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Practice

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DEPARTMENT OF CORRECTIONS
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Editorial

Taking action for a healthier future

The Department of Corrections has always invested in primary health services, with increasing emphasis on mental health services and alcohol and drug treatment. These services have been delivered alongside support from regional forensic mental health services operated by district health boards.

The August 2016 Practice Journal (Vol 4, No 1) gave a summary of an important piece of research into comorbid substance abuse and mental health disorders amongst prisoners. Unsurprising to those working in correctional practice, the study reflected that the prevalence of mental health disorders was very high, with 91% of prisoners reporting a diagnosis of any mental disorder over their lifetime, and 62% reporting a diagnosis in the last 12 months.

Building on this and other research, in recent years Corrections has been doing more for offenders with mental health needs. This issue of the journal reports on some key initiatives in this area.

Joanne Love and Rachel Rogers lead the way with an article on Corrections' *Intervention and Support Project*. The article highlights some startling statistics on self-harm, and examines overseas suicide and self-harm prevention, before introducing us to the high level design for the Model of Care that will support new ways of working with some of the most vulnerable people in our care.

Gilbert Azuela's article *The development of Mental Health and Reintegration Services* highlights the relationships Corrections is building with our service providers (Emerge, Pillars, Pact, and Rural Canterbury and WellSouth Primary Health Organisations) through our Chief Executive Governance Board and the Service Development Working Group. Another highlight is the stories people in our care can tell about how our clinicians and counsellors are changing their lives. Sonia Barnes shares the findings of the preliminary *Evaluation of the Improved Mental Health Service*, and reveals that "offenders and staff involved with the service were overwhelmingly positive about its value for improving offender mental health".

Improvements recommended in referral processes and triaging can only make the services more effective. Jill Bowman, in the *Evaluation of the counsellors and social workers services*, identifies that services are working as intended, with the referral process highlighted as a strength.

Consideration of health and well-being moves beyond prisoners to focus on staff with Mike Cosman's article *The journey to achieve a safer and healthier workplace*, and Alan Walmsley's article reports on the *Physical Readiness Assessment*. A telling quote from one staff member reads "I thank the department for helping me become a healthy version of me. Good for me, great for my family and more importantly I am more able to assist my work colleagues in a time of need" – evidence that Corrections' focus on health and safety is not only vital for business, but good for individuals and their whānau as well.

"Health" people will always find something that resonates in articles that are not about health at all! Ashley Shearer's piece on the Duke of Edinburgh Awards is a good example; the tenacity of the young men in our Youth Units as they complete the physical requirements for the award can only be commended.

A focus on health and well-being may be a useful way to reintegrate gang members, or are family and intimate relationships the key? Read Armon Tamatea's article on gangs and reintegration to find out more.

There are, as always, some excellent contributions by the research team – check out *Employment needs post-release: A gendered analysis of expectations, outcomes and service effectiveness* by Bronwyn Morrison, Marianne Bevan, and Jill Bowman, or John Locker and Bronwyn Morrison's *The parachute problem: negotiating the ups and downs of Randomised Controlled Trial use in criminal justice settings*. Their conclusion: "Alternative methods (to randomised controls trials) can and do provide sufficient (or better) evidence about 'what works'". From a health perspective that really works for me.

Happy reading and be healthy out there!

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Intervention and Support Project

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Joanne started at Corrections in September 2017 as Clinical Adviser for the Intervention and Support Project. Her professional background is mental health nursing, having worked in crisis teams, as a police watch house nurse, a clinical nurse specialist and in psychiatric liaison roles. Her Master of Nursing thesis was around the recognition by police officers of mental illness in detainees.

Rachel started at Corrections in August 2017 as Senior Adviser for the Intervention and Support Project. Her background is in community safety and emergency management. Rachel has worked in the Victorian Fire Service and New Zealand local government in a range of hands-on and managerial roles. Rachel has a Master of Arts in Psychology focused on behaviour modification, as well as post-graduate diplomas in community safety, and emergency management.

Introduction

Evidence suggests there are more people with mental health and addiction problems in prison than ever before. In some instances, being in custody can exacerbate and cause mental health difficulties and heighten the risk of those who are susceptible to self-harm and suicide. Funding was successfully sought to 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. The MoC is a whole of prison approach that will help strengthen those individuals, allowing them to fulfil their potential and reducing self-harm and suicide.

The Intervention and Support Project team (hereafter referred to as "the project team") undertook a series of literature reviews, qualitative interviews and site visits to investigate self-harm, suicide and the management of these conditions within prisons. The intent was to determine the themes that need to be addressed when creating a MoC. The High Level Design MoC was completed in April 2018 and the process of detailed design and recruitment of new teams is underway.

Background

The Department of Corrections recently completed two reviews which were precursors to the Intervention and Support Project. Jones' (2017) review of *Suicide in New Zealand Prisons 1 July 2010 to 30 June 2016* and Alleyne's (2017) preliminary review entitled *Transforming intervention and support for at-risk prisoners* were used to underpin the Intervention and Support Project. Alleyne's (2017) review revealed that Corrections is managing more people with mental illness than ever before and recommended that a new MoC be developed to improve the intervention and support to people with self-harm and suicidality. Alleyne's review supported that workforce development, screening, multi-disciplinary teams, social connections, improved physical environments and prison culture should all be addressed collectively to improve prisoner mental health and well-being outcomes.

From an international context, the WHO report *Preventing Suicide in Jails and Prisons* (2007) stated that work is required to reduce suicide and increase mental well-being in prisons. The report recommends that prisoners should receive the same level of health care as they would receive in their wider community. In acknowledgment of this, the project team looked at how to use evidence-based best practice in the provision of mental health care in New Zealand's prison system.

Self-harming behaviour in New Zealand prisons: a review of the data

Deliberate self-harm is the term given to a range of behaviours where people try to hurt themselves on purpose but do not intend to die. The major point of difference between suicide attempts and self-harm is the intent to die.

The project team reviewed the data and identified trends in self-harming behaviour in New Zealand prisons. While there has been exploration around suicide, there is less research around self-harm in correctional settings. It is estimated that for every suicide there are 60 incidents of self-harming behaviour (McArthur, Camilleri & Webb, 1999). The 39 deaths, believed to be suicide, between 2010 and 2016 (Jones, 2017) led the project team to consider that there

may have been 2,340 instances of self-harm within New Zealand prisons during the same timeframe. A review of the Corrections Integrated Offender Management System (IOMS) for the same period showed 2,051 reported instances of self-harm, which reflected the estimated findings reasonably closely.

In New Zealand, the number of prisoners who engage in self-harm has remained stable with minor fluctuations from year to year. However, the number of times each individual engages in self-harming behaviour varies dramatically. The majority of reports involve an individual with a single self-harming event, significantly dropping for those who self-harm twice. At the extreme end of the scale, one single individual was responsible for 103 reports of self-harm between 2010 and 2016.

The number of reported instances of self-harm peaked in 2011 and declined in 2013 and 2014. Since 2014, reported occurrences have been steadily rising. Remand prisoners, newly sentenced prisoners, and prisoners new to prison are at increased vulnerability for suicide and self-harming behaviour. It should be noted that the prison population rate is increasing at a much faster rate than the reported self-harming rates.

A review of the time of day of reported self-harm incidents showed most instances occurring during daylight hours, with less occurring overnight. This was at odds with international literature highlighting night-time as a high risk period.

Figure 1:

Frequency of prisoner self-harming 2010 and 2016 (From COBRA)

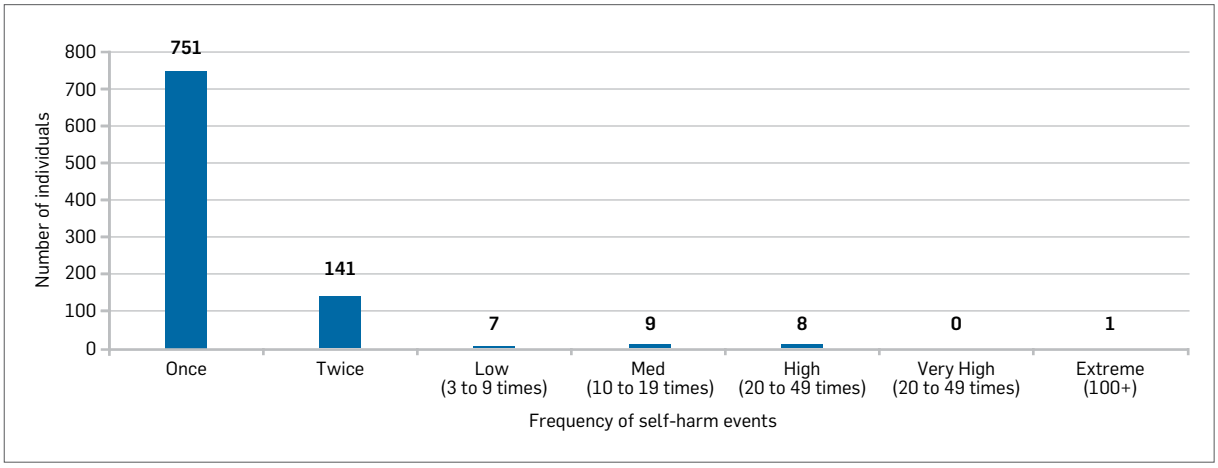
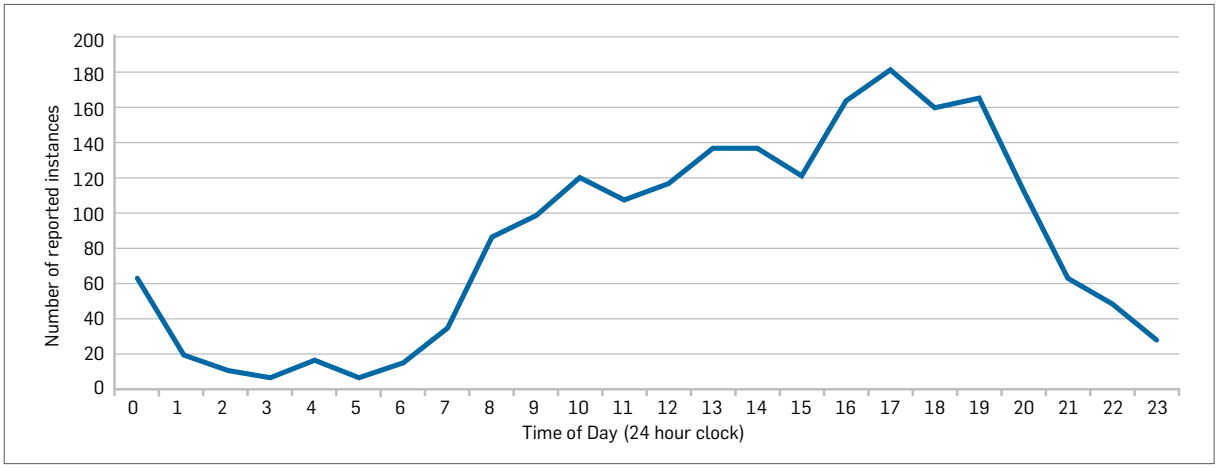


Figure 2:

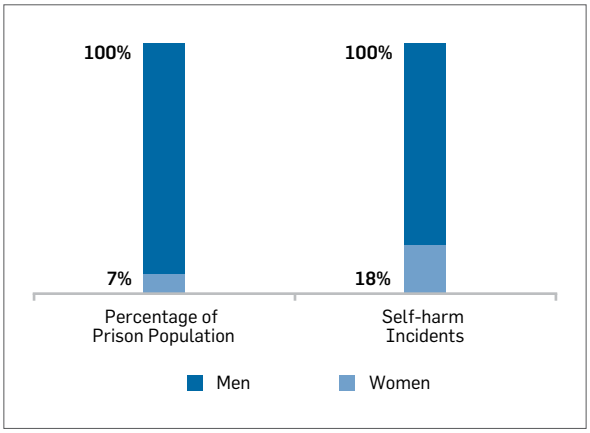
Reported instances of self-harm in New Zealand prisons by time of day for the period 1/7/2010 to 30/6/2016 (From COBRA)



Female prisoners are overrepresented in the statistics. Women make up 7% of New Zealand's prison population but account for 18% of the reported self-harm instances.

Figure 3:

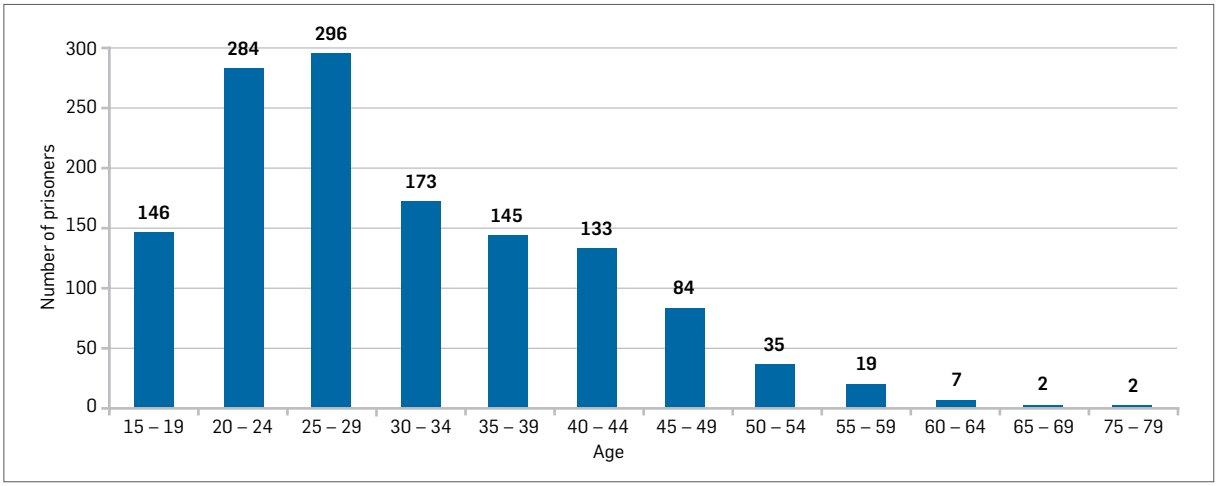
Self-harm Incidents: Comparison between male and female prisoners between 2010 and 2016 (From COBRA)



Age is also a factor, with the majority of self-harmers in New Zealand prisons aged between 20–29 years.

Figure 4:

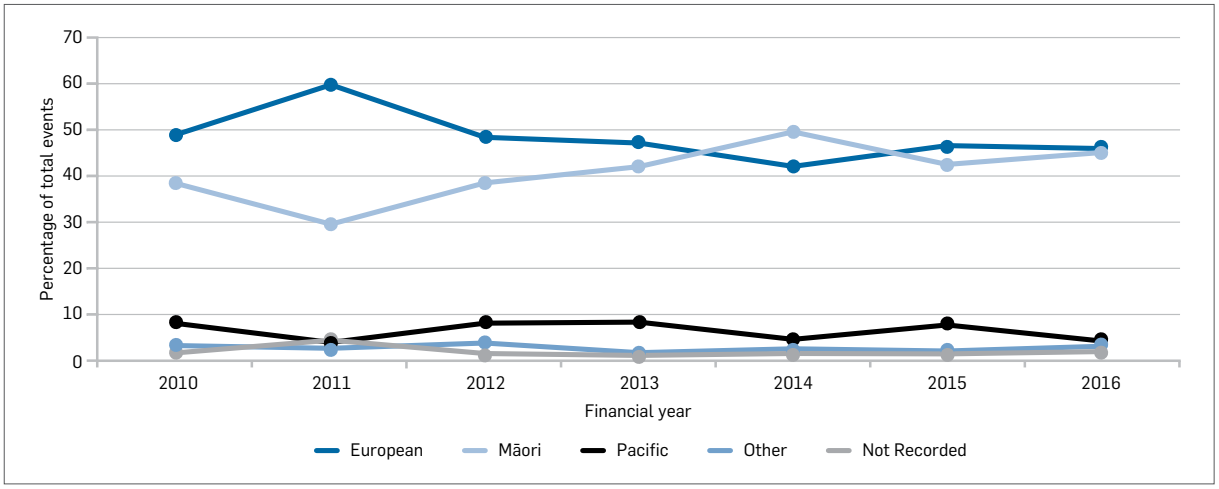
Number of self-harm events by age between 2010 and 2016 (From COBRA)



There are differences in the rate of self-harming by ethnicity, with the gap between European and Māori decreasing. While the data shows we have a higher percentage of Māori in the prison population, the instances of self-harming behaviour are less for Māori but trending slightly upwards (compared to their European counterparts).

Figure 5:

Percentage of self-harm incidents between 2010 and 2016 by ethnicity (From COBRA)



A review of offender cell/prison movements shows that the average number of cell movements is higher for people who self-harm than people who do not self-harm. The average number of prison transfers is also higher for people who self-harm, as is the number of unit transfers within a prison. Prisoners who self-harm transfer between units and between prisons at a rate double that of those who do not self-harm. While we cannot infer causality from this data, there would appear to be a connection between self-harming behaviour and cell movements.

These findings regarding ethnic and cultural diversity, age, gender, as well as prisoner classification will be taken into account by the project team in the development of the detailed design of the MoC.

International review of literature and guidelines

The project team carried out an international literature review to examine strategies that reduced distress, self-harm and suicide in prisons and correctional settings. The results validated Alleyne's (2017) review findings that the following areas warrant attention:

- workforce development
- screening
- multi-disciplinary teams
- social connections
- improved physical environments
- prison culture.

Some additional themes also emerged which included:

- use of a "stepped care approach" in the treatment of mental health issues
- the importance of mental health triage
- individualised care plans
- increasing prisoner resilience and health literacy
- reducing stigma around mental illness
- increased information sharing pathways.

In addition, the evidence suggested that being placed in custody can exacerbate mental health difficulties (Plugge, Byng, Bentley, Moore, Czachorowski, McColl & Jones, 2016) and heighten the risk of those who are susceptible to self-harm and suicide. This suggests that greater emphasis is required on the prevention of mental illness in prisons, to ease future pressures on the individual, whānau, prison systems and society as a whole.

