant that prisoners in a bubble could share a cell and could be given time out of their cells together, for example in exercise yards.

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[109] The date of this interview was 7 October 2021 which was outside our review period. However, the circumstances at the prison at that time were the same as within the review period.

728. To try to reduce the transmission of COVID-19, we observed that two sites re-commissioned old buildings as isolation or quarantine units. This meant that some prisoners were held in environments that were poorly maintained.

729. Other sites re-purposed units for quarantine, in some cases using units that had been designated for vulnerable prisoners who were then moved into mainstream units.

General regime restrictions

730. Even if they were not in quarantine, all prisoners experienced restrictions, including no visits from whānau, less time out of their cells, fewer telephone calls, virtual (rather than in-person) health appointments, fewer rehabilitation programmes, and fewer opportunities for employment, trades training, or other meaningful activities such as kapa haka or arts programmes. Prisoners were not able to access education tutors. Prison gyms were closed.

731. All prisoners' mail was subjected to a quarantine period of 48 hours. However, some prisoners told us they had to wait weeks before receiving their mail.

> *"It's hard mentally – no contact with family. I've written letters out to my family/daughter, but these are delayed by three days. It's almost two weeks and they still haven't arrived. Partner sent in phone cards fast-post last week but still not received. Was given phone card last week by a Corrections Officer so was able to make 15-minute phone call." [Prisoner]*

732. Custodial staff shortages, due to staff illness or isolation requirements, further increased the restrictions. This meant, for example, that prisoners might miss health appointments as there were not enough custodial staff to escort them, or prisoners might not get time out of their cells as there were not enough staff to unlock them.

733. Staff had to wear full personal protective equipment (PPE) which included goggles, face shield, gown and gloves over their Corrections uniform including their stab-proof vest. For many staff this was hot and uncomfortable, and we were told that sometimes staff minimised the times they had to wear full PPE due to the discomfort. This meant some staff limited their interactions with prisoners.

734. For Corrections Health Services, the COVID-19 pandemic meant staff had additional duties including screening, testing and vaccinating prisoners for COVID-19, as well as supporting prisoners who were displaying symptoms. While health staff continued to carry out all other essential duties, such as medication administration, they were often not able to provide many of the usual health services such as Initial Health Assessments, screening, triage of health concerns and health promotion activities. Health staff shortages due to illness and isolation requirements also impacted on the provision of health care to prisoners.

735. The wider health system in New Zealand was placed under extreme pressure during the COVID-19 pandemic, and subsequent delays to external health appointments may have contributed to the complex circumstances for some prisoners as our next case study illustrates:

Case study 7 – Mr F

Mr F was a remand-convicted man in his forties at the time of his self-harm threat to life incident in 2021. Mr F had been in prison multiple times.

Mr F suffered from headaches from a historic traumatic brain injury, and was on a hospital waiting list for surgery for an existing medical condition. He was on medications for pain and depression. He had a wound on his forehead from banging his head and had a known history of suicide attempts and self-harm.

Staff noted that Mr F was increasingly frustrated, angry and distressed. He reported severe back pain, not relieved by medication.

He had been referred to a physiotherapist for this, but his appointment had been rescheduled four times. He also complained of pain from his other existing medical condition, but there were continual delays to the surgery to rectify this. The delays were deemed to have been exacerbated by stresses placed on hospitals by COVID-19. The day before Mr F's self-harm threat to life incident, he was reviewed by the prison Medical Officer who noted that his pain score was very high. However, there is no record of Mr F's pain medication being reviewed, or of him being offered other interventions to help him manage his pain.

The next day, Mr F was found hanging from a ligature in his cell. He was cut down by custodial officers and received medical treatment.

When Mr F was released from prison, he was still on the hospital waiting list for surgery.

Mitigation of impacts of restrictions

736. Corrections took several steps to mitigate the impacts of the restrictions, though we observed that mitigations varied across the prison network.

737. Corrections introduced laptops for prison staff to use, installed wi-fi at prison sites, and encouraged the increased use of telehealth and audio-visual link (AVL) suites. For example, we were told that AVL was used more for court appearances.

738. Due to the inability of forensic and other mental health clinicians to physically go on site for routine face-to-face assessments, AVL or telephone appointments were introduced and Corrections staff were informed that mental health provision should be prioritised for AVL access.[110] While not considered best practice, AVL sessions did allow prisoners to attend regular monitoring/check-in sessions with staff from forensic mental health services. Medical officers also made use of technology to assess patients and provide advice to nurses working on site.

739. Case managers and Corrections psychologists were unable to fully support prisoners' rehabilitation but, as set out in a Corrections intranet story, they used virtual or telephone appointments to provide some support.

740. Custodial staff at some prisons used the newly supplied laptops and wi-fi to enable virtual visits with family/whānau, though these were dependent on staff availability.

