

The National Study of Psychiatric Morbidity in New Zealand Prisons

Questions and Answers

How have prisons dealt with mental illness in the past?

Regional forensic psychiatric services were established following the 1988 Mason Report. Prison staff have had the responsibility for referring inmates who may have a mental illness to the prison medical services. Those services may in turn refer onto the forensic psychiatric services.

How will this change?

This practice will not change. The Department of Corrections is in the process of implementing enhanced assessment, induction and case management systems for inmates. This will improve the identification and management of suicide/self-harm risk/mental illness. There is also a review of the suicide/self harm form used in the immediate reception to prison. These should have positive future benefits relating to suicide/self harm issues with inmates.

Why has mental illness become such a problem in prisons?

We don't know that mental illness is more of a problem now than in the past. Since Corrections was set up at the end of 1995, it has been trying to build up a picture of the offender base. A survey of intellectual disability among prison inmates was done in 1997. We now know the extent of the problem, and the research gives a baseline upon which to develop improvements.

What will happen now to an inmate who has a mental health problem?

Inmates with mental health problems will go through the same process as in the past. If indicators are present, a referral is made to the forensic psychiatric services for assessment and, if necessary, treatment planning and provision. The case is then managed either within prison or in a secure in-patient setting (dependent upon the assessed individual's need). The treatment of inmates diagnosed as having a mental illness remains the responsibility of forensic psychiatric services. Release/reintegration plans are developed to incorporate other professionals involved in the case plan and to best address the ongoing management of the mental health needs and rehabilitation of the inmate.

Will prisons change systems to accommodate mentally ill patients?

Primary health services are provided through the Department of Corrections. The responsibility for the treatment of mentally ill patients who require specialist mental health services remains the responsibility of the health system. However the Department of Corrections will ensure continuous improvement of staff training in mental health through regional trainers and initial prison officer training programmes. Additionally there is a review of the effectiveness of the forms currently used to indicate suicide/self harm risk. This may result in improved policy, implementation and associated training. Corrections' Integrated Offender Management project is developing best practice systems to assess and manage offenders at all stages of their

sentence, which will increase the likelihood of picking up the mental health needs of inmates through more thorough assessment. Improved sentence planning and sentence management will assist in co-ordinating the treatment recommendations of the forensic psychiatric service.

All prisons will use Integrated Offender Management to conduct induction and assessment of all inmates. These assessments take into account the individual needs of each inmate and enable staff to place offenders in an appropriate group and provide the appropriate management for that inmate while in prison. This is assisted by the Integrated Offender Management System (IOMS), the Department's new computer system, which contains the records of all offenders who are or have been involved with the corrections service.

What's the procedure now when an inmate comes into prison?

Each inmate has an assessment, which includes a screening process to provide at an early stage an indication of the inmate's well-being and whether the inmate is "at risk". There are a number of questions asked including has the inmate ever seen a psychiatrist, or is there anything the institution should know so they can help the inmate. The prison's receiving officer is also required to note any pre-reception information about the inmate and any observations during the reception process that may give cause for concern.

If an inmate is identified as being at risk, then he or she will go onto a special management regime until a health professional can carry out a further assessment.

With these screening and assessment procedures, inmates with a diagnosed or suspected psychiatric disorder will be referred through prison medical and nursing staff to forensic psychiatric services for assessment and treatment. Some inmates are transferred to inpatient facilities. Others remain in prison but their treatment continues to be overseen by forensic services and managed by prison health staff.

Are the findings in the report surprising?

Anecdotal reports had indicated that the number of mentally ill inmates in prison was high and these results confirm that it is higher in the prison population than in the general population. This is not exactly surprising as the known risk factors for offenders are similar to the risk factors for mental illness. However, the estimated number requiring intensive treatment was higher than anticipated. These results are very similar to findings in recently conducted studies overseas, and this New Zealand information is comparable to international information.

Why is there no ethnic specific analysis in the Study?

This is recognised as a shortcoming. The study authors are intending to undertake further analysis of psychiatric morbidity by ethnicity and the Ministry of Health is discussing this with them.

What about the 135 people identified in the report as needing psychiatric treatment?

This figure is an estimate extrapolated out from the survey sample. Some of that number would have already been referred and would have been awaiting treatment. For ethical reasons we can't go back into the data to try to find those people, but if any inmate has demonstrated distress or disturbed behaviour, a referral to the forensic mental health services would have been made.

Will the forensic services be able to meet the needs of all the identified mental illness in prisons?

This research gives us excellent information about need and the extent of current unmet need. It is known that the forensic services at times are stretched in their ability to respond to demand. This evidence of need will be fed into the Ministry of Health and HFA's review of forensic services currently underway. This review, the first since the establishment of the forensic units in 1989, aims to identify areas that need expanding, updating and improving.

What problems do these illnesses cause in prisons?

Firstly they cause distress to the individual and may cause the inmate to isolate themselves from others. Secondly safety may be a problem. The safety first of the mentally ill inmate, the safety of other inmates, and the safety of staff particularly for the additional responsibilities they take on when managing an inmate with a mental illness.