Australian research highlighted a novel approach to the issues around suicide in a series of articles named *A Situational Approach to Suicide Prevention* (Ashfield, Macdonald & Smith, 2017). The authors suggest society needs to approach suicide awareness and prevention from a social perspective (as opposed to emerging from a sole focus on mental illness) in order to achieve better outcomes. Their studies support that situational or psychological distress are predominant in completed and attempted suicides and that to work towards identifying this distress, rather than **solely** searching out mental illness would be a more effective strategy.

The above article illustrates that the language services use may discourage people from seeking and offering help; that communities will not make it their business to seek or work with mental **illness**, as it is seen as the responsibility of health professionals. Alternately, these communities may find supporting someone with a mental health "**difficulty**" more achievable. This perspective on the situational factors that can lead to suicide seeks to normalise distress at life events. It acknowledges at times there will be professional help and medication required but not to the global extent we have now. This series of articles suggest that society has a tendency now to equate distress with signs of mental illness when in fact this may not always be the case. The project team endorse these findings and recognise that identifying psychological distress **as well as** mental illness, previous and current self-harm and "risk to self" history is of paramount importance in the prison setting.

"At risk" units: Interviews with staff and prisoners

The project team visited nine prisons between August and December 2017. During these visits semi-structured qualitative interviews and informal discussions took place. These interviews included custodial staff, health centre staff, forensic mental health staff and a range of prisoners (remand, convicted, male and female). The purpose of the interviews was to discuss "at risk" units (ARUs), their operating procedures and ways in which Corrections could improve the delivery and quality of care.

Prisoners described screening processes for suicidality and mental illness as archaic and a "tick box" exercise that is easy to "fake", having learned how to answer the questions so as not to identify as "at risk". These prisoners believed that admitting to suicidal ideas would weaken them in the eyes of other prisoners and brand them as "mental" or "psycho", leaving them more vulnerable than before the disclosure.

If placed in an ARU, prisoners were divided over the need for anti-ligature bedding and clothing. In general, prisoners understood the need for the anti-ligature gowns (to keep them safe) but all of the prisoners interviewed considered the gowns to be uncomfortable, ill-fitting and dehumanising. Prisoners could also understand the initial removal of underwear, whilst in the high risk anti-ligature cells. However, for female prisoners in particular, this was found to be excessively humiliating.

Prisoners proposed that having trained mental heath professionals working at reception with staff to complete the "at risk" screening assessments would enable more detailed, knowledge-based interviews resulting in increased quality of information and engagement.

Once placed in "ARUs", prisoners said they were extremely bored, saying in hindsight they would have been better off not declaring themselves "at risk" or suicidal, where they are stripped of their belongings and placed in a bare cell with no TV and nothing to do.

> *"No activity is bad. You can't occupy a fragile mind. You need something to do both in the At Risk Unit and in general population. If you weren't mad when you went in you would be when you came out; staring at four blank walls with nothing to do for 23 hours a day!"*
>
> **Prisoner A,** Rimutaka Prison

Prisoners also reported that exercise and the ability to undertake work were important aspects to address in their recovery that they had no access to currently in ARUs.

> *"Being able to work would help. It means a lot to me, the thought that I am giving back to society when I work. It wouldn't work for everyone but it makes me feel good about myself."*
>
> **Prisoner B,** Rimutaka Prison

Prisoners also described the importance of hope and how lack of hope for the future made life seem desolate. One prisoner recounted how, through art and sewing, he was able to hope for the future. Every night he would lie in his cell and plan what he would draw and sew the next day. It was the hope of creativity that gave meaning to his life and helped him work through suicidal ideation. He recounted how, whilst in the ARU, he was unable to draw or sew because he'd had all articles taken from him. This removed his only hope.

Model of Care

A MoC describes the way health services are delivered. It outlines best practice in care and services for a person as they progress through stages of health or illness (Agency for Clinical Innovation, 2013).

The Intervention and Support MoC was created using the principles of the United Kingdom National Institute of Care Excellence guidelines (2017), which provide the highest level of clinical based evidence. The use of a "stepped care approach" (Ho, Yeung, Ng & Chan, 2016) was chosen to underpin the process as it allows for a smooth transition between levels of intensity of treatment. This approach also allows resources to be pooled together to target care where and when it is required.

The new MoC will "dovetail" with current services (i.e., primary mental health delivered by health centre nurses, medical officers, mental health clinicians and forensic mental health services) to create new ways of working with staff and external agencies that support people reintegrating and engaging with

community health providers. The MoC will introduce Intervention and Support Practice (ISP) teams to be based at the three pilot sites. These multi-disciplinary teams will be comprised of mental health and cultural assessment professionals, who will screen, assess and treat people with moderate to severe mental health conditions (including self-harm and suicidality) and provide services for those people who do not fit the "mild to moderate" cohort and are below the threshold for criteria for forensic mental health services. The MoC can be conveyed through the following themes:

Screening and assessment

Reception risk and mental health screening tools are being reviewed for sensitivity, specificity and suitability. The newly created ISP teams will carry out mental health triage and intake assessments. Addiction withdrawal support and cultural assessment will be incorporated into these assessments as required. Support for a prisoner identified as vulnerable to self-harm or suicide will be identified and treatment accessed using a "stepped care approach" adjusting the level of intervention and support as their needs change. Part of the outcome of the intake assessment will be referral to other providers as appropriate, e.g. primary mental health, social work, psychology or forensic mental health services.

Stepped care

The UK Royal College of Psychiatrists recommends a "stepped care" approach to mental health care allowing earlier access to services for people at risk of self-harm and suicide (Georgiou et al., 2016). Although there is evidence that not all people who suicide are mentally ill, a "stepped care" approach to mental health assists in starting dialogue with people about their social connections, mental health, stressors and coping strategies. The "stepped care" approach acknowledges that people have the ability to manage their own health and well-being and it is the role of health services to coach people to grow this ability. It can be argued that health services should not be alone in this task and that social and government agencies have a part to play in supporting this. This would appear to be in keeping with the previously mentioned situational approach to suicide prevention where it is argued that society as a whole has a part to play in preventing suicide in communities.

In its infancy, the "stepped care" approach described pathways in primary care for people with depression and anxiety, but it has been shown to work in many areas of mental health (Ho, et al, 2016). A "stepped care" approach to mental health services will support the right level of intensity of services, in the right place, at the right time, by the right people.

Individual Care Plans

Individual Care Plans will be tailored to the needs of the prisoners, and will be developed using the Intervention and Support Decision-making Framework. This framework will provide guidance on how to identify and manage specific risks, including best unit placement, clothing, bedding, and access to activities. Management of people vulnerable to self-harm or suicide in mainstream units with appropriate support will be the preferred option. The ISP team will consult with the patient and the multi-disciplinary practice team (e.g. custodial staff and case managers) and will review the individual's needs on an ongoing basis with adjustment to the Individual Care Plan as their needs change.

Individual Care Plans will also take into account the small number of prisoners who require a more intensive care plan. These plans will cater for the very complex cases and involve a greater level of multi-agency coordination and input.

Multi-disciplinary practice

The project team has investigated accountability pathways in multi-disciplinary practice and from this work developed guidelines for Multi-Disciplinary Practice (MDP) within prison settings. These guidelines will address membership, operating structure, identify roles and accountabilities for members, and outline a clear decision making process. Cultural assessors and other specialised supports will be included as part of the MDP approach to address the needs of the individual.

A strong emphasis will be placed on multi-agency partnerships, in particular between Corrections and forensic mental health services. This is to ensure that problem behaviours that shift between active mental disorder and personality disorder do not go unaddressed by virtue of failing to meet threshold criteria at a given time.

Intervention and Support Units

ARUs will become Intervention and Support Units (ISUs). The project team investigated therapeutic environments in the context of mental health, self-harm and suicide in prisons. Therapeutic environments refer to physical, social and psychologically safe spaces that are designed to be healing (Eliassen, Sørlie, Sexton & Høifødt, 2016). With ISUs, it refers to the physical environment and the manner in which we will conduct the business of mental health services, not only in our ISUs, but in prisons overall. There is acknowledgment in international literature of the need for correctional services to be transformed into "psychologically informed, planned environments" (Bantjes, Swartz & Niewoudt, 2017) with therapeutic communities that

target specific behaviours in an attempt to bridge gaps between therapy and custody.

The project team will work with ISU staff to identify areas that can become therapeutic spaces incorporating sensory modulation techniques that reduce distress. For example, techniques may include access to nature/plants, wall murals, bean bags, pet therapy and sensory trolleys.

It is envisaged the ISP teams will work in ISUs alongside custodial staff, giving ready access to professional and multi-disciplinary mental health support. It is planned that with the enhancement of the physical environments there will also be more opportunities for prisoners in ISUs to engage in meaningful activities, to get out of their cells, and to socialise with each other.

The use of anti-ligature bedding and clothing in ARUs and the restriction of articles "in cell" are currently being investigated for comfort, safety and suitability with the intention of improving the patient experience in this area.

The project team identified an opportunity in ARUs regarding the ability to mix prisoners with different security classifications. Currently, prisoners with different security classifications cannot mix, however, in some cases this could be done safely in the ARUs. An exemption is being sought to address this issue, allowing more "out of cell time" for people. This will encourage social connection and assist in reducing suicidal ideation and psychological distress.

Prisoner resilience

To build prisoner resilience, the project will introduce mental health literacy programmes. Prisoner peer support programmes and listener schemes are also being investigated. Evidence shows these programmes can be very helpful to distressed and suicidal people in custody. Care will be taken to ensure adequate supports and clear boundaries are in place allowing peers to carry out their duties in an appropriate and safe manner.

Collection, storage and sharing of data

The legal parameters of information-sharing protocols between health and custody will be further examined. The intention is to create safe information-sharing pathways that benefit the patients and recognise that custody staff require limited health data to support and inform care.

Preparing for the change

The MoC is a transformational change in practice for Corrections. In recognition of the size and scale of the change, support will be provided to pilot sites through change management activities. This will include targeted communications and training to prepare staff for the implementation of the new MoC and support to successfully embed it into business as usual practice. In preparation for this, the provision of staff training, staff capability and current training have been reviewed in the context of mental health and suicide awareness.

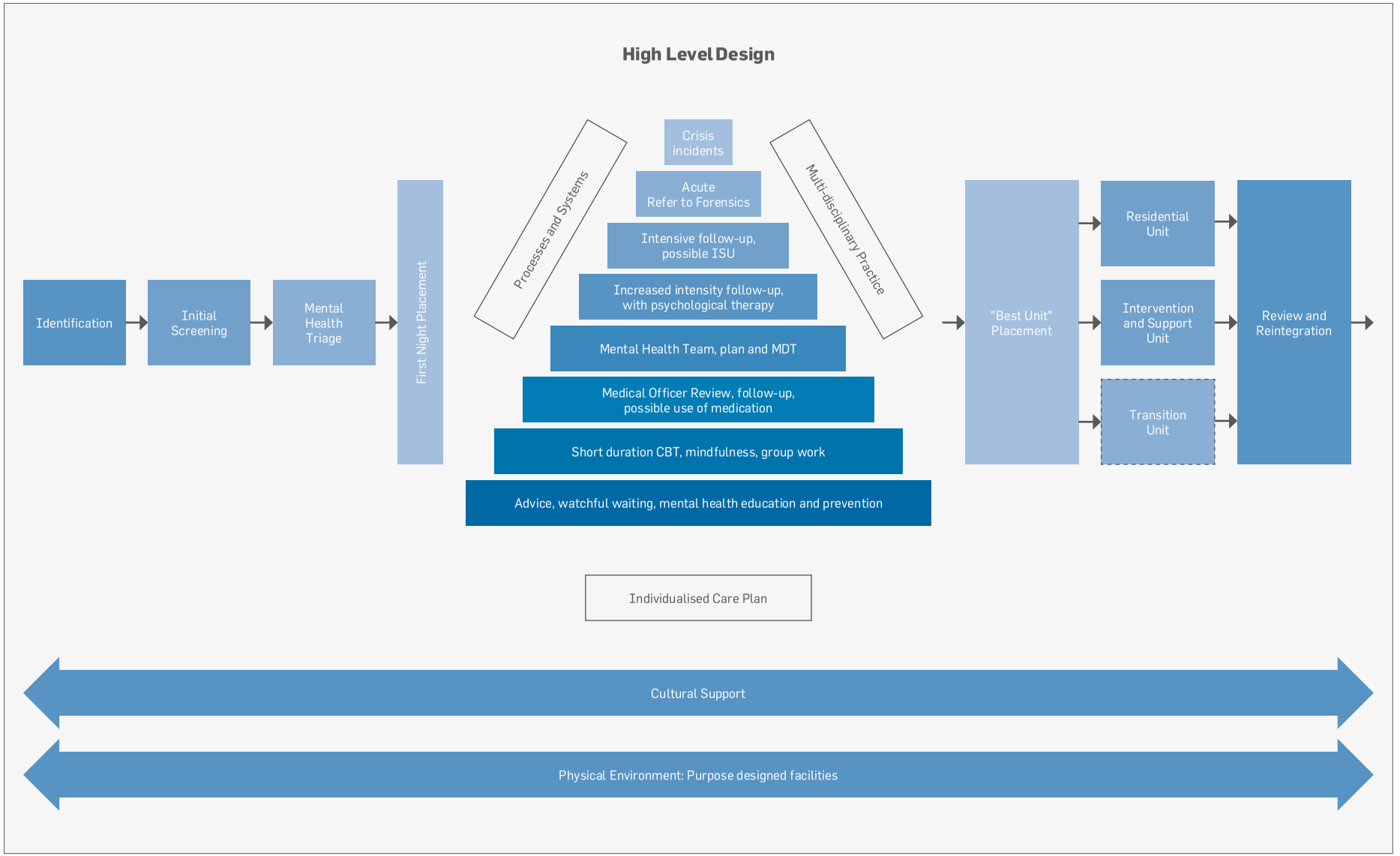
Corrections officers currently receive around 7.5 hours introductory training in suicide awareness; this includes how to conduct "at risk" assessments. Subsequent suicide awareness refresher training is 4 hours every two years. Currently, there is no specialised training or necessary staff qualification for staff to work in an "at risk unit." Staff recruitment and selection guidance is provided by Human Resources for High Risk Units and within this, for ARUs. The future plan will see all frontline staff receiving an introduction to mental health training with updated suicide awareness training. This will support staff in identifying and managing psychological distress with a view to reducing self-harm and suicide. Further specialised mental health training will also be provided for ISU custody staff. The introduction of professional supervision for custodial staff working in ISUs will also promote best practice in this area.

What's next?

The new MoC will be introduced at three pilot sites: Auckland Prison, Auckland Region Women's Correctional Facility and Christchurch Men's Prison. At the time of writing (May 2018) the ISP teams are being recruited. Following evaluation, the new MoC will be rolled out nationally.

The project team is currently working on the detailed design of the MoC, including:

- reviewing the use of current screening tools
- developing mental health triage and intake assessment procedures
- outlining what a therapeutic environment looks like in the prison context
- working with our key stakeholders, including Māori services, to ensure the detailed design is responsive to culture, age and gender.


High Level Design
Identification
Initial Screening
Mental Health Triage
First Night Placement
Processes and Systems
Multi-disciplinary Practice
Crisis incidents
Acute Refer to Forensics
Intensive follow-up, possible ISU
Increased intensity follow-up, with psychological therapy
Mental Health Team, plan and MDT
Medical Officer Review, follow-up, possible use of medication
Short duration CBT, mindfulness, group work
Advice, watchful waiting, mental health education and prevention
"Best Unit" Placement
Residential Unit
Intervention and Support Unit
Transition Unit
Review and Reintegration
Individualised Care Plan
Cultural Support
Physical Environment: Purpose designed facilities

Conclusion

The project team undertook a series of reviews of local and international evidence based practices to reduce self-harm and suicide in prisons. This included input from frontline staff and prisoners.

This work allowed the team to create a MoC for the delivery of prison-based mental health services in New Zealand prisons with the intention of reducing self-harm and suicide. The new MoC will be piloted at three prison sites, evaluated, and introduced to all prisons over time.

It is acknowledged that Corrections staff save lives every day, and work with many complex, troubled people in custody. The MoC will allow staff more flexibility to treat distressed prisoners as individuals with different needs. The model proposes that at times vulnerable prisoners can be supported in mainstream prison environments and that least restrictive practice will be more therapeutic for people's mental health in the long term. The model also supports an increase in therapeutic physical environments not only in ISUs but in the wider prison environment.

Corrections has a great opportunity to improve mental health and wellbeing for all people in custody in New Zealand The introduction of the new, whole of prison MoC will support a community of change in making mental health, self-harm and suicide everyone's business.

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Development of Mental Health and Reintegration Services in the New Zealand Department of Corrections

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Author biography

Gilbert Azuela is a Clinical Adviser at the New Zealand Department of Corrections, and part of the Mental Health and Reintegration Services (MHRS) team. He is responsible for the monitoring of key performance indicators and clinical quality standards of the MHRS programmes. Gilbert supports the successful implementation of these programmes across New Zealand's prisons and community corrections sites.

Introduction

Mental health disorders occur globally and have a severe impact on people's well-being (Kessler, Aguilar-Gaxiola, Alonso, Chatterji, Lee, Ormel & Wang, 2009). In New Zealand, the prevalence of mental health disorders is comparable to the rest of the world, with approximately 20% of the population meeting the criteria of mild to severe mental health issues (Oakley Browne, Wells & Scott, 2006).

Psychiatric morbidity in New Zealand prisons is higher than in the general population. In particular, conditions such as psychosis, major depression, bipolar disorder, and substance misuse and dependence are more common amongst prisoners (Brinded, Simpson, Laidlaw, Fairley & Malcolm, 2001). The health needs of prisoners and offenders are multiple and overlapping, and there is often a correlation between mental health, substance misuse and abuse, and other co-morbid conditions (Williamson, 2007; Bowman, 2016).

In 2015, the Department of Corrections commissioned an investigative study into mental health disorders and co-morbid substance use disorders amongst prisoners. The study showed a higher prevalence of co-morbid disorders among prisoners compared to the general population (Indig, Gear & Wilhelm, 2016). These findings evidenced the high need for treatment options within prisons, and suggested that mental health services have a significant role to play in the care and support of prisoners. With the aim of developing mental health services, Corrections explored funding opportunities.