> *"[We introduced] Zoom virtual meetings with whānau during lockdown … It worked very well. Great tool." [Principal Corrections Officer]*

741. We were told that some sites also took a more flexible approach to the timing of virtual family/whānau visits or telephone calls. For example, allowing these to occur in the evenings. The Inspectorate review team considers that this is a positive initiative which should be continued where possible.

742. Prisoners were offered a free telephone card (at least $5 weekly) during the first lockdown to help them stay in touch with family/whānau, a policy which continued for prisons not allowing in-person visits. 'Welcome packs' containing snacks and activity sheets were provided in each cell.

743. Education teams around the country arranged educational activities for prisoners at their sites. In addition, activity booklets were created and printed centrally, and by August 2021 at least 18 different activity booklets had been distributed to prisons nationwide.

110 See, for example, Corrections factsheet 'Prisoner Health and Wellbeing AL1-4', dated 18 December 2020.

Ongoing staffing shortages

744. At the time of writing (February 2022), most COVID-19 restrictions in New Zealand had been lifted, though it was still a requirement to isolate for seven days after returning a positive COVID-19 test. However, the shortage of custodial staff continued to have an impact at most prisons. We have observed that many prisoners are still experiencing restricted time outside of their cells, and that some prisoners continue to have difficulties accessing health services due to a lack of custodial staff for escorts. We have also observed that there are longer than usual wait times for programmes such as drug treatment programmes.

745. We acknowledge that the COVID-19 pandemic has exacerbated existing challenges with recruiting and retaining staff. For example, border restrictions prevented overseas applicants from entering New Zealand which impacted upon custodial and health staff recruitment programmes. However, the impact of the continuing restrictions on prisoners' wellbeing is not yet fully understood.

Summary

746. In its response to the COVID-19 pandemic, Corrections put in place a set of highly restrictive measures that aimed to prevent illness and death from COVID-19. With no prisoner deaths due to COVID-19 during the review period, and few people requiring hospitalisation, this approach was effective in preventing illness and death from COVID-19. The work of prison staff in implementing this approach must be commended.

747. However, the restrictive measures meant many prisoners were subjected to prolonged periods of isolation, with loss of social support, loss of purposeful activities, and reduced opportunities for rehabilitation. Evidence suggests that the unintended consequences of the restrictions have had a detrimental effect on the mental health of many prisoners and may have contributed to an increased risk of suicide or self-harm for some.

748. Corrections attempted to mitigate the impacts of the restrictions with the introduction of technology, and more flexible approaches were used at some sites. These mitigations were beneficial and should be continued and implemented at other prisons where possible.

749. Many prisoners are continuing to experience restrictions due to ongoing staff shortages; the possible long-term impacts of these restrictions are not yet fully understood.

Areas for consideration: Impact of COVID-19

53. Corrections must continue its review of its response to the COVID-19 pandemic to ensure learnings (particularly in relation to the quarantine of prisoners and the impacts of the restrictions on isolation, lack of contact with family/whānau, access to healthcare, and access to meaningful and constructive activities) are planned for in the event of a future pandemic, or other significant and prolonged restrictions on access by family/whānau, lawyers and other professionals, and volunteers.

54. Corrections should consider building on the new technological and flexible approaches that were introduced as a result of COVID-19 (e.g. telehealth, virtual visits on laptops, additional use of AVL, and more flexibility with timing of virtual visits).

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Appendix A – Additional demographic and statistical information

Figure 11: Numbers of people involved in a self-harm threat to life incident in New Zealand prisons, by financial year and custodial status (sentenced or remand)

Financial Year	Number of sentenced people involved in a self-harm threat to life incident	Number of people on remand involved in a self-harm threat to life incident	Total number of people involved in a self-harm threat to life incident
2016/17	5	15	20
2017/18	7	16	23
2018/19	10	20	30
2019/20	15	43	58
2020/21	4	23	27
TOTAL	41	117	158

Figure 12: Method used for self-harm threat to life incidents in New Zealand prisons from 1 July 2016 to 30 June 2021

Method	Number of Self-Harm Threat to Life Incidents
Ligature	161
Laceration	54
Other	14
Swallows items	8
Head banging	5
Suffocation	5
Overdose	4
Inserts items into body	2
TOTAL	253

Figure 13: Self-harm threat to life incidents in New Zealand prisons, by prison site, from 1 July 2016 to 30 June 2021

Prison site	Number of self-harm threat to life incidents
Arohata Prison	1
Auckland Prison	29
Auckland Region Women's Corrections Facility	37
Auckland South Corrections Facility[111]	1
Christchurch Men's Prison	45
Christchurch Women's Prison	21
Hawkes Bay Prison	13
Invercargill Prison	7
Manawatū Prison	6
Mt Eden Corrections Facility	25
Northland Region Corrections Facility	12
Otago Corrections Facility	7
Rimutaka Prison	20
Rolleston Prison	0
Spring Hill Corrections Facility	14
Tongariro Prison	1
Waikeria Prison	11
Whanganui Prison	3
TOTAL	253

[111] Auckland South Corrections Facility is operated by Serco New Zealand under a Public Private Partnership with Corrections and reporting of these incidents may be done differently.