The report shows clear links between drug and alcohol problems and mental illness. What changes will be made to lessen the amount of substance abuse in prisons?

Corrections has a drug strategy which links in with the Government's national strategy. Prisons have put huge effort in the past three or four years to stop the supply of drugs coming into prisons and to lessen the demand by offering treatment programmes. The use of drug dogs, random checks of visitors, criminal charges for visitors bringing in drugs to prison, random drug testing of inmates and regular testing of identified drug users in prison along with an associated penalty system has been implemented nationally. There are about a dozen drug free units in prisons, and an intensive drug treatment programme is currently being trialled and evaluated, with a decision expected soon on expanding the programme into other prisons. In addition substance abuse prevention is one of the intensive core programmes for high-risk offenders being developed as part of Integrated Offender Management.

What is being done to curb the suicide rate in prisons?

Since it was set up in 1995, a key priority of Corrections has been minimising suicide in prisons. It is important to note that the prison suicide rate is about half what it was 10 years ago. Actions taken to develop or enhance preventative measures include: suicide awareness training for staff; at-risk assessments for all inmates entering prisons; and active management of at-risk inmates including an observation regime and 'safe' cells designed to minimise opportunities for self-harm.

Reception forms now include questions relating to suicide/self harm. Assessment and induction processes through Integrated Offender Management include assessment of the risk of suicide/self harm, and any indications result in a referral to forensic psychiatric services and appropriate interventions.

All of these initiatives have been complemented by the set up of forensic mental health services following the 1988 Mason report.

How do the observation cells work and are they in all prisons?

Observation cells provide an environment to manage inmates who are at risk of harming themselves. They also maximise the ability of staff to monitor and manage at-risk inmates.

There are two types of observation cells: round room and general observation cells. A round room is a cell designed to provide a segregated environment for the management of violent inmates. The design of these cells minimises the risk of self-harm and injury to other inmates and staff.

A general observation cell provides a place for inmates exhibiting acute behavioural disorders that cannot be managed appropriately and safely in the prison mainstream. Staff can maintain regular observations of inmates' behaviour.

The Department is nearing completion of a \$5.7 million project to build 51 observation cells at prisons around New Zealand. New cells have recently been completed at Rimutaka Prison and Waikeria Prison and are in the design stage at Wanganui Prison.

What positive changes for inmates with mental health problems have been made over the past few years?

Since the Mason Report was released in 1988, forensic psychiatric services have been established regionally through the country. This service provides 'outpatient' services (assessment and treatment) plus secure treatment facilities for those requiring intensive treatment.

Changes have been made while this research was being done. The Department of Corrections has increased its focus on rehabilitation and treatment according to an inmate's needs, and taken a tougher line on the monitoring of drug use in prisons. Through its Integrated Offender Management project Corrections is placing much more emphasis on better induction, assessment and management of inmates, alongside interventions targeted to offenders' treatment needs. In addition earlier this year it was agreed to place a forensic psychiatric nurse for four days a week at each of Mt Eden and Auckland Prisons, which both have special needs units for inmates unable to be managed in the mainstream prison environment.

How will inmates with mental health problems be supported in the community when released?

For those with identified mental health needs, the forensic psychiatric service should provide referrals for ongoing community support. While this is the responsibility of the forensic psychiatric service, the Department of Corrections would support this through

its own processes. As part of the Integrated Offender Management project the Department looked at linkages to post-release support for inmates and reintegrating them into the community.

Do we know if the majority of these problems develop while people are in prison, or are they pre-existing?

We don't really know, but it appears that some inmates will have a mental health condition before coming to prison which was not detected before their arrival at prison. It is also likely that for some inmates, mental illness manifests itself while in prison.

What cost is associated with prisons dealing with mental health problems?

The operating cost of general health services in prisons nationally is just under \$2 million, plus the Department employs 70 FTE health service nurses and it employs doctors on contract, however it is not possible to separate out the cost of services associated with mental health problems from the general health service costs. In addition the Department's Psychological Service has about 70 psychologists providing services to inmates and offenders on community-based sentences.

Is there a typical prisoner profile more likely to suffer mental illness?

The report does not provide an in-depth profile of a typical inmate likely to suffer from mental illness. It does however indicate that women inmates showed the highest incidences of mental illness and substance abuse, followed by remand males then sentenced male inmates. The clear exception to this pattern is the lifetime prevalence of alcohol and cannabis where male inmates (both sentenced and remand) showed a higher prevalence than women inmates. There was little difference in personality disorders between women and men.

What interface is there between mental health services and prisons?

At the national level there is a formal agreement for the provision of services between Corrections and the health services. At an operational level, there have been examples of prison nurses doing placements at forensic psychiatric services and of forensic psychiatric services providing training for prison staff. Additionally, at Mt Eden and Auckland prisons forensic psychiatric nurses have been placed in the prison.