In mid-2016, Corrections secured funding of $14m to increase access to mental health and reintegration services for the prisoner and offender population. The proposal outlined four pilot initiatives that would be delivered over a two-year period:

1. Improving Mental Health Service: mental health clinicians would be based in 16 prisons and four community corrections sites to increase mental health support to prisoners and offenders.
2. Wrap around family/whānau support service for identified prisoners and offenders.
3. Supported living service: transitional temporary community accommodation.
4. Counsellors and social workers in women's prisons.

Corrections sought interest from existing mental health service providers for added support in developing and delivering the services.

The four pilot services

1. Improving Mental Health Service

People presenting with mental health conditions are often seen in primary health care. The provision of qualified mental health clinicians to deliver evidence-based interventions to people presenting with mild to moderate mental health needs was an identified need. Clinicians were expected to be registered nurses, psychologists, or occupational therapists with a specialist background in mental health screening, assessment and evidence-based interventions. These clinicians were to be placed in 15 prisons and four community corrections sites. The number of prisons was expanded during implementation to include one additional prison that had been trialling a mental health service with an in-reach mental health clinician, making 16 prisons in total for this initiative.[1]

1 Auckland South Corrections Facility and Mt Eden Corrections Facility were excluded from the initiative as both sites already had primary mental health services in place as part of their model of care.

The emphasis of the service is to support prisoners and offenders to stabilise their mental health so they can better manage their sentences, participate in and maximise the effectiveness of rehabilitation programmes, engage in employment opportunities and manage the transition between prison and the community.

This service has an additional training and education component aimed at increasing the mental health knowledge and awareness of Corrections staff. This education component is an important facet of the service and includes supporting staff to understand the different presentations of people with mental health needs and useful techniques in managing people with mental health conditions. This education is delivered with the intention of increasing the capability and confidence of Corrections staff to work effectively with prisoners and offenders who present with mental health needs.

2. Wrap Around Family/Whānau Service

This service supports families/whānau of prisoners and offenders who currently engage with a mental health clinician through the Improving Mental Health Service. The Wrap Around Family/Whānau Service (WAF) worker engages with that person's family and links them with the necessary supports in the community. This service continues as the person transitions from prison to the community, and aims to improve the social, health and education outcomes of the whole whānau.

3. Supported Living Service

This service offers a 13 week transitional accommodation and support service for prisoners released to the Auckland and Hamilton area. The released prisoner must meet criteria that include a mental health or cognitive impairment that impacts on their ability to function independently in the community, ongoing health and treatment needs, and high and complex reintegrative needs. This service is designed to assist people in the initial stage of leaving prison by linking them to existing community resources, helping them to socialise and actively engage with the community, and to secure permanent and stable accommodation, employment, health services and financial support.

4. Counsellors and Social Workers in Women's Prisons

This service aims to improve female prisoners' wellbeing, reduce incidents of harm to self or others, and retain women's positive relationships with families. This service provides access to professional counsellors and social workers to address female-specific needs around trauma, victimhood, and family. These professionals equip the women with a greater variety of skills to cope with their lives in prison and upon release.

Implementation of the initiatives across prison and community corrections sites

Corrections decided to directly recruit and employ the counsellors and social workers for the women's prisons. This service commenced in November 2016 with one counsellor and one social worker per site, following an induction period that included Frontline Start[2] and a specific two-day "welcome to the new service". Guidelines to support practice were developed for the counsellors and social workers and their managers. Referral pathways and treatment modalities were not specified to allow a service to develop that could respond to the varied and complex needs of the women.

In contrast, a decision was made to contract out the other three initiatives. In August 2016, the Request for Proposal (RFP) for IMH and WAF went out to market, while the supported living service was a tender by invitation as Corrections had experience in working with providers on similar supported accommodation services.

Corrections awarded contracts to five providers with extensive experience and expertise in delivering services to people with mental health needs. The table on the following page represents the MHRS services delivered by region and provider.

2 An introductory course to working at Corrections for all staff working at the frontline.

Table 1:

Contracted Providers of the New Zealand Department of Corrections MHRS

Providers	New Zealand Regions	MHRS		
		Improving Mental Health	Wrap around family/ whānau	Supported Living
Emerge Aotearoa and Pillars	Northern Central	✓	✓	✓
PACT	Lower North	✓	✓	
Rural Canterbury Primary Health Organisation (RCPHO) and WellSouth Primary Health Organisation (WSPHO)	Southern	✓	✓	

The providers commenced their recruitment process following successful contract negotiations for 38 mental health clinicians and four WAF workers. However, there were challenges with recruitment over the four regions, in particular in the Northern and Central regions, and this resulted in an unanticipated delay to the start of some of the services.

The hiring of mental health clinicians was targeted to registered nurses, psychologists, social workers and occupational therapists. The focus was on employing clinicians with the ability to:

- conduct comprehensive mental health assessments
- formulate collaborative care plans
- provide evidence-based interventions.

Mental health clinicians must:

- have extensive mental health experience
- belong to a registered body
- have the ability to work collaboratively in a challenging environment.

All candidates had to be approved by Corrections to ensure their experience and skills matched contractual expectations. Corrections supported recruitment processes where possible.

In addition, the contracted provider began the search for appropriate housing to deliver the Supported Living service in Auckland and Hamilton. Securing appropriate housing introduced new challenges to the intent of the programme and ultimately Corrections was required to exclude some offenders (such as child sex offenders) in order to confirm housing in both regions.

The Supported Living service began delivery in June 2017 in Auckland and in November 2017 in Hamilton. The service supports offenders to prepare for their exit from Corrections oversight, and transition into the wider community. It facilitates ongoing access to various services, including health, treatment, employment, education, housing, welfare and family/ whānau reconnections.

In April 2017, the first of four planned induction workshops was held at national office in Wellington for the newly recruited clinicians, WAF workers, and support workers. The first part of the induction workshop was five days in duration, and had an emphasis on introducing provider staff to Corrections' operations and to the MHRS operational processes and design. Providers' managers joined their staff for these workshops, where they were able to gain an understanding of how Corrections works, in order to support their staff as the services commenced.

This induction was followed by site orientation as part of a comprehensive introduction to the Corrections' environment. Provider staff then returned to Wellington for the second part of the induction workshop. This workshop focused on reflections from their experience on site and aimed to forge valuable collegial relationships. When the induction was completed, the staff moved to their respective sites and began to deliver mental health services, WAF services and supported living services.

Multi-level collaboration between Corrections and providers

Building relationships and collaborative partnerships are important in developing and implementing mental health services (Magnabosco, 2006). The following were established to embed effective relationships between Corrections staff, their stakeholders, and the providers.

1. Mental Health and Reintegration governance board

The MHRS has an executive governance board responsible for monitoring performance and leading the direction of the services. This governance board consists of the chief executives and/or senior managers from the contracted providers and key people from Corrections. The governance board reviews key challenges and successes and ensures that the programmes' intent and purpose remain in focus. The governance board reviews recommendations on current best practice and considers trends both nationally and internationally that may have an impact, positive or negative, on the delivery and outcomes of the services.

2. Regional clinical governance

Clinical governance supports the clinical quality in delivering mental health services. Corrections has MHRS clinical governance groups across the four regions: Northern, Central, Lower North, and Southern. The groups are led by the regional clinical director and include the MHRS clinical advisers, clinicians, WAF worker, provider managers, and, in some cases, other stakeholders e.g. forensic services who provide care across each region. The regional groups meet separately each quarter and review clinical and service quality against the Improving Mental Health Quality Framework. Additionally, this meeting is the forum where serious and sentinels events are discussed and reviewed. The clinical governance groups discuss and find solutions for issues such as waitlists, care plans, appropriate treatments and interventions, collaboration between primary and secondary services, and the impact of the operational aspects of service delivery. Any high risk or difficult issues are escalated to the MHRS Steering Group.

3. MHRS Steering Group

The MHRS Steering Group was created to replace the Programme Governance Board, whose responsibility it was to oversee the service design and implementation. The Steering Group represents a variety of interests within Corrections, including quality and assurance, psychology, health and probation. The primary role of this group is to ensure that services meet objectives and deliver the projected benefits during the pilot phase. The Steering Group meets once a month to discuss reports from the clinical advisors on clinical performance and quality, with an emphasis on strategic clinical service development and safety. They also discuss operational and contractual matters with the senior adviser (contracts).

How are we going?

The social workers and counsellors commenced services in women's prisons in November 2016. The other three pilot initiatives were introduced in April 2017. To date, these services have seen a high uptake through referrals, face-to-face sessions and education delivery (see Tables 2 and 3).

Table 2:

Referrals, face-to-face hours and education hours of Improving Mental Health Service

	Improving Mental Health	Referrals	Hours of Face-to-Face Time Delivered	Hours of Education Delivered
April 2017 – Jan 2018	Prisons	2,136	6,276	1,525
	Community	588	1,715	720
	Total	2,724	7,991	2,245

Table 3:

Referrals, declines, and active clients of WAF, Supported Living, counsellors, and social workers

	Counsellors Nov 2016 – Jan 2018	Social Workers Nov 2016 – Jan 2018	WAF April 2017 – Jan 2018	Supported Living April 2017– Jan 2018
Referrals	715	570	61	61
Declines	0	0	0	30
Active	163	163	39	4

This quantitative data indicates that prisoners and offenders are able to access mental health services within prison and community corrections. The number of referrals reflects a steadily increasing trend. The number of education hours delivered to Corrections staff contributes to staff level of awareness and engagement to MHRS. It also suggests a complementary practice through relationship building between MHRS clinicians, custody staff, Corrections' health teams, and forensic teams.

Positive outcomes for improving mental health

Personal stories that reflect the value of the services are collected regularly from all services since the programme commenced. Each month the mental health clinicians, social workers and counsellors provide a story of success to illustrate the impact and positive outcomes that clients are experiencing.

> *Twenty-seven year old male. Came to the service with depression and anxiety, and 14 years of P use. First time in prison, and was scared. He discussed his upbringing – having to watch his dad rape and beat his mum. Started taking P at 13, as it was "the only thing that made me feel warm". Stated that being off the drugs and actually having someone to talk to and work with has helped him feel the best that he has in his life so far. He states that he has the motivation to keep himself on track when he is released.*
>
> **(Mental Health Clinician – 01)**

> *Man with social anxiety who always thought he was "dumb" and "a slow thinker". Turns out he is a kinaesthetic learner and lost focus with traditional teaching methods. Today tells me that he doesn't think he needs meds, and the work we're doing together is really helpful. His self esteem is improving and he has gone from planning to live with mum on release and going back to his old life, to moving out and going to MIT and purposely not returning to his old life.*
>
> **(Mental Health Clinician – 02)**

> *I first met with Ms A, a 36 year old mother of four, at the end of January 2017. She had served 3.5 years of a 17 year, non parole sentence. She often experienced physical symptoms and complaints that most often had no explanation or real manifestation. Ms A's hope for counselling on the first day we met was "not to feel so broken" and "to move forward". Her grief at her separation from her four children and her long term sentence was overwhelming and close to consuming her completely. The bulk of the work we did together was around her profound grief and trauma at the multiple losses she had experienced throughout her life. After many months of treatment she had the following statement to make: "I am no longer overwhelmed when things go wrong. I just know I can get through crap times because I have survived so much in the past. I have a new hope for the future and a restored belief in myself…I just don't let crap weigh me down anymore. I have my mana back!"*
>
> **(Counsellor – 01)**

Increased motivation, improved self-esteem, self-discovery of their learning style, and regaining self trust are just few of the many positive impacts that prisoners and offenders who are receiving MHRS have identified.

Looking ahead

Corrections is committed to ensuring the successful implementation and development of MHRS and we are actively identifying challenges and barriers and addressing them as the pilot progresses. We are monitoring opportunities to develop the services through the following structured processes and also through informal meetings with lead managers in prisons and community corrections sites to identify programme-wide development needs and site-specific barriers and opportunities. This strategy will ensure that services can be delivered as core business solutions once the pilot has been completed.

1. Programme evaluation

The MHRS evaluation has two phases. The first phase evaluated the programme's operational processes, including fidelity to service design, uptake of referrals, and successes and challenges of the programme's delivery. Results of the first evaluation are reported in Sonia Barnes' article in this journal (see p19).

The second part of the evaluation will have a strong focus on outcomes to determine if the objectives of the MHRS programmes are being achieved. Outcomes expected include improving continuity of mental health care for prisoners transitioning from prison to community, improving timely access to mental health treatment, and improving individuals' mental health stability in prison and community corrections. The outcome evaluation will also assess reintegration success, reduction of incidents of dangerous and harmful behaviours, level of participation and completion of rehabilitative programmes, engagement with family and community supports, employment outcomes, and reduction of time on benefits. In addition, the capability of Corrections' staff to manage offenders with mental health needs will be evaluated.

2. MHRS Service Development Working Group

The MHRS Service Development Working Group was formed after the MHRS combined workshop in October 2017. At this workshop the operational managers from the contracted service providers offered their time and expertise to help ensure the quality of the services and work alongside Corrections in a collaborative and proactive manner. The MHRS Service Development Working Group meets monthly to identify and agree service development needs, e.g. a review of the assessment tool agreed at the beginning of the pilot.

3. Quality frameworks

Measuring the quality of the services is critical to achieving desired outcomes and supporting continuous improvement. Quality frameworks for each element of the programme have been developed with the Improving Mental Health Service framework. The quality framework for the mental health clinicians has a three stage approach, with self assessment, manager review and review by the MHRS clinical advisors all in place.

4. Practice model of care

The primary care model is the foundation of prison health services (Møller, Sto¨ver, Ju¨rgens, Gatherer, & Nikogosian, 2007). However, when there is an unmet health need, a review of the primary care model is required (Warr & Hoyle, 2007; Williamson, 2007). The need for a practice model of care specific to mental health is paramount to support the mental health clinicians and for Corrections to deliver efficient and effective mental health services. The model of care will undergo further development as the Intervention and Support Project (see article by Love & Rogers, p4) model of care takes shape to ensure referral pathways are clear, and services are integrated.

Conclusion

The establishment of mental health services in prisons and community corrections is fundamental in providing a quality healthcare service to prisoners and offenders. The four MHRS pilot initiatives: improving mental health, wrap around family/whānau, supported living and social workers and counsellors are being embedded by the New Zealand Department of Corrections as part of healthcare delivery. These services have multiple successes and positive impacts for prisoners, offenders and Corrections staff. The MHRS plays a significant role in supporting individuals' wellbeing so they can make better life choices and engage more meaningfully in rehabilitation.

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Evaluation of the Improved Mental Health service

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Author biography

Sonia designed and managed an evaluation of the Mental Health and Reintegration Services during her secondment to Corrections in 2017. Prior to working for Corrections she worked in research and evaluation roles for Police in NZ and in the UK. She has completed research and evaluation projects in a range of areas including family violence, mental health, youth, ethnic diversity, neighbourhood policing and police training.

Introduction

The Improved Mental Health (IMH) service started operating in Rolleston and Christchurch Men's prisons and at Palmerston North Community Corrections in April 2017, and was operating across all sites by the end of August 2017. The purpose of the service is to improve the mental health of offenders experiencing mild to moderate mental health needs. In brief, IMH clinicians have been contracted to conduct mental health assessments of offenders, make referrals and/or develop care plans and, where appropriate, provide treatment of up to 10 sessions. On completion of treatment it is expected that the clinician will conduct another assessment to measure improvement. The clinicians are also expected to help build capability of Corrections staff in relation to managing offenders with mental health needs. Further detail about the IMH service is provided in Gilbert Azuela's article on p13.

In December 2017, an evaluation was conducted to investigate how well the service was operating, and to report on progress towards achieving the expected outcomes. This evaluation drew on the analysis of interviews with offenders, staff and clinicians, and administrative data. Interviews were conducted in six prisons and three Community Corrections sites[1] in August and September 2017. Administrative data used in the evaluation included data from reporting spreadsheets maintained by IMH clinicians, data from REFER Online (the Department's electronic referral system) and the Integrated Offender Management System (IOMS).

The timing of the evaluation meant that only limited information could be obtained as the service had been in operation only a few months. In particular, there was limited data on the exit and transition processes, or how staff interacted with the various services.

Summary of findings

Overall, findings from the evaluation indicate that the service is operating as intended, and is contributing to improvements in offender mental health. There is also evidence of increased general staff awareness of mental health issues.

Corrections staff are referring offenders with mild to moderate mental health needs (for example stress, depression, anxiety) to the service, and in most cases are using the electronic referral system, as intended, to make these referrals. IMH clinicians are working with these offenders – generally over a period of up to five weeks – to improve their mental health. Most offenders are showing a reduction in their level of psychological distress after engaging with the IMH service. The evaluation also provides evidence of positive changes in how offenders are managing their emotions and behaviour, and improving their ability to respond to stress as a result of engagement with the IMH service.

The focus and extent of efforts to increase the capability of Department staff to support offenders with mental health needs is variable, but there are early indications that Department staff are becoming more confident in identifying offenders that may benefit from the IMH service.

1 Auckland Region Women's Corrections Facility, Auckland Prison, Christchurch Men's Prison, Christchurch Women's Prison, Manawatu Prison, Rolleston Prison, Otara Community Corrections, Mangere Community Corrections, Palmerston North Community Corrections.

Detailed findings: Progress towards outcomes

The main benefit expected from the introduction of the IMH service is that it will lead to an improvement in offender mental health. The evaluation found extensive evidence to suggest that positive changes in offender behaviour resulted from participation in IMH.

In particular, offenders commented on:

- improved ability to discuss their emotions and what was going on for them
- greater awareness of why they were feeling what they were feeling
- improved ability to identify triggers for heightened emotions
- reduced feelings of isolation
- improvements in mood.