Figure 14: Number of self-harm threat to life incidents individual people were involved in, in New Zealand prisons, from 1 July 2016 to 30 June 2021

Number of people	Number of self-harm threat to life incidents
126	1
14	2
7	3
4	4
1	5
2	6
1	7
1	10
1	11
1	17

Appendix B – ISU capacity and ISPT presence

Figure 15: New Zealand prisons at July 2022, showing Intervention and Support Unit capacity and whether an Intervention and Support Practice Team is present at the site

Prison	ISU Capacity	ISPT present
Arohata Prison	5	-
Auckland Prison	8	Yes
Auckland Region Women's Corrections Facility	14	Yes
Christchurch Men's Prison	16	Yes
Christchurch Women's Prison	2	Yes
Hawkes Bay Regional Prison	13	-
Invercargill Prison	2	-
Mount Eden Corrections Facility	27	Yes
Northland Region Corrections Facility	12	-
Otago Corrections Facility	8	Under establishment
Rimutaka Prison	24	Yes
Spring Hill Corrections Facility	16	-
Whanganui Prison	9	-

NB – Manawatū Prison, Rolleston Prison, Tongariro Prison and Waikeria Prison do not have an ISU.

Appendix C – Acknowledgements

The Inspectorate review team would like to thank:

- Staff from the Office of the Ombudsman New Zealand for their interest in and support of this work
- Tira Tūhāhā Prison Chaplaincy Aotearoa New Zealand
- The Corrections Information Centre team for their work on the literature review
- Maxwell Matenga for kindly providing the karakia
- Frontline staff who participated in focus groups
- All the other subject matter experts who gave us their time.

Appendix E – Corrections' Response

03 July 2023

Janis Adair
Chief Inspector
Department of Corrections

By email: janis.adair@corrections.govt.nz

Tēnā koe Janis

Re: Thematic Report – Apparent Suicide and Self-Harm Threat to Life Incidents in New Zealand Prisons 2016-2021

Thank you for sharing your draft report and providing an opportunity to respond. Whilst the theme of the report is sobering, you have clearly delivered on your commitment to inquire into this important area. We appreciate both the acknowledgement of the work Corrections has already undertaken since the review period, as well as the further areas to consider in strengthening our approaches to preventing suicide and self-harm among the people in prison.

Your report is informed by the experiences of real people, and it is a tragedy that they passed away whilst in prison. It is for these people who are facing mental health issues, and their friends and whānau, that we must strive to do better. We would also like to extend our sincerest gratitude to the staff who show up everyday and carry out their jobs with such care and compassion whilst at the forefront of such indelible circumstances.

As your report notes, Corrections is already making substantial efforts to prevent suicide and self-harm events in our prisons. This includes the development of an action plan to directly address these issues, as well as significant investments into mental health and addiction support.

You have made six overarching recommendations, all of which we accept. We consider that all the recommendations outlined are pragmatic and align well with Corrections' strategic direction. They also align well with work already underway to address suicide and self-harm within our environment. We also agree to consider all 54 areas for consideration outlined in your report.

Addressing the recommendations and areas of consideration will be a long-term undertaking which will be led primarily through collaboration between the Chief Custodial Officer and the Director Mental Health & Addictions. Our response will align closely with other related programmes of work, including work underway to respond to your recent thematic review into segregation. We therefore also intend to

work closely with the Chief Adviser System Transformation, who is overseeing the response to the segregation review.

Thank you again for your extensive investigation. We are grateful for the valuable recommendations that you have offered, and are also greatly encouraged to see the strong overlap between your findings and the work that we already have underway to address the issue of suicide and self-harm within our environment.

Ngā mihi nui

Dr Juanita Ryan
Deputy Chief Executive Health

Leigh Marsh
National Commissioner

2

Karakia Hiki Wairua

Takāia te mauāhara
Takāia te pare-kawakawa
Takāia ki te korowai aroha e

Takāia kia rongo te whānau i te mahanatanga
E mārakerake ai
E pūrangiaho ao te kitenga atu
I te tika, i te pono

E heru hapāinga ao te whānau
E noho nei i te pōkeao
I te ara pōharuharu
I te pō tē kitea ai te hua whakamua

Huraina te mauri a Rongo
E tau ai, kia wātea te whānau
Kia tūturu o whiti, whakamaua kia tina
Haumi e!
Hui e!
Tāiki e!

Wrap up the animosity
Wrap up the mourning
Wrap up the cloak of love

Wrap the cloak of love around the whānau so they feel the warmth
So that it is clear for the whānau left behind who are seeking answers

To lift the mana of the family who are beneath a dark cloud
On a rocky road
In a space where it was hard to find a way forward

Rongo prevail and be present
To restore peace, to clear any negative omens on the whānau
Bind together, tight and unbreakable
United ready to progress
Unite as one
Come together
As one

OFFICE OF THE INSPECTORATE
Te Tari Tirohia