General questions on New Zealand's mental health service

What is a forensic patient?

Special (or forensic) patients are a small group of individuals who have entered the mental health services via the Courts and, for the most part, have been charged with serious offences. There are less than 80 special patients currently under care in New Zealand. Special patients are under the care of the forensic mental health service and usually under 24 hour supervised care.

How have our mental health services changed?

New Zealand's mental health services have changed considerably since the 1970s. Mental health service delivery has changed from a primarily institutionally based focus to include significant elements of community based care; there is a multi-disciplinary team approach given in care with a strong focus on rehabilitation supporting people to function as fully as possible as members of society.

The Mental Health (Compulsory Assessment and Treatment) Act 1982 now means that compulsory treatment is done within a framework which monitors patients rights and ensures appropriate informed consent where possible.

How does New Zealand compare with mental health services overseas?

New Zealand compares favourably with other similar nations and shares many of the same problems.

There are now some excellent and innovative mental health services in New Zealand gaining recognition for being at or near the leading edge in, for example, consumer and cultural (Māori) participation.

Up-skilling the workforce as well as attention to recruitment and retention issues remains an urgent priority.

Who gets treated for mental illness in New Zealand?

Mental health services don't operate in a vacuum. Primary health and other health specialist settings also deal with mental health problems e.g. paediatricians working with children with attention deficit/hyperactivity disorder (ADHD). Services prioritise people who are seriously ill or have the highest support needs i.e. people who can't get the help they need in any other setting.

How much do we spend on mental health services?

Funding for mental health services has increased steadily since 1993. Between 1993/94 and 1997/98, real expenditure on mental health services increased from approximately \$274M to \$475M, excluding GST. Steady increases are due to baseline growth, specific funding allocated by the Government to support implementation of the mental health Strategy from 1994/95, reprioritisation by the HFA and the Mason funding from 1996/97 onwards. Transfers from the Department of Social Welfare (DSW) in 1995/96 also contributed to this growth with the shift in responsibility for funding psychiatric disability services to the health sector. The DSW transfers did not represent service growth.

Funding for mental health services will increase steadily on the Mason funding path to 2000/01. From 2001/02, funding is expected to increase in line with increases in baseline health funding.

What is being done to upskill the mental health workforce?

There has been an increase in the number of training places for mental health workers, but more needs to be done. Examples of increases in training in mental health:

“ *support workers in mental health* ”

A national certificate for mental health support workers was established and launched last year (1998 - CHECK). In 1998 there were 97 students undertaking the national certificate. One programme is specifically targeted for Māori support workers. This year (1999) there is expected to be 300 students taking this training.

“ *post -graduate mental health nursing* ”

There are significant workforce development issues for mental health nursing particularly in areas of developing and retaining nurses. There has been a reported increase by 24% in the number of registered nurses working in mental health (1994-8). A three year pilot programme for new graduate nurses wanting to enter mental health is currently nearing completion. Also Capital Coast Health in partnership with Whitihera Community Polytechnic provided a one year full time programme for 45 new graduate nurses. The success of this programme resulted in similar programmes being offered nationally.

In 1996 the Clinical Training Agency (CTA) made funds available to pilot two programmes for advanced mental health for nurses. The first courses were provided by Victoria University and the Northland Polytechnic. Since the pilots there has been significant expansion of these programmes.

“ *post-graduate certificate in forensic psychiatric care* ”

There remain too few trained health professionals in this area. A programme has been designed to meet the recommendations from a 1988 inquiry into psychiatric care. The programme was delivered from three sites but there remains variations in programme content and in providers releasing staff for training. In 1996 19 equivalent full time training places (EFT) were funded through education and 6 EFTs through the CHE sector. In 1998 the total being funded was 28.32 EFTs.

“ *dual diagnosis training* ”

As recognition for the issues regarding management of consumers with a moderate to severe mental disorder and a coexisting drug or alcohol, in 1998 the CTA funded 90 places in Dual Diagnosis training.

How well are we doing?

The recent review by the Mental Health Commission of the National Mental Health Strategy showed that since 1994, service growth has been dramatic and continuing. Expenditure in mental health has risen 75 percent and there has been:

- a 53 percent staff increase in community mental health services for adults, (467 full-time positions)
- a 105 percent increase in high dependency community residential beds, (709 beds)
- a 107 percent increase in the number of people accessing the new and improved anti-psychotic medication now available, (2097 people)
- a 22 percent increase in psychiatrists, (46 full-time positions)
- a 25 percent increase in child and youth service staff, (67 full-time positions)
- a 38 percent increase in NGOs providing kaupapa Maori services, (from 23 to over 60).

The number of Hospital and Health Services employing consumer advisors has risen from two to 13.

The Mental Health Commission also found that there was **still much to do**. There are still many issues to be tackled including staff shortages, recruitment and retention difficulties, insufficient funding and discrimination. Mental Health has received generous additional funding, but came from a very poorly resourced position. Further additional funding is still needed to ensure the strategy's targets are met.