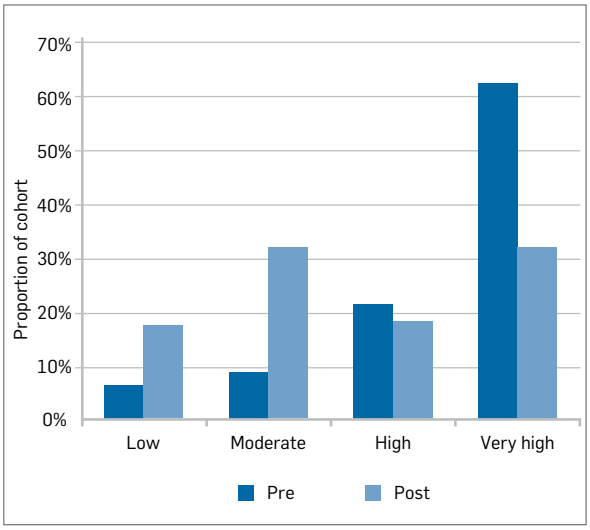
> *"Before I saw her I don't think I'd laughed or smiled for about six months, I'm actually laughing now. That's amazing when you can start laughing again. I put that through to having someone different to talk to."*
>
> **Prison IMH service user**

Offenders also described examples of managing difficult situations more effectively, and particularly without the inclination to use violence or other harmful behaviours. Offenders with anger control issues were proud to describe how they had managed incidents which, in the past, may have triggered violent outbursts, putting the wellbeing of Corrections staff and themselves at risk. For some, the positive change was knowing when and how to turn and walk away. For others it extended to engaging with the system in a more constructive way, like starting a discussion, or writing a letter.

> *"... I'm a way better, calmer prisoner here. Even when I've had difficulties with management, I had a few skirmishes, I did it all properly, I quoted the Corrections Act, put it into a letter, not once did I say f**k, and I got what I wanted."*
>
> **Prison IMH service user**

Some offenders had re-connected with family/whānau, describing those relationships as important in motivating them to continue a stable lifestyle.

Kessler10 assessments were conducted on both entry to and exit from the service for 112 offenders (21% of offenders who had exited the service at 24 October 2017). Analysis of level of change between entry and exit scores supported the findings of positive changes in behaviour.



The graph above shows the proportion of offenders within each category of level of psychological distress (low to very high) when assessed prior to engaging with the IMH service, and on exit from the service. Prior to engagement with the service, a higher proportion of offenders had high or very high levels of psychological distress[2] than low or moderate levels of psychological distress. On exit from the service, many who originally scored in the "high" and "very high" distress bands had moved down the scale to "low" and "moderate" distress bands; significantly fewer offenders were assessed as having high or very high levels of psychological distress.

Detailed findings: service operation

Referrals

By the end of October 2017, IMH clinicians across all sites had received nearly 1,400 referrals relating to 1,317 offenders (a small number of the offenders were referred to the service more than once, mostly as a result of transfer to another site). Most of the IMH service referrals (78%) were made in prisons.

The most common referral reasons were anxiety and depression[3]. Findings from the qualitative evaluation suggested that problems relating to stress or anger were also common reasons for referrals.

Analysis of referrals received by IMH clinicians suggested the recommended referral pathway (using Corrections' "REFER Online") was not always used. This in turn helped identify barriers to use of this electronic referral process: corrections officers were found to be not sufficiently confident to refer using REFER Online

2 It is important to note that someone may present with a mild to moderate mental health need (e.g., depression) but experience a "high" or "very high" level of psychological distress.

3 This data was entered as free text. A coding exercise was undertaken but 35% of this data was recorded as "other" so these findings should be treated with caution.

as a result of limited access to computers in their units, uncertainty about the correct consent form to use, and fears around breaching confidentiality relating to the information required to be entered. IMH clinicians reported that they had been helping Corrections staff to upskill in using the online referral system.

At Community Corrections sites, probation officers tended to talk directly to the clinician when they identified an offender who might benefit from their support. Under these circumstances the clinician would typically assess the offender's suitability on the spot, then ask the probation officer to complete a referral form later if the offender met the IMH service criteria. Possibly as a consequence of the more direct process, inappropriate referrals for the IMH service were recorded less frequently in the community (2%) than in prisons (10%).

It was intended that prison health centre managers would triage referrals in the electronic system to ensure that only appropriate referrals would be sent to IMH clinicians. Triaging was working well at some sites, but not all. Where triaging was not well-practiced, clinicians were expending time on unnecessary assessments. When offenders were assessed but not accepted to the service, it was mainly because their mental health needs were at a level of severity that referral to the prison forensic service was the more appropriate path (some were already receiving input from forensics).

Assessment

IMH clinicians are required to use the Kessler10 tool to assess the level of psychological distress of offenders at entry to, and exit from the service. The assessment involves asking an individual 10 questions about psychological distress and then scoring each of the questions on a 1 (none of the time) to 5 (all of the time) scale. Item scores are then summed to provide an overall assessment: the lowest possible score is 10 and the highest is 50.

At 24 October 2017, IMH clinicians had engaged with 70% (973) of offenders for whom they had received referrals. For about a quarter of these offenders, an assessment of psychological distress on entry to the service had not been recorded. For the purposes of analysis, the entry assessment scores that had been recorded were grouped according to the following categories[4]:

- **10–15:** low level of psychological distress
- **16–21:** moderate level of psychological distress
- **22–29:** high level of psychological distress
- **30–50:** very high level of psychological distress.

Of the offenders for whom pre-assessments had been recorded, most were assessed as having high (30%) or very high (49%) levels of psychological distress. There were no apparent differences in the profile of psychological distress scores between offenders receiving the service in prisons and those in the community.

Treatment

All clinicians delivered interventions to offenders in one-on-one sessions. Working with offenders began with the IMH clinician building rapport and establishing a relationship.

In prisons, IMH clinicians generally worked with offenders in offices or rooms in the offender's unit. At two of the sites, however, services were generally delivered at the health centre. One clinician observed that offenders engaged better when seen at the health centre because it afforded greater privacy.

Clinicians reported employing a range of tools and techniques such as "talking therapies", use of props to prompt discussion, developing plans for coping, mindfulness sessions and providing resources, strategies, and tools.

Feedback from offenders on what they found useful in working with the clinicians focused on (in order of frequency mentioned):

- Talking one-on-one with the clinician
- Receiving books, texts or other resources
- Help overcoming issues related to past experiences which had acted as barriers to moving forwards in their lives
- Setting goals
- "Anger management"
- Discussing commencement of medication, or the need to adjust dosage
- Referrals to or liaison with other services
- Relaxation techniques (e.g., controlling breathing)
- Journal writing
- Mindfulness.

Clinicians reported that they saw offenders weekly or fortnightly but would sometimes see them more often when they were in crisis. The frequency of sessions generally reduced as an offender's mental state improved. However, clinicians reported that frequency of sessions sometimes had to be reduced for workload management reasons, as level of demand for the service at times was high.

4 Turning Point Alcohol and Drug Centre (2010). *Screening and Assessment.* Retrieved January 04, 2018, from http://www.dacas.org.au/Clinical_Resources/Screening_and_Assessment.aspx

Exiting the service

The majority of offenders who had received the service, and had since exited, engaged in up to five sessions with IMH clinicians over a period of up to five weeks.

For the IMH service in prisons, only 15% of offenders who exited were recorded as having "completed[5]" the service. This relatively low level of completion reflected a range of factors which prematurely curtailed involvement of prisoners. Common events included offenders being released (22%), transferring to another prison (13%), or simply choosing to cease involvement (20%). Completion rates were lower in the community; only 5% of offenders who engaged with the IMH service were recorded as having "completed" the service. Similar types of reasons for early discontinuation were observed: the offender declined to continue (26%), they breached conditions and were re-sentenced (21%), they failed to attend sessions (13%), or their sentence ended (11%).

While delivery of incomplete service is not ideal, it is reasonable to assume that a few sessions will nevertheless have effects superior to having offered no service at all. It is also likely that, as the service matures, retention rates will improve, as will the operational efficiencies that enable referrals to be made earlier in the sentence.

The IMH service is available to offenders only whilst they are serving their sentence. A number of offenders commented on the speed with which they were able to see the Corrections-contracted IMH clinicians, once referred, which compared favourably with long waiting times experienced in the past in accessing similar services when not under Corrections management. However, this raised an issue of the feasibility of referring offenders on to other services once that offender's sentence had ended. Both clinicians and offenders mentioned anxieties about options for on-going support for those who needed it but who had completed their sentence.

Education of Corrections staff

The IMH clinician role allocates five hours per week for the education of Corrections staff. This training is intended to build staff capacity to identify and respond productively to offenders who present with mental health needs. Lack of knowledge was seen as a barrier to staff recognising signs and symptoms that need to be reported to clinicians. Clinicians were of the view that upskilling Corrections staff in recognising mental health issues would improve the timing and suitability of referrals to the service. Corrections officers supported those views in their feedback. IMH clinicians generally acknowledged that there was "room for development" in staff understanding of mental health issues.

Conclusion

The evaluation revealed that offenders and staff involved with the service were overwhelmingly positive about its value for improving offender mental health. Evaluation evidence indicated that levels of psychological distress had been reduced for offenders who had completed the service.

The evaluation also identified some areas of service operation that could be improved. These included the need to increase the use of the electronic referral system, refinement of referral and triaging processes, the need to increase treatment completion rates, and issues associated with referrals of offenders once their sentences came to an end.

Despite challenges with the referral process, clinicians are working with offenders with mild to moderate mental health needs (such as anxiety and depression) as intended, and using a range of tools and techniques with them in individual treatment sessions. Offenders commented on the usefulness of these sessions and there are early indications from analysis of the Kessler10 assessments that offenders are showing reductions in levels of psychological distress. However, Kessler10 assessments are only being conducted for about one fifth of those who exit the service. This needs to increase substantially, as a measure of change in level of mental distress is not only informative for clinicians, but is also a useful indicator for monitoring the service.

5 Analysis of exit reasons is based on interpretation and coding of large volumes of free text entries and therefore these findings should be treated with caution. An exit reason was coded as "completed" if the free text entry indicated that the goals of treatment had been met.

Evaluation of the counsellors and social workers services

Jill Bowman
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Author biography

Jill joined the Department of Corrections' Research and Analysis Team in 2010. She manages a variety of research and evaluation projects and has a particular interest in the outcomes of released prisoners, issues relating to alcohol and drugs, and the needs of female offenders. As well as working for Corrections, she volunteers at Arohata Prison, teaching quilting to the women undertaking the drug treatment programme.

Introduction

Counsellors and social workers started working in the three women's prisons in November 2016. The three prisons are Auckland Region Women's Corrections Facility (ARWCF), Arohata Prison (Arohata), and Christchurch Women's Prison (CWP). As well as providing practical assistance to their clients while they are in prison, counsellors and social workers are expected to help them build resilience, enabling them to engage in rehabilitation programmes while in prison, and to reintegrate more effectively on their release.

Priority groups for social workers are mothers who have children in the community, mothers who have, or wish to have, babies with them in prison, pregnant women, women under the age of 20 years, and men or women who identify as transgender. The focus of counsellors is on women who have experienced trauma, either recently or historically, including those who are unable to engage in rehabilitative treatment as a result, and women who are generally struggling to cope in prison.

The services were evaluated in late 2017, nine months after their introduction, to understand how well they were operating and to assess progress towards achieving the expected benefits of the services. The evaluation comprised a qualitative evaluation of the two services conducted by Malatest International, a review of the files of women receiving the services, and analysis of administrative data.

The qualitative evaluation findings were based on interviews with three social workers and three counsellors at two of the women's prisons, as well as with corrections officers and health staff. Five women who had received support from the social workers and eight women who had received counselling were also interviewed.

File information for the social workers service was sourced from Corrections' offender management system (IOMS) for 10 randomly selected women at each of the three prisons who had seen a social worker. File information for the counselling service was derived from 17 anonymised summaries from Corrections medical records database. These files were also evenly spread from across the three prisons.

The administrative data was extracted from reporting spreadsheets maintained by the social workers and counsellors themselves. In a small scale study such as this, findings should be interpreted as provisional only, especially given the early stage of implementation, and the relatively small number of cases examined.

Evaluation findings

Social workers

Two social workers at ARWCF, and one each at Arohata and CWP, commenced taking referrals on 24 November 2016. Between the commencement of the service and 24 October 2017, when the evaluation was completed, there had been 449 referrals to social workers across the three prisons. Although a few had been referred more than once, the majority were initial referrals. More than half (59%) of the women referred were Māori, which is consistent with the proportion of Māori in the total women's prison population (58%). Women in the 25–29 year age group comprised just under a third of total referrals (30%), although they comprise 19% of the prison population. Just under half (49%) were prisoners on remand; of the sentenced women referred, 55% were serving their first sentence.

While most referrals (79%) resulted in the social worker engaging with the woman and having at least an initial one-on-one session, this did not always occur: some referrals were passed on immediately to other services (e.g. the Health team), while others did not proceed, probably for a variety of reasons (e.g. the woman may have been released before an appointment could be arranged).

The evaluation established that referrals to the social workers were mostly consistent with the intention of the service: for general issues relating to children, care and protection concerns, and pregnancy. Care and protection issues accounted for a significant proportion of cases: 30% of the 449 cases referred. Other issues relating to children comprised 26% of referrals, and pregnancy 17%.

The file reviews regularly produced evidence of social workers assisting mothers in practical ways to keep in touch with their children. This might be through arranging phone calls and letters, or negotiating with Oranga Tamariki social workers in cases where they were already involved. Family court proceedings were another focus of activity: social workers arranged for women to participate in the hearings, liaised with lawyers, explained the meaning of court documents, and facilitated the signing and exchange of documents. When Oranga Tamariki was involved, women typically sought help on care arrangements for children; the social workers frequently noted having explained the role of Oranga Tamariki, clarified processes, reviewed with the women reasons for previous decisions, and made arrangements for future key meetings or hearings. Other support that social workers provided related to facilitating contact with a child where there had been no contact for (sometimes, several) years, contacting schools to check on the child's progress, arranging counselling for a child, and facilitating prison visits from children.

With women in prison who were pregnant, social workers were found to be devoting their efforts primarily into preparing for the birth, such as by contacting midwives and making necessary arrangements. They also provided relevant advice and support throughout the pregnancy. Social workers were occasionally concerned about the safety of a baby, and accordingly had notified Oranga Tamariki about the pregnancy. In one case Oranga Tamariki advised of their intention to uplift the baby immediately after birth and place the child with a foster family; the social worker supported the mother through these processes. In other cases, assistance was given on application for placement in the Mothers with Babies unit, or helping women already in one of these units with their parenting. Arranging parenting support in the community post-release was also noted in a number of files.

Women approached the social workers for help with a range of other issues also. Lack of accommodation on release was common, especially for those who were pregnant or had children, or who had been in a recent relationship with an abusive partner. Social workers record having investigated housing options, often drawing on the knowledge and networks of other personnel, such as the Department's Out of Gate service. Social workers also assisted with completing enrolment forms for a medical centre (often to ensure prescription meds could be obtained after release), applying for a benefit, and organising assessments for possible entry to rehabilitation services in the community. Women also sought help with a wide range of practical needs such as contacting lawyers, drafting letters, applying for a baby's birth certificate, and obtaining banking and other financial information. The evaluation noted that most requests appeared to fit within the parameters of what the social worker service was intended for, although some requests appeared to be the kind of thing that other staff, such as corrections officers, could equally well assist with.

Transgender prisoners featured amongst the prisoners referred: their needs included being put in touch with support networks, and issues relating to double-bunking; one preferred to share with a non-trans woman, another wanted help with clothing, and another in relation to her children.

At the time of the evaluation 59% of the referrals had been actioned and the file closed. Of these closed files, the women had had, on average, four sessions over five weeks. However, social workers tended to leave files open until women were released from prison or transferred given that the problems for which they sought help often required follow-up actions.

For women who transferred between prisons, the social workers appeared to be liaising well with each in terms of case handover. Support to transition from prison into the community was generally more challenging, as release could occur (for some women) unexpectedly due to Parole Board decisions, or release on bail. Wherever possible, social workers sought to organise a range of supports in the community that could pick up where their own efforts had left off. However, funding was occasionally a challenge for some who required specialised types of assistance.

Counsellors

Two counsellors at ARWCF and one each at Arohata and CWP started work at the end of November 2016. Between this start date and the end of October 2017, 562 referrals had been made to these counsellors. More than half (57%) of the 429 prisoners involved in these referrals (some were referred more than once) were Māori women. Women in the 25–29 year age group comprised just under a quarter (23%) of referrals and those in the 30–39 age group comprised a third (33%). Just over half (53%) of the referrals were for sentenced prisoners and, of these, 55% were serving their first sentence.

Only about half of the referrals made resulted in the counsellor engaging with the woman concerned. Some were deferred to a later date, some were referred on to other services, and some were judged not to be appropriate referrals.

Historical abuse (including sexual abuse) was the most common reason (39%) given for a referral across all prisons, confirming the known high prevalence of such issues in this population. The review of anonymised files elaborated on the specific issues that women discussed with counsellors: historical sexual abuse or other trauma accounted for a number of the referrals, and psychological, sexual and physical abuse/family violence were other common reasons for referral.

Current stress concerns accounted for the next most significant type of referral, including struggling to adapt to prison life. Mental health – especially anxiety – issues also featured.

Sometimes the reason for the referral was not specifically a counselling need, but the counsellors would nevertheless provide what was sought. For example, one woman wanted help to "understand family violence"; the counsellor responded by providing what might best be described as psycho-education around this issue. Sometimes an issue related to settling into prison also called for simple education about how things worked there. All prisoners receive a unit induction interview within 72 hours of arrival, but the requests for more education about prison life raised some questions about whether there might be other more efficient ways of providing this kind of support: for example, group sessions for new arrivals could be facilitated by a corrections officer[1], and counsellors might provide group sessions on issues such as healthy relationships[2].

The qualitative evaluation noted that the counsellors appreciated having flexibility about how they worked with the women they were seeing, and were providing counselling in a range of ways that made best use of their professional backgrounds and skills. Interventions in use included cognitive-behavioural therapy, mindfulness training, narrative therapy, art therapy, and approaches using techniques involving letter writing and even a "dream diary".

At the time of evaluation around half of the referred cases at ARWCF had been closed, with a higher proportion from Arohata and CWP. Like social workers, counsellors also tended to leave files open to avoid the need for preparation of new referrals when the need arose. Of the closed referrals, however, about a fifth comprised one session, and a further third had two or three sessions. Another fifth (17%) had received more than 10 sessions; the majority of these at ARWCF (the maximum number of counselling sessions with any referred woman was 41). Counsellors advocated that the maximum number of sessions should remain flexible, given the difficult issues for which they were seeing many of the women.

Counselling usually ceased when women were judged as having achieved their goals. Other cases were closed when women decided they no longer wanted to continue, had been referred and commenced counselling with an ACC-funded counsellor, were transferred to another prison, or were released.

Counsellors described their work as "equipping women with the tools and coping strategies they would need" on release. They spoke in terms of gradually moving women towards independence, including by extending the time between sessions, or by terminating a course of counselling but letting the woman know she could re-engage if needed.

Progress towards outcomes across the two services

Overall, the social workers and counsellors services appeared to be operating successfully at all three women's prisons. Referral processes were operating successfully, and women receiving the new services, in the main, appeared to be very positive about the quality of help received, and its benefits to them.

A few issues were identified by the evaluation for improvement. These included the need for better access to private spaces where sessions could be conducted, and a perceived need for better information sharing between the two teams (at time of the evaluation a significant number of women – 177 – had seen both a counsellor and a social worker). However, good collaboration was evident in other ways, such as the extent to which counsellors and social workers referred women to the other service if they identified a relevant need.

1 Corrections' new induction programme for women in prison, Kia Rite, is intended to provide information needed by new arrivals.

2 Group programmes covering healthy relationships are being introduced into women's prison.

Another issue identified by both counsellors and social workers, perhaps a sign of the success of the service, was heavy caseloads. This, combined with the complexity of the cases they were working with, necessitated the introduction of waiting lists, ranging from a couple of days for priority cases to up to nine weeks for non-priority cases. This problem has been addressed to an extent through employment of an additional social worker and counsellor at both ARWCF and Arohata since the evaluation was conducted.

The services had resulted in positive impacts on the mental health of the women receiving the services as well as on the wider prison environment. The anxiety of women who had received help from social workers to resolve issues around their children's circumstances was reported to have reduced significantly. In addition, the assistance provided by the social workers reduced the time demands on other staff, particularly case managers, in dealing with issues that the latter would previously have been called upon for. The role also provided a vital point of contact for Oranga Tamariki social workers, who not infrequently were still involved with women who were pregnant or had children. This contact point applied to other agencies and individuals with whom the women were engaged.

Positive outcomes reported for women who received counselling included increased self-esteem and improved ability to trust. Behaviour changes were noted following the development of understanding about personal trauma and its influence on their actions. Women reported feeling able to "let go" of things that had caused their trauma; some felt more able to connect and engage with others, including family/whānau. A common response also was increased ability to cope with and manage emotions.

Counselling also had a beneficial impact on the prison environment, with women better able to self-manage, and to maintain positive relationships with other prisoners and staff. Corrections officers also reported seeing benefits from the service – notwithstanding initial lack of understanding of counselling when the service was introduced. One staff member stated that a raised awareness of the impacts of trauma encouraged her to modify the way she responded to the women being managed.

Overall, the positive outcomes observed confirm the value of having introduced social workers and counsellors services into women's prisons. Further evaluation of these services is scheduled to occur in the future once the services are well and truly bedded in to these prisons.

Pursuing consistency: Multiple sites; one drug treatment approach

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Author biography

Ed has over 10 years' experience operating alcohol and other drug (AOD) services within correctional settings, initially working in the UK on the innovative Drug Intervention Programme (DIP), which directed adult offenders into drug treatment. Moving to New Zealand in 2010, he has worked in Drug Treatment Programmes (DTPs) in prisons for the last seven years. He joined Odyssey in 2016 to oversee DTP implementation at three Department of Corrections' sites.

Odyssey has been running a Drug Treatment Programme (DTP) at Auckland Prison since 2010. In early 2017, this contract was renewed and Odyssey was awarded two further DTP contracts: at Spring Hill Correctional Facility in Waikato and at Christchurch Prison (in partnership with Odyssey House Christchurch).

Implementing an intensive prison-based drug treatment programme is not without its challenges. Of course these challenges increase exponentially with the number of sites being established – each site has a unique culture, context and population. While we valued the diversity across the sites we were operating in, we were conscious of the need to establish consistency in our approach and commonality across programme aspirations, content, processes and procedures.

We were keen to avoid the risks that might arise should programmes evolve locally and independently. These include the potential for:

- Confusion about our treatment approach and model of best practice
- Lack of clarity for prisoners and Corrections staff about the nature and practice of an Odyssey DTP
- Disparate and/or irregular quality monitoring
- Version control and updates to systems and processes managed in an ad hoc or cumbersome fashion.

In the light of these risk factors, maintaining consistency was top of mind throughout the implementation process and, indeed, has been an ongoing consideration within the day-to-day operations at each location.

To support these efforts, we developed a tool that would provide a solid foundation for the implementation and subsequent operation of the three DTPs. This tool has become known as the "Quality Wheel".

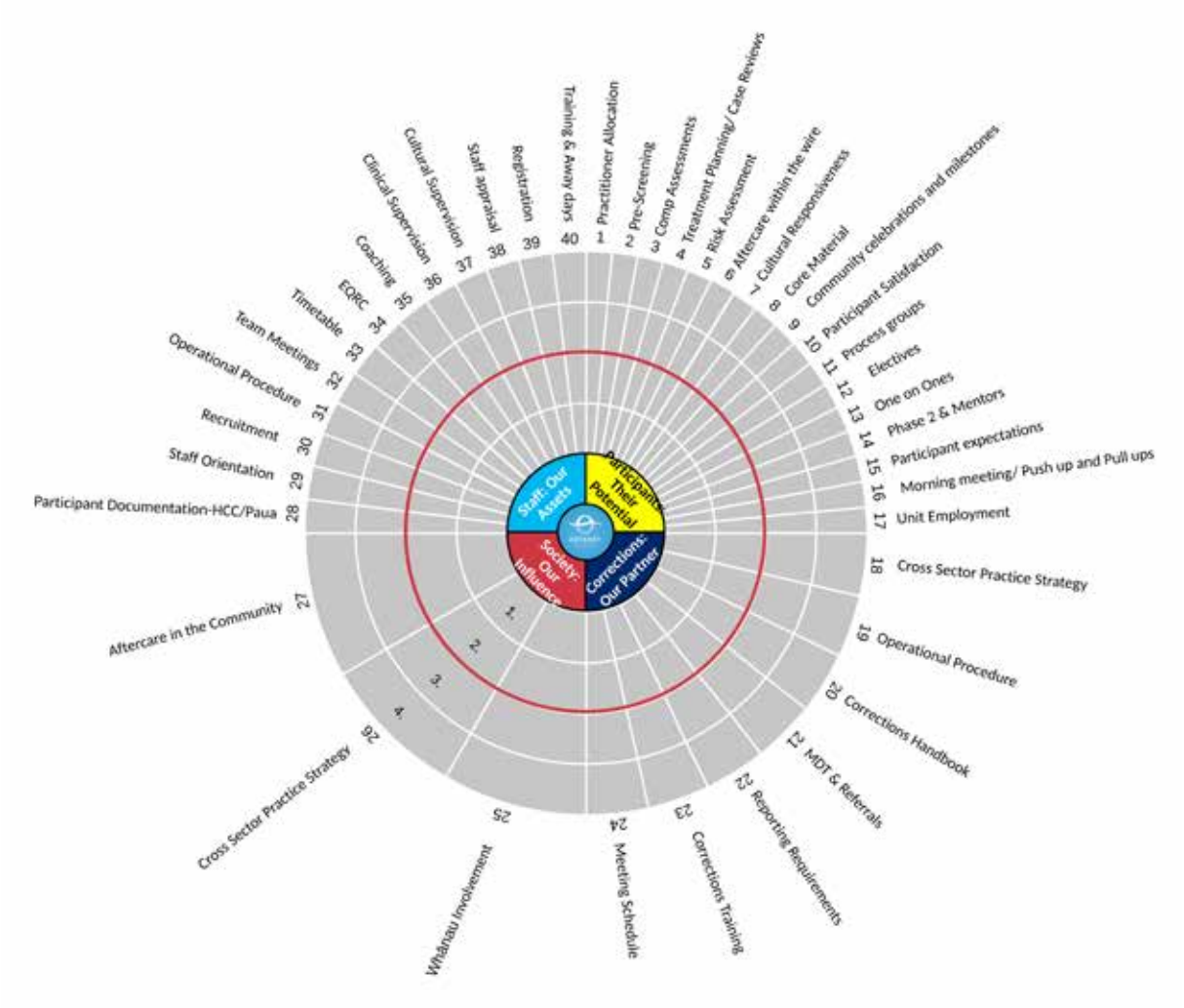
The Quality Wheel was developed and trialled across the three sites throughout 2017. The tool has been instrumental in driving the successful implementation of new models of service delivery across each location.

What is the Quality Wheel?

The Quality Wheel is a cloud-based tool we designed in-house that operates much like a front door or "portal" to all aspects of the programme. It was designed to provide a simplified interface to a complex system. Staff can access the wheel via a simple web link; no sign-up is required. They are then able to view and interact with the wheel. It is hosted in software called "Lucidchart" which enabled us to create our own base template from scratch resulting in a visual that communicated a clear message.

The wheel evolved along with the implementation process as we considered how to pull together the variables. What we ended up with looked like this:

Odyssey Drug Treatment Programme Quality Wheel (2017)



How it works

The Quality Wheel achieves consistency by targeting four core areas:

1. Fostering collaboration
2. Reinforcing the vision
3. Developing clear, accessible resources and systems
4. Monitoring quality.

Fostering collaboration

Collaboration throughout the implementation process was essential to develop a shared vision and maintain consistency in our approach. We initially focused on collaborating with staff at the coalface to ensure resources and processes were both relevant and responsive to their needs, and the needs of participants.

This also facilitated greater acceptance of the service vision, policies and processes by the wider staff network, which in turn secured successful implementation.

We used cloud-based* documents that could be accessed by clicking the relevant area of the wheel. Every project document was accessible through the wheel and every document was set up to allow suggestions and comments by staff.

In this way, staff were able to provide real-time feedback based on their (and participants) actual experience of using materials and resources within the DTP. For example, if a staff member, while running a group, noticed that instructions were too complex, or language did not suit a given situation, or an additional step might be needed in an exercise, they were able to comment within the master document.

An automated email would then alert the project manager, who would be able to accept or reject the suggestion within minutes. Thus, content and processes have evolved dynamically in response to staff and participant feedback.

(*To maintain data security, the cloud was only used for content and policy, not to store any personal client information.)

Reinforcing the vision

We can sometimes lose sight of the big picture as we become focused on the day-to-day practicalities of project implementation. Ultimately, our DTP programmes are about changing lives and keeping this fact at the forefront both motivates staff and provides clarity in decision making.

The wheel was designed to visually convey how each aspect of the programme contributes to this central vision. Each spoke of the wheel points towards the greater purpose. The hub of the wheel is broken into four quadrants:

1. Participants: Their Potential
2. Corrections: Our Partner
3. Society: Our Influence
4. Staff: Our Assets.

These quadrants, which represent our aspirational values for the DTPs, are described in greater detail when users click through to the supporting documents. However, we believe they also speak for themselves in the context of the programme and the business of changing lives.

Consistency in the detail of the programme needed to go hand-in-hand with a clear view of the big picture, and the wheel provides a constant reminder of what we are about.

Developing clear, accessible resources and systems

While we already had a DTP running at Auckland Prison, we still needed to update our resources to reflect new contract specifications. This also provided an opportunity to consider whether there were additional changes we might wish to implement, so we reviewed and rewrote the entire syllabus.

We temporarily moved our document cache to the cloud-based platform and made every effort to ensure the layout was intuitive and clear. This allowed us to direct users to the current versions of all documentation, minimising confusion around version control and ensuring outdated versions were not being used. It also meant staff new to Odyssey did not need to familiarise themselves with potentially complex file paths on shared drives.

We also provided a master list of documents to support navigation of the various elements of the programme.

Monitoring quality

Perhaps the most important function of the wheel was to provide a visually striking and intuitive quality monitoring and assessment tool. At specified intervals, the clinical managers at each site are required to review the 40 spokes of the wheel within their programmes and score them appropriately.

The basic principle when assigning a score to each spoke is as follows:

Score of 1 = Below baseline

Score of 2 = Baseline (meets contract specifications)

Score of 3 = Baseline plus (meets two or more additional criteria)

Score of 4 = Baseline plus plus (good news story).

We developed a scoring guide that gave specific criteria for each of the 40 spokes. See example below for spoke 8 "Core Material":

8. Core Material	
Monthly Baseline – Records indicate all DTP participants have experienced 3 hours of psychoeducational material per week. (HCC see client assessment report '*clinical attendance*'). Evidence of exceeding this (Baseline +), would include 2 or more of the following – • + Clinical Manager has sat in on 3 or more sessions within the month • + Evidence of participants using the education language in their daily interactions and at morning meeting. Eg – traits of an addict, drama triangle roles etc. • + 3 random clinical notation samples are of suitable quality (see note guide) To qualify for level 4 (Baseline ++) provide a good news story	**Good news story?** **Score – 1–4** ☐

Once a score for each of the 40 spokes has been ascertained, managers can then colour their wheel by clicking the dots adjacent to it, reflecting this score.

This allows each site to illustrate at a glance the performance of their units over a given time period. (i.e. 1 = one layer of colour, 2 = two blocks up to four where the whole spoke is coloured (As in spokes 14, 16 and 24 below).

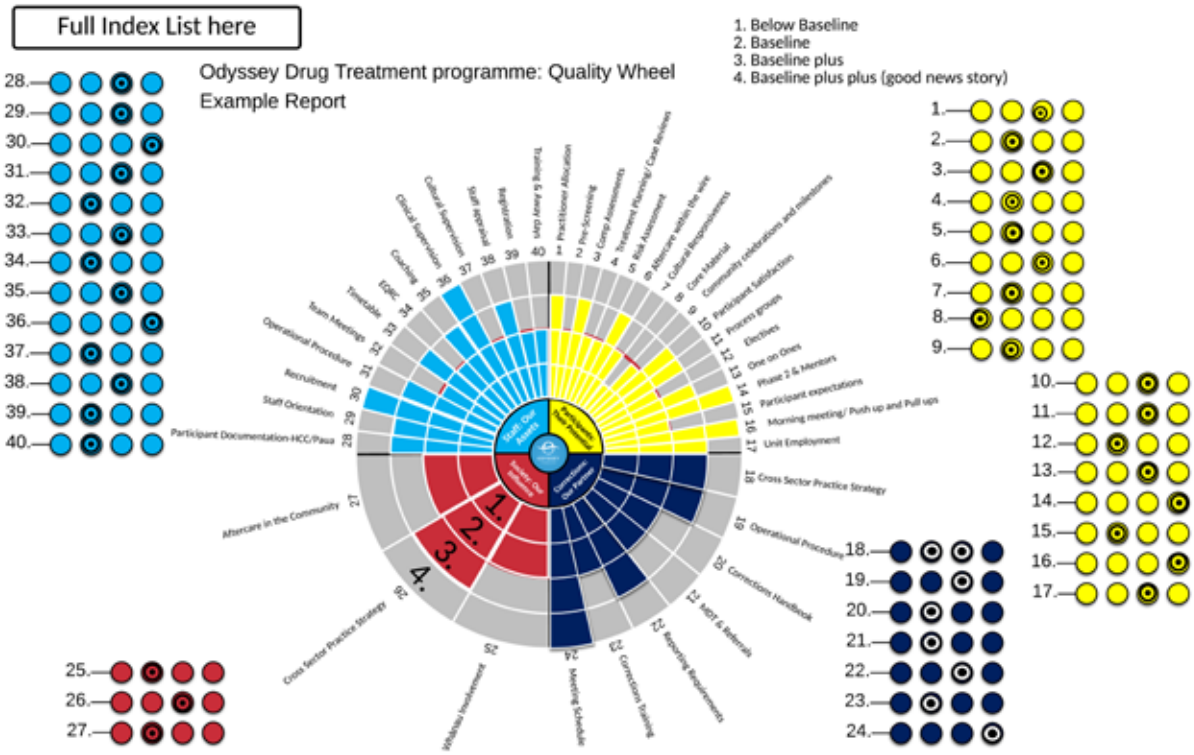
Initial evaluation

Ten months in, staff feedback has been very positive and the uptake has been relatively smooth, particularly in regards to accessing the content through the wheel.

The wheel has been particularly valuable over the set-up phase, connecting the sites and enabling us to learn from one another. This has led to valuable discussions at our clinical steering group meetings.

The wheel has also proved useful for connecting staff with practical guidance and the thinking that lies behind each process. For example, the pre-screening spoke opens the page (pictured on the following page), which outlines the tasks, the purpose *and* the relevance to contract specifications/reporting requirements.

Odyssey Drug Treatment Programme Quality Wheel (Example Report)



Pre-Screening

Monthly Baseline – All participants in the most recent intake had direct contact from Odyssey staff (or evidence of attempts), before starting the programme – ideally ahead of their arrival into the unit (either face to face or via telephone), and undertook the Pre-Screening Form.

Evidence of exceeding this would include 2 or more of the following –

- + Participants are briefed on this decision to allow informed choice
- + Mental health and security checks occur
- + Participants are made aware in this timeframe and it is explained what this means
- ++ Good news story.

Purpose of Pre-Screening assessment

- To provide information to encourage informed choice.
- To identify any specific needs or requirements of participants before they arrive into the unit (e.g. health needs).
- To give participants the sense that this is a crossroads in their life.
- To identify & decline unsuitable participants.

Produce an assessment report in the APF format – (Activity Progress Form)

The contract states –

Each Individual Drug Treatment Programme Participant Assessment Report will include:

- *A statement of the prisoner's suitability or unsuitability for the Drug Treatment Programme and the assessed reasons for this.*
- *If the prisoner has been assessed as suitable, the Participant Assessment Report will also include:*
  - *Confirmation that informed, written consent was provided by the prisoner;*
  - *A brief analysis of the prisoner's risk of AOD-related harm and treatment needs;*
  - *A brief analysis of the prisoner's responsivity barriers/needs (including level of motivation, cultural needs).*

The APF needs to be submitted to the DTU schedulers no more than 5 days after the assessment.

This has allowed practitioners to gain more insight into each process, including how it links into broader Corrections systems. For prisoners, this has resulted in receiving clearer, more consistent information from Odyssey. This has enormous value as it sets up the expectations clearly ahead of arrival, lessening the potential for culture shock and increasing the likelihood of a smooth and positive transition. Ultimately this increases the retention rate and therefore the efficacy of the entire programme.

The quality monitoring/reporting function of the wheel has taken some time to establish and embed. We are still working through how we can enhance the measurement and evaluation aspect of the wheel going forward.

One of the hazards we all face is inadvertently adding to the administrative burden for staff. While the tool increases efficiency in some regards, it does not negate or eclipse the necessity to undertake the established data entry or quality monitoring tasks. Given the experimental nature of the tool, the quality monitoring aspect is not yet fully integrated organisationally and clinical managers are still required to run the standard quality audits in addition to this tool.

A further aspect to consider is the nature of cloud hosting. The enormous benefits of using the cloud must be balanced against the risks, which include: staff being put off by *more* passwords and usernames, the potential for intellectual property disputes, potential difficulties accessing data when it is not stored on your own servers, unreliable internet connections with insufficient bandwidth and the big one – security.

We moved with caution in the light of these risks. For example, we ensured that no personal/client information was hosted in this space. While there are no quick answers to these concerns, the tide is turning across all industries towards cloud-based software. Those of us working in the "people industry" have a number of additional considerations to take into account. However, we risk being left behind if we move too slowly and there are some very robust risk mitigation strategies we can employ.

Conclusion

The Quality Wheel has helped Odyssey ensure consistency of implementation across its three DTPs.

However, it must be noted that while the use of technology has allowed us to communicate in new and more efficient ways and support a shared purpose and understanding of a common approach, we recognise that not all processes or resources will suit each site all of the time. Similarly, innovation can be stifled in the pursuit of consistency, and care must be taken to ensure communication and feedback channels foster staff initiative and experimentation where appropriate. Cookie-cutter solutions may maintain consistency but they also lack personality.

The wheel, like any tool, needs a skilled operator, someone to faithfully maintain it with care and understanding. This includes maintaining good relationships, meeting regularly and allowing flexibility around the model. These factors are also essential to success.

The wider Corrections estate is broad and diverse – the prisoner make up, regional differences, site characteristics and contexts all contribute to the distinct cultures found at each facility. While this can pose a challenge for centralising systems, it is also to be celebrated, as it fosters diversity for a diverse muster.

Investment in systems is not enough in itself – it must go hand-in-hand with an acceptance of the cultural differences at each site and a willingness to empower local decision making. When organisational leadership invests in its relationships with staff on the floor, this will empower staff to invest in the relationships that really matter: those with the prisoners.

Early intervention and support: Corrections' Methamphetamine Pilot

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Author biography

Caitlin specialises in the design and implementation of alcohol and other drug (AOD) rehabilitation programmes. Caitlin has both worked on and led various AOD projects including residential AOD programmes, offender digital health services, the AOD Aftercare Worker Pilot and the methamphetamine screening and treatment pilot. Prior to her senior adviser role, Caitlin worked as a probation officer in Auckland.

Methamphetamine use was first identified in the general New Zealand population in the late 1990s and reached a peak in the early 2000s (Prasad, Rychert, Wilkins, & Wong, 2015). Research conducted by the Ministry of Health found amphetamine/methamphetamine use amongst New Zealanders aged 16 to 64 declined from 2.7% of the population in 2003 to 1.1% in 2015/16 (Ministry of Health, 2016). Despite this decline within the general New Zealand population, high levels of methamphetamine use amongst the prison population remains. The Department of Corrections commissioned a study in 2015 which looked at comorbid methamphetamine use disorders and mental health disorders amongst people in prison. The study revealed that over half (56%) of people in prison have used methamphetamine over the course of their life, and of these 58% reported they had used methamphetamine in the past year (Indig, Gear and Wilhelm, 2016). Furthermore, 38% of people in prison had either an abuse or dependence disorder[1] at some point during their lives, while 16% were identified as having abused or been dependent on methamphetamine in the past 12 months (Indig et al., 2016).

Corrections' response

In light of the significant harms associated with methamphetamine abuse and dependence disorders, with funding from the Proceeds of Crime Fund, the Department has implemented new services aimed at early intervention, treatment and support for people with mental health and methamphetamine-related needs. Treatment and care was expanded in 2017 for people in prison and on community-based sentences and orders experiencing mild to moderate mental health issues. In the same year, the Department introduced a pilot for screening and targeted treatment for methamphetamine users. The pilot included three key components:

1. Screening, Brief Intervention and Referral to Treatment (SBIRT)
2. group-based methamphetamine-specific programmes
3. a group-based mental health and wellbeing programme.

This article will focus on describing SBIRT and one of the group-based programmes.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is an evidence-based practice developed to provide universal screening, early intervention and referrals to treatment for people who use alcohol and drugs (SAMSHA, 2011). It was originally developed to be used in primary care and other health settings such as hospital emergency rooms, and was predominantly focused on screening for risky alcohol use only. It has, however, been more widely adopted, and is often used in other settings such as police stations and prisons, and is used to screen for problematic drug use as well.

SBIRT is made up of three components:

- **Screening** – people are screened for problematic substance use using a standardised tool. The results provide an indication of the level of substance-related risk and the required level of intervention.
- **Brief intervention** – a single session providing feedback and advice using a motivational approach.
- **Referral to treatment** – for those who are identified as needing additional support or treatment.

It is a brief but comprehensive process, with the initial screening component completed in approximately ten minutes, and the brief intervention lasting between five minutes and one hour.

1 Abuse is when a person uses alcohol or drugs regularly, despite the fact that it causes issues in their life. Dependence is characterised by a person developing a tolerance to a substance, going through withdrawal symptoms without it, and struggling to cut back on it.

SBIRT is unique, as the universal screening component allows health care professionals to identify people with problematic or risky substance use even if they are not actively seeking support or treatment (Prendergast, Cartier, & Lee, 2014). While not all individuals who use drugs require treatment, drug use creates risks of developing abuse or dependence disorders (Prendergast, McCollister, & Warda, 2017). Experts argue that screening and early intervention, appropriate to the identified level of risk, can help low and moderate users to identify and change risky behaviour, preventing progression to more problematic AOD use in the future (SAMSHA, 2013). In criminal justice settings, this can have significant effects on public health and public safety by reducing criminal behaviour and increasing psychosocial functioning (Prendergast & Cartier, 2013).

Implementation

In September 2017 the Department contracted Odyssey, a community-based AOD treatment provider, to deliver SBIRT at Mount Eden Corrections Facility (MECF). For a number of reasons this prison was identified as a good location to trial the SBIRT approach. Firstly, it is the largest remand facility in New Zealand, housing approximately 1,000 men of remand accused, remand convicted, and sentenced status. The significant remand population (approximately 90%) and the high percentage of people on short sentences means there is a high turnover, with a throughput of approximately 38,000 per year. Such a fast-moving environment was considered an ideal location to trial SBIRT, as it could be used to screen a large number of people in a very short timeframe, increasing the pilot's reach and maximising potential benefits.

Implementing SBIRT at MECF also presented an opportunity to address a gap in AOD service delivery for people on remand and short sentences. Given many are only in MECF for a short period of time, they are often released before they have undertaken AOD screening with a nurse or case manager. With a target to complete an SBIRT with each individual within two to seven days of reception, implementing the pilot at MECF would significantly increase the number of people on remand and short sentences being screened for AOD, as well as maximise opportunities for early intervention.

Focusing on remand prisoners may also lead to improved outcomes for the SBIRT itself. Research suggests that people on remand are ideal candidates as their recent incarceration can precipitate a "teachable moment". They may be in custody for an alleged drug-related crime or as a result of their alcohol or drug use, which could also be a source of motivation to address their substance use issues (Prendergast et al., 2014).

Further to this, the potential for prevention and early intervention could be maximised by implementing the service at MECF, which houses the largest youth population under 25 in New Zealand. Findings from the 2015 comorbidity study showed that people in prison aged 17 to 24 years had the highest rates of methamphetamine use in the past 12 months, however the rates of methamphetamine abuse and dependence disorders in this group was lower than those in the 25 to 44 year age group. Furthermore, those under 25 developed stimulant dependence within 10 months of having first used; two and a half times faster than those aged 45 years and older (Indig et al., 2016). This suggests that targeting people under 25 with SBIRT could maximise outcomes of the methamphetamine pilot, particularly early identification and intervention.

SBIRT: Screening

The Alcohol and Substance Involvement Screening Test (ASIST)

The Department opted to use the ASIST[2] as the screening tool for the SBIRT. ASIST is used by frontline staff, including probation officers, case managers and nurses, across the Department to screen for problematic AOD use. It was agreed that it was important to use the same tool to ensure the data collected through the SBIRT could be used by Departmental staff in future. Evidence shows the ASIST is an effective screening tool as it has strong psychometric properties and is easy to use, with minimal training required (Wolff & Shi, 2015).

The first phase of Corrections' methamphetamine pilot included making a change to the ASIST tool by adding methamphetamine as a specific option under the "amphetamine type" stimulant drug category. The standard ASIST screens for amphetamine type drugs, options for which were listed as "speed", diet pills and ecstasy. Thus, there was no way to specifically identify methamphetamine use. With the modified version, those completing the ASIST would provide either a "yes" or "no" response when asked if they have ever used methamphetamine, as well as how often they have used methamphetamine in the past three months.

Using the enhanced ASIST as the screening tool for SBIRT has allowed for the clearer identification of methamphetamine users and presented an opportunity for early intervention. It is also intended to help the Department to better track levels of methamphetamine

2 The ASIST is a modified version of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) developed by the World Health Organisation. ASIST does not include tobacco, as prison health services already have a comprehensive screening process linked to the provision of nicotine replacement therapy. The ASIST screens for a range of substances and determines a risk score for each substance (i.e. lower, moderate or high).

use in both the prison and community offender population, not only over the pilot period but also in the years to come.

SBIRT: Brief Intervention and Referral to Treatment

Options for brief intervention and referral to treatment are largely dependent on the participant's prison status and the results of their ASIST. All participants identified as methamphetamine users are referred to the "Meth and Me" short course delivered and developed by Odyssey. The course is delivered to small groups of people in two-hour blocks over two sessions. Participants gain an understanding of the effects of methamphetamine use. They then learn relapse prevention strategies, such as managing cravings and risky situations. It was specifically designed as a brief, psycho-educational course, so it would be suitable for remand accused, remand convicted and sentenced prisoners with varying levels of AOD need. As people with high needs usually require additional and ongoing treatment, Odyssey staff are expected to work closely with participants' case managers to ensure that they are aware of the participants' treatment needs and can undertake sentence planning, and initiate referrals, as appropriate. For those without a case manager, referral to treatment activities involves sharing information with participants about various treatment and support options in prison and the community.

Uptake and success to date

Between September 2017 and February 2018, 225 people in MECF have completed SBIRT with an Odyssey staff member. Uptake is around 80%, with only 20% of eligible people who are offered SBIRT declining. Reasons for declining include lack of interest or self-reported nil AOD use. Of the 225 people that have agreed and have completed SBIRT with an Odyssey staff member, 161 (72%) have indicated they have used methamphetamine either in the last three months or at some point over their lifetime. The majority of these people (144) were referred to the "Meth and Me" short course, and some with high AOD needs were also referred to Odyssey's residential treatment in the community.

The identification of methamphetamine users and the subsequent referral to appropriate courses and treatment is one of the key successes of this pilot to date. Another success of the pilot is the demonstration of collaborative work between the prison and the contracted provider, Odyssey. Both parties worked closely to ensure the pilot was implemented smoothly, and collaboration continues as Odyssey staff engage with case managers and corrections officers on a daily basis in their work at the prison. In addition, feedback questionnaires completed at the end of SBIRT and the "Meth and Me" short course are demonstrating that the services are received well and considered helpful by participants, with some thanking staff for providing information and resources they did not know were available to them.

Key challenges

Although the pilot is still in the early stages of implementation, the Department and the provider are already working through key challenges in an effort to refine the service. Working in a remand prison is the biggest challenge for a number of reasons. Firstly, a significant number of SBIRT participants have not been in prison long enough to be allocated a case manager, which makes it difficult for Odyssey staff to refer people with high needs to suitable treatment. This is because people in prison often have multiple needs which need to be addressed, and decisions regarding timing and sequencing of treatment need to be made by case managers, who have a broader understanding of how an individual's different needs are best responded to. This issue is exacerbated by the high number of participants with remand accused status, as it is difficult to predict the outcome of their future court appearances, in particular whether they will remain in prison or be released into the community.

The Department is currently working closely with Odyssey to overcome these challenges, and strengthen the referral to treatment component of SBIRT, particularly those with remand accused status. Approximately 40% of this group have an active community sentence and an allocated probation officer. Odyssey staff will increase communication and liaison with participants' probation officers to inform pre-sentence reports and help with planning for community-based treatment and support for those that are released. Progress with this work will be monitored through monthly reporting data.

Next steps

The Department will continue to work with Odyssey to identify opportunities to further enhance the service at MECF. Additional information regarding the pilot's progress to date, areas for improvement and potential opportunities for expansion are expected to be gleaned from an evaluation, which is due for completion later this year.

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Alcohol and other drug testing trial of community-based offenders

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Author biography

Nyree joined the Department of Corrections in 2010 as a probation officer. Since then she has been a practice leader and is now a Senior Practice Adviser in the Chief Probation Officer's Team. Nyree has a passion for probation practice and uses her experience in the field to help continuous improvement in this area.

Background

Testing for alcohol and other drugs (AOD) in the community enables Corrections and Police to intervene with offenders/bailees who are subject to an abstinence condition imposed by the courts or the Parole Board, and who are at risk of causing harm from substance misuse.

International research and experience tell us that testing for alcohol and drugs is most effective when it's done alongside appropriate interventions. Corrections staff have a suite of rehabilitation options available and are trained to identify the most appropriate intervention for each individual. Testing is therefore another tool alongside programmes and motivational approaches that allows us to work with people to support change and help keep communities safe.

Every year, approximately 5,000 people serving community-based sentences/orders and around 15,000 bailees have an alcohol and/or drug abstinence condition imposed upon them. For probation officers and Police, an abstinence condition has traditionally been problematic to manage as non-compliance was difficult to detect and even more difficult to evidence in court. This is because legislation did not provide clear authority to test people serving a community-based sentence/order, even when they were subject to abstinence conditions.

The Alcohol and Other Drug Testing (AODT) of Community-based Offenders and Bailees Legislation Bill, introduced in July 2014, addressed that problem by creating an explicit legislative mandate for AOD testing of people serving a sentence/order and bailees subject to abstinence conditions.

On 8 November 2016, the Bill received its third reading and was divided into a number of Acts (Sentencing (Drug and Alcohol Testing) Amendment Act 2016), superseding existing legislation and enabling testing to occur in the community from 16 May 2017.

Two year trial in the Northern region

On 1 March 2016 the AODT Governance Board (comprising Corrections and Police staff) elected to trial AOD testing capability in the Northern Region for 24 months. The Northern Region was chosen as it represents 40% of the national target group of people with abstinence conditions. A trial enables Police and Corrections to test and understand the different technologies and their capabilities, and to identify the ideal frequency of testing and response requirements.

The trial uses a mixture of:

- Urine testing for drugs and alcohol (conducted on a randomised basis and where there are reasonable grounds)
- Breath alcohol testing (BAT) of bailees, and of specific people on sentence/order
- Alcohol detection anklet (ADA) monitoring for a small number of people who are at a high risk of causing harm if they consume alcohol.

It is expected that these testing and monitoring approaches will lead to:

- Reduced drug and alcohol use amongst offenders and bailees with an abstinence condition
- Improved compliance with conditions of sentences and orders, including bail
- Improved engagement with rehabilitation services
- Reduced harm caused by alcohol and other drug misuse through a change in the rate of offending
- Individual health benefits.

The trial began on 16 May 2017 for Community Corrections at two sites and extended to the remainder of the Northern Region from 1 September 2017. The staged approach provided for testing of processes and procedures with a smaller cohort which allowed for consolidation and further amendments to be made to enable a successful roll-out to a wider audience.

Event-based urine testing (e.g. if the probation officer has cause to suspect an offender may not comply with their abstinence condition) has now been made available to other regions on a case-by-case basis. ADA and random urine testing remain limited to the Northern region.

The trial will end in May 2019. Decisions to extend the service will be made closer to this time and after evaluation, in which case a national roll-out would be planned and implemented.

Why are we testing for alcohol and drugs?

We know that alcohol and drugs are an issue amongst offenders. A recent study found that 47% of New Zealand prisoners had received a diagnosis of a substance use disorder within the last 12 months, and 87% of prisoners had a lifetime diagnosis (Bowman, 2016). It's also estimated that more than 50% of crime is committed by people under the influence of drugs and alcohol.

Testing for alcohol and drugs allows us to better intervene with a person according to their identified AOD needs. People often understate their use, believing that honesty will only get them into trouble if they have an abstinence condition. Testing provides an evidence base for treatment and allows us to open dialogue with a person about their AOD use. This means we are able to target a person's intervention to their actual need. This aligns to the Risk-Needs-Responsivity model (RNR) adopted by the Department of Corrections, which works to ensure the right interventions are being delivered to the right people at the right time.

We have many tools to determine a person's level of risk, both static and dynamic, and also their need. One such screening tool is the Alcohol, Smoking and Substance Involvement Tool (ASSIST), which can identify someone's use of each substance and the impact this has on their life and wellbeing. AOD testing is another tool for determining the level of intervention appropriate for each individual.

International literature and New Zealand experience suggests that testing alone does not reduce re-offending or protect communities from harm. Positive outcomes are only achievable with the accompaniment of comprehensive case management and a suite of rehabilitation programmes delivered with a person-centric approach. To this end, the focus of the trial has been two-fold – the testing itself and the use of suitable intervention options for those found to be using alcohol or drugs.

How and who are we testing?

The majority of Corrections testing is randomised urine testing. Once an abstinence condition is imposed, the individual is assigned to a testing tier by a probation officer. This is a two step process where an automated calculator provides the initial tier (based on static risk factors) and the probation officer then uses their professional decision-making to determine the final tier based on other factors known about the case which may affect the level of risk in relation to alcohol and drugs.

Cases can be assigned to tiers one, two, three or four, which determine the frequency of their testing. Tier one is reasonable grounds urine testing only. This means a probation officer can request a test if they have cause to suspect a person is not adhering to their abstinence condition. Alternatively, the probation officer can organise a test if they become aware of a potentially high risk situation (e.g., reunion, tangi, special birthday) and choose to test after the event.

Those on tiers two and three are entered into a "randomiser", where tier two is set at a lower rate than tier three. At the beginning of each month the randomiser is run and a number of cases are assigned for testing. A centralised team at national office organises this testing to occur throughout the month and liaises with the probation officer for an appropriate time, usually to coincide with a report-in. Each person is given a short window of notice prior to their test (up to 24 hours) which allows them to organise themselves but not long enough to successfully compromise the test (e.g., by abstaining, dilution). Those on tiers two and three are also subject to reasonable grounds testing.

People considered at a high risk of causing alcohol related harm are allocated to tier four and, if suitable, are fitted with an alcohol detection anklet (ADA). The anklet is worn 24/7 and can determine if a "drinking event" has occurred based on the way a person excretes alcohol through their skin. It takes these "transdermal" readings in half hour intervals. The results from the anklet are not supplied in real time, rather a daily report is sent to the central AODT coordination team, for dissemination to the probation officer. If a probation officer believes a person is suitable for ADA they refer them through the regional high risk response team. All cases on tier four are also usually placed on a random regime (tier two or three) and are subject to reasonable grounds testing. This is because ADA does not measure drug use. The exception is if the individual has only been given a condition for alcohol whereby a random drug testing regime is not necessary.

If a person's risk/need changes throughout their sentence or order, the probation officer can choose to increase or decrease their testing tier.

The Police use breath alcohol testing (BAT) for bailees and are working through the processes to also incorporate urine testing of defendants on electronically monitored (EM) bail. They are also using ADA for their highest risk defendants on EM Bail.

Working together

With increased monitoring, some concerns were expressed by staff regarding the working relationship between the offender and the probation officer. Probation officers are trained to operate in the spirit of motivational interviewing and the intention of testing is not solely to hold people to account. Instead, testing provides evidence that allows probation officers to make professional decisions that assist with rehabilitation and harm reduction.

The combination of motivational interviewing, appropriate programmes and testing provide the right foundation to support change.

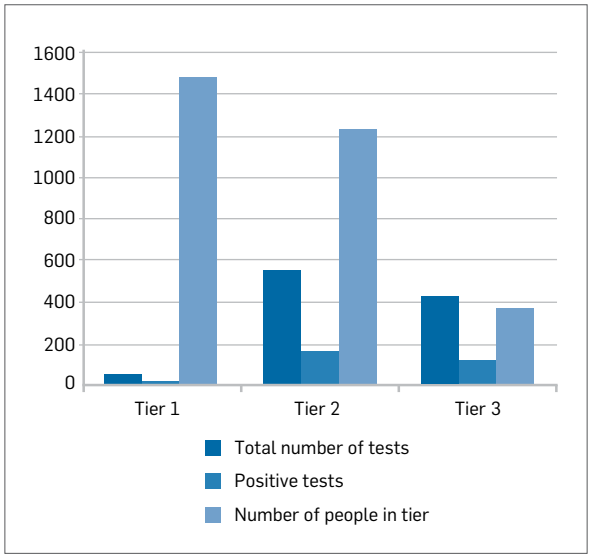
It is accepted that this can be a difficult cohort of people to motivate to address their issues with alcohol and drugs. Enforcement action (such as formally "breaching" a person, or, in some cases, recalling them to prison) is sometimes appropriate together with other actions (increased reporting, referral for programmes, targeted motivational approaches) to balance personal accountability with opportunities for intervention and support.

What tools and interventions are available to probation officers?

There are many interventions available for alcohol and drug issues, ranging from low to high intensity. For those with a lower assessed need, probation officers can deliver brief interventions when the person reports in. Alternatively, probation officers can refer to external services such as Care NZ and Salvation Army where someone presents with moderate to high needs. Corrections funds residential services and even contracts a free 24/7 helpline; "RecoveRing" is specifically for offenders to call, whether they are struggling with their substance use or just want further information. Probation officers have easy access to all the rehabilitative options available in an interventions catalogue on the Corrections intranet.

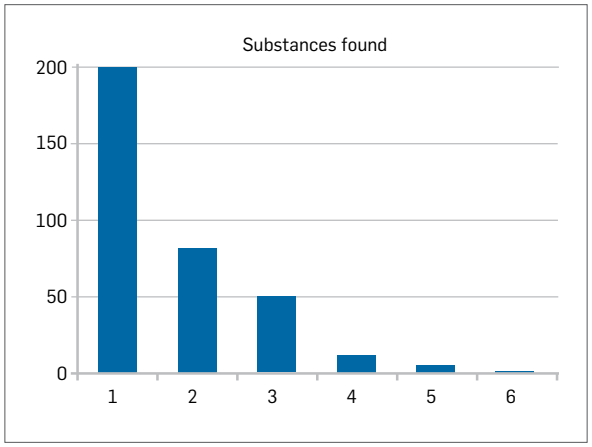
What's been happening on the trial?

The following graph shows the number of positive urine tests for each tier since the beginning of the trial:

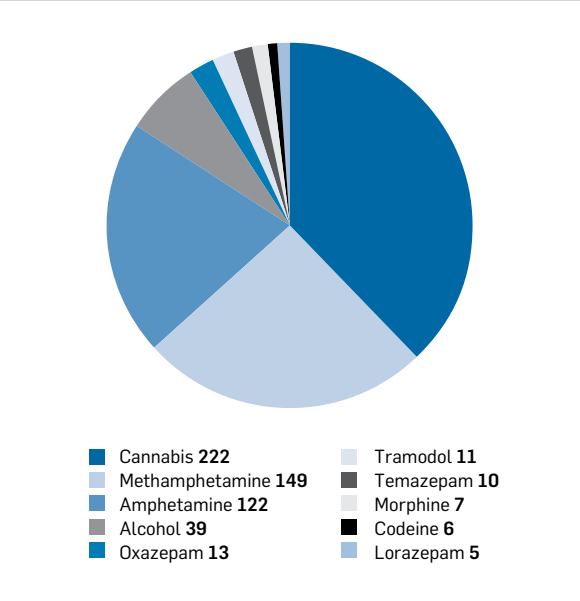


The total number of cases assigned to a testing tier was 3,080 at 1 March 2018. At that date there had been 1,046 urine tests in total, of which 306 have returned positive.

While most (199 tests) returned positive for one substance, many were found with two or more substances as per the following table:



A breakdown of the top 10 substances found is as follows:



Cannabis was by far the most common substance detected. High rates of methamphetamine and amphetamine were also found.

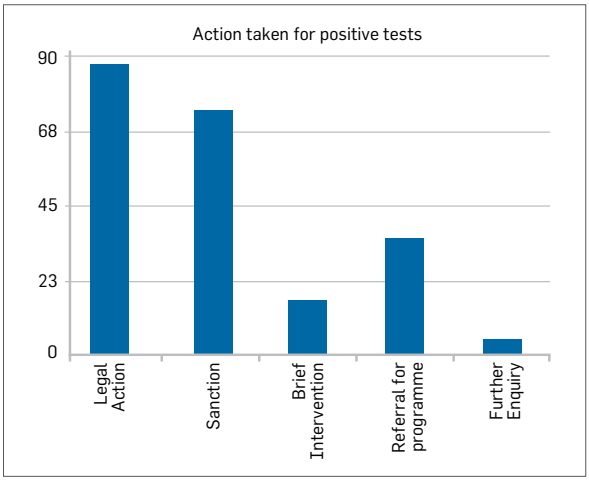
In respect of ADA, at 1 March 2018 there had been 51 cases monitored through an anklet since the trial began (Police and Corrections both monitor in this way). Only four people had returned confirmed drinking events and when compared to the number of "tests" (every half hour while the anklet is worn) that equates to a sober rate of 95.9%. International research conducted on similar devices has found those who wear the anklet for 90 days have a lower recidivism rate and in cases where recidivism occurred, this was significantly delayed (Flango & Cheesman, 2009). The sober rates experienced to date are encouraging.

How are we responding to positive tests?

Data was taken from 1 September 2017, the day the trial went live to the entire Northern Region, to 4 April 2018. Between these dates 241 positive tests were returned for 216 offenders.

Given that only one response was recorded by the AOD Testing Coordination Team (AODTCT) for each positive test it was difficult to know from the data alone what exactly has been happening in the journey of each person tested. A deeper dive was therefore necessary to obtain a more realistic picture.

Actions were recorded for 220 of these tests as shown in the graph below:

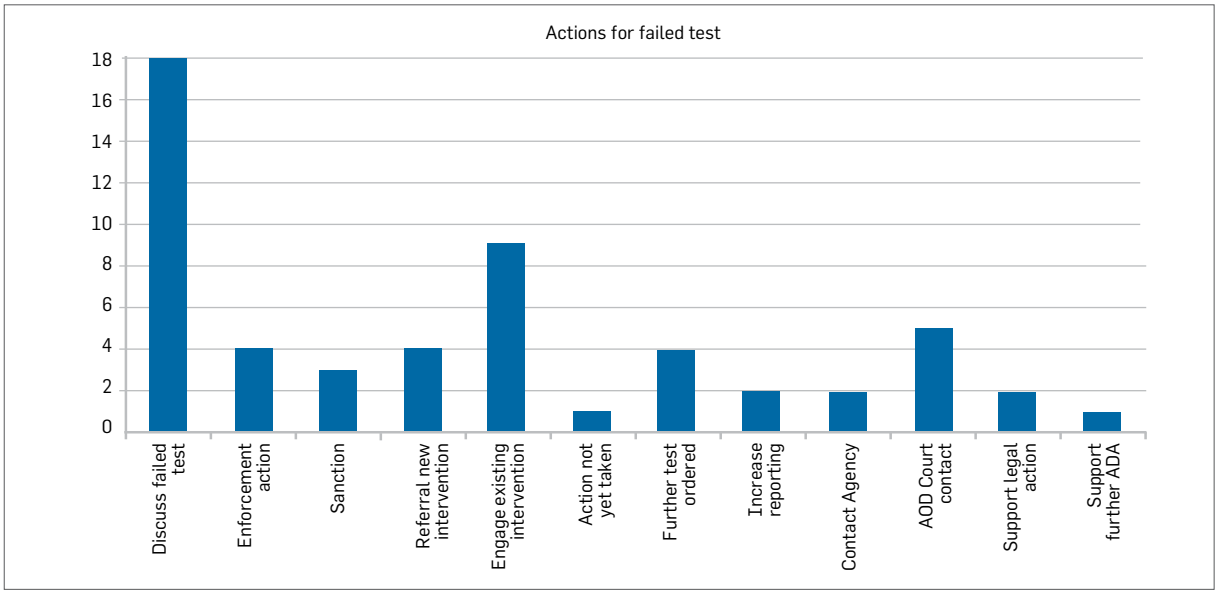


Information recorded in file notes for 20 people who returned failed tests for alcohol and/or drugs was examined. For these 20 people, a total of 55 actions were taken. The information obtained was indicative of the complexity of each single case. Five of those examined were attending or had completed the specialist AOD Treatment Court[1]. In all of the cases where these people had returned positive tests they were brought back before the judge of the AOD Treatment Court to discuss the way forward. One of these people, who has completed Higher Ground, the Salvation Army Bridge Programme and who attends Alcoholics Anonymous meetings, was encouraged to re-engage with current intervention provider CADS and other supports.

In some cases, probation officers were engaging with community mental health services as well as intervention providers. In one case the probation officer was working with Oranga Tamariki as the person testing positive was heavily pregnant.

In all but two cases, the probation officers had recorded having conversations with the person about their positive result, including how it would inform future management. In one case, no action had yet been taken, indicating that the positive result had only just been received.

1 Offenders attend the AOD Court on a regular basis, talk with the judge about their intervention and discuss testing results. At the end of the process the judge decides on sentencing.



In higher risk cases, a positive result was used to support an application to maintain ADA past 90 days and in one case, where the person had a number of breaches before the court, it was used to support an application for an Extended Supervision Order.

This data tells us that testing people for alcohol and drugs is effective in beginning and/or maintaining dialogue around substance abuse issues, which can be used to support new or existing intervention while holding people to account for non-compliance with abstinence conditions.

Moving forwards

Testing people on community-based sentences/orders for alcohol and drugs is still relatively new to New Zealand Community Corrections, but at the time of writing (May 2018) things are tracking well.

An interim evaluation in February 2018 found that probation officers were generally confident they knew how to respond to positive test results. They expressed a general preference for rehabilitative responses rather than breaches, and identified community safety as the most important factor in making those decisions.

A person's risk to the community is always at the forefront of our practice. The more we know what the risk factors are and the extent of these, the greater chance we have at succeeding in reducing re-offending. Testing for alcohol and drugs provides real evidence for managing a person's risk, allowing probation officers to make informed decisions that best support the person through their sentence and beyond.

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Employment needs post-release: A gendered analysis of expectations, outcomes and service effectiveness

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Marianne Bevan started at Corrections in May 2014, and has completed a range of research and evaluation projects related to women's offending, the case management of women in prison, family violence offending, prisoners' trauma exposure, and youth units. Prior to working at Corrections, she conducted research, and implemented projects on gender and security sector reform in Timor-Leste, Togo, Ghana and Liberia.

Jill Bowman has worked in Corrections' Research and Analysis team for eight years following a variety of roles in both the private and public sectors. She volunteers at Arohata Prison, teaching quilting to women in the Drug Treatment Unit.

Introduction

It is widely agreed that, irrespective of gender, prisoners experience a broad range of challenges following their release from prison. Internationally, research has conclusively shown that men and women encounter a number of common problems on exiting prison, including issues finding stable accommodation, obtaining and maintaining employment, avoiding anti-social peers, abstaining from drugs and/or alcohol, accessing health (including mental health) services and treatment, and (re)connecting with intimate partners, children, and family (Duwe, 2015; Bevan & Wehipeihana, 2015; Calverley, 2013; Flower, 2010; Petersilia, 2003; Baldry et al 2006; Visher & Travis, 2003; Travis, Solomon & Waul, 2001).

Despite these shared difficulties, studies have routinely observed important differences between men and women's post-release experiences (Doherty et al, 2014; McIvor & Burman, 2011; Flower, 2010; Arditti & Few, 2006; McIvor, Trotter & Sheehan, 2009; Hannah-Moffat & Turnbull, 2009; Baldry, 2010). Without exception, international studies demonstrate that released female prisoners re-offend at lower levels than their male counterparts (see Spjeldnes & Goodkind, 2009). This fact holds across different jurisdictions and time periods, and is also the case in New Zealand. For example, in 2015–16, 21% of women released from prison returned to prison within 12 months of release, compared to 33% of men. Gender differences at 24 months are even more pronounced with 28% of women and 45% of men reimprisoned.[1]

Notwithstanding their lower levels of recidivism, women are often described as having more complex reintegration needs than men (see Doherty et al, 2014; Carlen and Tombs, 2006; Davies & Cook, 1999). A key area in which women are considered to be more disadvantaged relates to post-release employment. Studies have shown that female prisoners often have lower levels of educational attainment and more limited work histories than their male counterparts, and have typically endured greater economic deprivation prior to entering prison (Flower, 2010; Bachman et al, 2016; Carlen & Tombs, 2006; Spjeldnes & Goodkind, 2009). Research has further demonstrated that once inside prison, women also have fewer educational and vocational opportunities (Scroggins & O'Malley 2010; Davies & Cook,, 1999; Cho & Lalonde, 2005). It has also been argued that because crime is considered a more "normal" masculine endeavour, female prisoners also suffer greater social stigmatisation on their return to the community (Carlen and Worrall, 2004).

1 Based on releases in the 2014/15 fiscal year (Department of Corrections 2017)

In several countries this recognition has led to the introduction of re-entry programmes specifically designed for women (see Scroggins and Malley, 2010). Although reintegrative programmes such as Out of Gate have been introduced in New Zealand and are used by female offenders, no female-specific services have yet been developed, and the extent to which such a development is warranted is unknown. In fact, very little research has been undertaken on either male or female prisoners' post-release experiences in New Zealand, including employment experiences and, within this, whether any gendered differences exist (Bevan & Wehipeihana, 2015; Bowman, 2015; Gilbert & Elley, 2014).

A Department of Corrections' post-release employment study aimed to start filling this knowledge gap. The study involved interviews with 127 prisoners up to a month prior to release, with follow up interviews conducted after three to four months post-release (n=97), and a third interview conducted 12 months after the original release date (n=38). Initial interviews were conducted between November 2015 and January 2016, with follow up interviews undertaken between February and June 2016, and then again in November 2016 to February 2017. Those interviewed were broadly representative of the released prisoner population. The first phase interviews included 43 women and 84 men, the second phase included 25 women and 72 men, and phase three involved interviews with seven women and 31 men. A greater proportion of women in the original sample (65%) identified as Māori, compared to men (48%), and overall just over half of the phase one participants were Māori.

The interviews collected information about prisoners' education and employment experiences pre-prison, their post-release employment and/or study plans and what happened after prison, with a particular focus on employment outcomes. This article is based on information from the first two phases of interviews, and looks solely at gender differences and similarities (for a full description of the methodology and an overview of the study's main findings see Morrison and Bowman, 2017).

This article outlines the gender similarities and differences in relation to education and employment, and considers the implications of these for service design. It concludes with an appraisal of the Offender Recruitment Consultant (ORC) service, a Corrections-run recruitment service designed specifically to help offenders secure employment, which was separately evaluated in 2017. The post-release employment study contributed to the design of the ORC service. Consequently, the service offers a good example of where "evidence meets practice".

Life before prison

Research on re-entry has frequently demonstrated the importance of setting post-release experiences within the broader context of offenders' lives prior to imprisonment (Duwe, 2015; Doherty et al., 2014). Understanding gendered differences in pre-prison experiences is crucial if we wish to identify whether there are gender specific needs requiring different service provision.

Education and post school activities

Within the post-release study sample there were no differences in the age at which men and women had left school, with the average leaving age for both being 14.8 years. Women, however, were far more likely to have left school with qualifications than their male counterparts, and generally recounted more positive education experiences. They were also more likely to have left school voluntarily. Men were more likely to report having been expelled from school on account of disruptive behaviour. Significant numbers of both genders reported troubled childhoods which affected their education and had ongoing implications for how they approached learning environments in prison, such as vocational training, education, and group treatment settings. For many, their school years were strongly associated with trauma, such as bullying at school or physical or sexual abuse at home:

> *"I got a brain injury … I went back to school but I struggled and I should have been put in a lower class, but no one picked up on that until later. By then I'd been bullied and picked on by other kids about my reading and writing."*
>
> **Sophia, a Māori woman in her 30s who had learned to read and write during her prison sentence**

Despite leaving school around the same age, there were important differences in men and women's post-school activities. A reasonable proportion of men went directly from school into work or some form of applied study (such as an apprenticeship); the exception here was young men, who were more likely to have done little work or study since leaving school and were also more likely to have become involved in gangs either before, or soon after, leaving school. These young men were more likely to have commenced predominantly criminal lifestyles soon after leaving school. While some women had commenced work or study on leaving school, this was less prevalent, and women's study and employment had frequently been interrupted by the arrival of new relationships and/or becoming pregnant. The narrative of "met a boy, got pregnant" was very common amongst these women. The absence of

employment between school and starting a family had ongoing repercussions for women post-release, with women in the study exhibiting shorter work histories and a narrower range of vocational skills compared to men.

Employment backgrounds

Women were more likely to report having never or rarely worked, with almost a quarter of women falling into this category compared to less than a fifth of men. That said, women were also more likely to report having mostly or always worked since leaving school, with one in three women reporting relatively stable work histories compared to only one in five men. Men were more likely to have worked intermittently and often had a much broader range of work experience and vocational skills. For example, men's work histories included: labouring, meat works, farming, mechanics, welding, and a variety of factory-based jobs. Several had worked as chefs, butchers, and truck drivers, while a few had held management positions. Amongst women, a more limited and less diverse range of employment histories was observed, mostly unskilled and poorly paid. Common roles in the employment histories of the women were hotel cleaner, bartender, mental health or disability care workers, kohanga reo assistants, retail assistants and packers at meat works or orchards. A small number had also worked as prostitutes. Importantly, even where men and women's employment appeared to overlap (for example, working at the meat works and orchards) women's roles were often more menial and less well paid than their male counterparts.

Pre-prison context

Men were more likely to have been working immediately prior to incarceration. In contrast, few women in the study were working prior to their imprisonment; the criminal activity which led to their imprisonment often appeared to dominate and disrupt their lives to a much greater degree. Probably linked to this point, women in the study were also more likely to report methamphetamine use and mental health problems prior to arrival in prison. Despite the fact that women reported a higher incidence of mental health and drug addiction problems, men in the study were twice as likely to be receiving a supported living benefit. While a greater proportion of women were receiving benefits prior to prison, the vast majority were receiving job seeker benefits. One fifth of women were receiving sole parent benefits; however, it was also the case that few women in the study reported having full care responsibilities for their children, with most children being already in the care of relatives or Child, Youth and Family at the time of the women's offending and subsequent incarceration. Somewhat unexpectedly, therefore, child-care was seldom found to be a significant barrier to pre-prison employment for most of the women in this study.

Plans for life beyond prison

When asked shortly before release about their release plan, similar proportions of men and women (just under one fifth) reported having a job already organised. Men were generally more likely to be able to articulate their employment plans in specific terms (43% to 28%); however, women were more likely to state definitively that they had no intention of working post-release. Women's main reasons for not seeking employment were child-care responsibilities, health problems or, most commonly, the need to focus on obligations associated with fulfilling their release conditions.

Men were far more likely to see obtaining employment as an immediate post-release priority and generally saw employment as a pre-requisite to getting other parts of their lives "sorted". As Tom, a Māori male in his 30s, noted:

> *"I'm hoping to find a job pretty quickly, because without a job, I'm going to cause mischief … I know without a job I haven't got enough money to pay for what I need to survive out there, so the only thing I can do is go back to gang-banging[2] … work's the major factor for me."*

While some women also prioritised employment, most reported an array of more pressing needs and concerns which rendered work a low priority. In other words, men typically saw work as a means to get life sorted, women felt the need to get other areas of their lives sorted out before they could think about looking for work. On being asked if she planned to look for work post-release, for example, Tanya noted:

> *"I'll make sure I'm settled first … I want to make sure I spend as much time as possible with [my son] before he goes back to school and just make sure I'm in the right space of mind … settle down, yeah."*

Agency

A further point of gender difference related to a sense of personal agency. Men in the study expressed a far greater level of self-determination than women, and were, at least pre-release, more optimistic about their future employment prospects:

> *"Like I said, it's all on me. It's all on the person. How much you want it. That's how I look at things. If you're persistent and you work towards your goals, you will eventually get there."*
>
> **Aleki, Pacific male in his 20s**

2 Gang-banging here referred to committing crime as part of organised gang activities. For this offender such activities included burglaries and the use of intimidation and/or violence to extract outstanding debts owed to the gang from individuals.

"Jobs will come and go. I'm not stressed about that … As long as you are actively looking for work, you're going to get a job aren't you, you know? It's not like you'll be unemployed forever."

Ray, NZ European male in his 20s

In contrast, women in the study appeared more acutely aware of the limitations that their criminal convictions and lack of education placed on their future employment prospects. This was especially true in situations when women's previous employment experience was limited to carer, retail, or hospitality work:

"There's not much I can do now, because I've got a criminal record. The dream is I wanted to be a bartender … but it's till work and I've got over fifty dishonesty charges against my name, so it's pretty hard for me to get a job."

Dallas, a Māori woman in her 30s who left school at age 11

"How are we meant to get a job when they aren't going to accept us with these criminal histories? … It's a waste of time really if I'm just going to get shut off."

Janet, a Māori woman in her 20s, with a limited employment history

Post-release employment experiences

Although similar proportions of men and women when interviewed in prison said they had a job already organised for post-release, men were more likely to be working at the time of their second interview, and were twice as likely to have worked at all since leaving prison. At the time of the second interview, just under a third of the men were currently working compared to a fifth of the women. Men were more likely to have retained the position they had prior to imprisonment or continued working in the same type of occupation. As was the case pre-prison, men were working in a much greater variety of roles post-release (examples included: carpentry, butchery, window installation, plastering and sanding, truck driving, mechanics, and engineering roles). Women had worked in hospitality roles (typically cafes, restaurants or bar work), cleaning, fruit picking, and packing. Several women had also returned to prostitution post-release. Men were more likely to be in full time work, and most were earning more than the women in the study. Women were more likely to be part time or on casual contracts, where weekly hours of employment were unpredictable and often weather – or demand – dependent.

Barriers to employment

Men and women experienced similar barriers to employment, including their criminal record, trying to fit work around prison release conditions, or simply an overwhelming myriad of "things to do" to re-establish their lives. Interestingly, no women interviewed at stage two identified child-care responsibilities as an employment barrier, although several men in the study did. Women were more likely to mention geographical distance to employment opportunities as a problem, and the need to balance earning potential against travel costs. Men were more likely to identify lack of stable accommodation, food, and clothing as problems, a lack of driver licence, concerns about stand-down periods if their employment ceased, and drug testing at work as barriers. Several men acknowledged they needed to weigh up the potential pro-social benefits of legitimate employment with the fact that they could earn more money through "illegitimate" means. Finally, despite a greater prevalence of mental health issues pre-prison amongst women, it was typically men who mentioned that this detrimentally affected their ability to obtain and maintain employment following release.

Finding work

Women who were looking for work tended to report less success than men in finding work. With most having limited employment histories, few women had existing employment networks to leverage for opportunities. Women were consequently more likely to apply for jobs through formal application processes, and, consequently having to disclose convictions prior to meeting prospective employers. As a result, perhaps not surprisingly, few women found employment through these formal applications. Men, on the other hand, were more likely to have friends, family or previous employers willing to take them on, which meant fewer needed to formally apply or be interviewed for roles. In situations where formal recruitment procedures were followed, several reported that interviews had "not gone well":

"As soon as you say you had something on your criminal history, like, 'Nah' … then as soon as they ask you, 'Have you been to prison?' It's just shut down. They don't want you, they don't trust you."

Barry, NZ European dishonesty offender in his early 20s

Participants of both genders, although more typically men, reported wanting more help to broker employment, and noted the value of having a job organised prior to release. Many talked about wanting a case management-style service in which an individual worked with them in prison and beyond to find and maintain appropriate work, as well as helping

individuals manage competing demands in the first few months post-release.[3]

Employment and re-offending

In terms of re-offending and employment, while no women working at the phase two interviews had re-offended, half of the men who were working were facing new charges. For some men, their employment appeared to have indirectly contributed to re-offending: the onset of a steady income tempted some to purchase drugs and alcohol, or a vehicle with which they engaged in high risk activities such as "drifting". For others, working seemed to generate stress and anxiety, which reportedly contributed to drug and alcohol abuse. Importantly, no women who worked post-release revealed any link between offending and employment; rather for women, employment was more likely to be associated with desistance. What such findings reveal is that employment is not always a protective factor against re-offending in the absence of other supports. It was evident that many people needed continuing support to maintain employment in order to capitalise on the positive impacts employment can have on preventing re-offending. On the basis of the above findings, it may be that men are more in need of this type of in-work support than women.

Key implications for service design

Returning to the question of whether gender-specific reintegration services are needed in New Zealand, in respect of post-release employment needs, the current study does not provide strong evidence for gender-specific services; however, it does indicate that standard services could be made more responsive to the different needs of men and women. Certainly, men and women share many common problems associated with obtaining employment following a period of incarceration; however, women generally have shorter work histories, less breadth in their employment experience, and less access to existing employment networks to leverage for opportunities. Women are more likely to rely on formal recruitment processes in the first instance, but men may struggle more at the interview stage, especially in situations where disclosure of conviction histories is likely to arise. While men may need to access employment assistance soon after release, women may require assistance further down the road, usually after other reintegration foundations are in place. Once in employment, men, in particular, are likely to need help to maintain employment and broader support to ensure that employment strengthens their long-term desistance from crime.

Irrespective of gender, the post-release study found that people wanted a service which invested in them as individuals. They wanted continuity of help; from assistance to find employment placements pre-release, brokering contracts and employment conditions once employment was found, and ongoing support and encouragement to maintain employment thereafter. When "things fell over", they wanted someone to help them to get up and try again.

Evidence to practice: This Way For Work

In response to these needs, the Department introduced the "This Way For Work" initiative in late 2016. This included the implementation of the Department's own offender recruitment service, which included appointing 13 "Offender Recruitment Consultants" (ORCs). ORCs are Corrections' employees who help released prisoners and offenders serving community sentences to find work. ORCs may start working with offenders in prison, and then continue to work with offenders once they transition to the community. For those who are not "work ready", ORCs work with a variety of other internal and externally-contracted parties to help people get motivated and ready to work (for example through assisting with driver licencing, CV and job interview preparation, obtaining forklift licences and/or safety standard qualifications). ORCs also broker employment between offenders and potential employers, and assist offenders throughout the recruitment process. Once employment is obtained, ORC clients can also access on-going in-work support to help sustain employment.

Evaluated in mid-2017, the service was found to be highly successful. At the time of writing (May 2018), the service had placed over 1,000 Corrections jobseekers in employment (approximately seven percent of those placed in employment were women). In line with the post-release study findings, the evaluation identified a number of factors crucial to the success of the initiative. These are briefly detailed below.

Individualised and flexible delivery

A key reason for the success of the ORC service was the provision of individually-tailored support. Considerable variance was evident in the level of employment need amongst offenders. Some, such as those with child sex offences, or those who had limited employment experiences, took more time and effort to prepare for placement, and successfully place. There were some unique challenges apparent when placing women into employment, as women did not always have the required experience or a desire to work in some of the industries most likely to recruit through ORCs (such as construction). Some of the areas women

3 The Department now have a number of services which assist prisoners to set up work prior to release. These services include Guided Release for those serving sentences of two years or more, and the Offender Recruitment (ORC) service open to both prisoners nearing release and offenders in the community whether post-release or serving community sentences. This service is discussed in more detail below.

wanted work in (e.g., hairdressing) could take longer to find suitable placements. Despite such challenges, the service worked well because ORCs had the flexibility to tailor the level of service to these individual needs. ORCs worked closely with offenders to identify their work preferences and employment possibilities, and to source jobs that were a good "fit"[4]. This increased the likelihood that employment was sustainable.

Brokering employment overcome significant employment barriers

Having the same person engage with both offenders and employers made the process of finding employment and suitable employees significantly easier for both parties. That ORCs actively sought out employers enabled new, often unlisted, work opportunities to be identified. For offenders, having ORCs act as a go-between ensured that criminal records were fully disclosed by a third party in advance, removing a significant source of anxiety for offenders when they met prospective employers for the first time.

Helping offenders to be "work ready" was vital

The evaluation found that the most successful placements occurred when ORCS engaged with offenders who were "work ready". This meant that offenders had: a quality CV if this was needed; the right licences; reliable transport options; completed sentence requirements (e.g., rehabilitation programmes); "soft skills" needed to function in the workplace, such as time management and communication skills; and genuine motivation and desire to work. The ORC service worked particularly well when ORCs leveraged the array of auxiliary support services already in place (for example, employment support officers based in probation offices) to assist offenders to become work ready. The evaluation found being "work ready" increased the likelihood that employment would be sustainable, and increased employer satisfaction with job seekers. This aspect of service design also meant that female offenders are given the opportunity to receive assistance to get their CVs and covering letters prepared, and receive the support needed to develop their motivation to work later on in their sentence when other foundations are in place.

Employment services work best when they are linked to wider reintegration support services

A key finding of the post-release study was that employment tends to be associated with desistance, but not invariably; employment generally aids in achieving the stability needed to desist from crime, but instances were observed where specific stresses associated with employment appeared to be a factor in re-offending. Further, the evaluation found that employment could quickly be de-railed by problems such as poor relationships, renewed substance abuse, and lack of housing. Consequently, ongoing support with such broader issues was essential to help offenders manage these difficulties, and thereby maintain employment. ORCs provided this support in a range of ways: through checking in with employers and offenders to ensure offenders were turning up, helping with workplace disputes or negotiations with employers (for example about pay rises, leave entitlements), and, in some cases, assisting people to find accommodation or transport as issues arose.

As the ORC service matures it will be important to consider how it can optimally function alongside existing employment-related services and more general reintegration services, including new services, such as Guided Release.

4 Recently-held education "expos" at each of the women's prisons have sought to promote awareness of, and readiness for, a much broader range of employment options for women.

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Employer and employee perspectives on This Way For Work: Interviews and success stories

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Author biography

Lucy spent four months in the Department of Corrections' Community Partnerships team, getting success stories into the public arena. She has nearly 20 years' experience as a journalist in New Zealand and Australia and has worked as a government press secretary, including for two Corrections ministers. After three years in the Beehive she has recently returned to Parliament to work as a political reporter for the New Zealand Herald.

KEYWORDS: This Way for Work, reintegration, rehabilitation, offenders, employers

Introduction

The Department of Corrections' This Way For Work pilot, which commenced in October 2016, supports people with criminal convictions into employment. At March 2018, the pilot had proven to be highly successful, with 1,086 placements into permanent employment.

The pilot employs specialist recruiters known as offender recruitment consultants (ORCs) who work with employers to place people with criminal convictions (jobseekers) into sustainable employment. The pilot began with eight ORCs, however, the success of the pilot meant that in November 2017 an additional five ORCs were employed, making a total of 15.

The pilot also offers an Employer Starter Pack to remove financial barriers to employment. For example, employers may need to pay for personal safety equipment (such as work boots or a hard hat) for the new employee, or may need to buy new tools for them to use.

The interviews

For this article, five employers who have successfully hired and retained jobseekers through Corrections were interviewed. They were:

- Tom Nickels, CEO of Waste Management (MOU partner[1])
- Belinda Ritchie, Operations Manager of Ritchies Transport
- Tom Compton, General Manager of heavy haulage company CV Compton (MOU partner)
- Ben Po Ching, Managing Director of B&H Builders (MOU partner)
- Annette de Wet, Resource Manager of ICB Retaining and Construction (MOU partner).

Four people hired by these employers after leaving prison were also interviewed.

The aim of the interviews was to gather perspectives from employers and employees that were slightly more in-depth and anecdotal than the brief evaluation of the This Way For Work pilot (Johnston, 2018).

Employers were asked for their perspectives on This Way For Work, the rationale behind their decisions to hire former offenders, any challenges they or their workers faced during or after the hiring process and the outcomes so far.

The former offenders, all of whom have so far successfully transitioned from prison to the workforce, were asked about their journey from prison to employment and how it had helped change their lives for the better.

Hiring through Corrections

All five employers spoke of two factors that led to their decision to hire staff through Corrections – a skills shortage and a sense of social responsibility. Another common theme was they were willing to give offenders a second chance because "we realise that people do not even want to talk to someone with a criminal record".

ICB Retaining and Construction Resource Manager Annette de Wet who has a relationship with Corrections of more than 13 years, was aware that employees could be hired through Corrections. ICB began its own employment relationship with Corrections in early 2017.

1 An MOU partner is an employer who has formally partnered with the Department of Corrections via a Memorandum of Understanding (MoU).

Asked why ICB decided to hire through This Way to Work, de Wet said: "We hired through Corrections because of my previous experience. Having the in-work support and overall back-up from Corrections if we ran into any problems influenced the decision. That, as well as social responsibility to give these guys a break, was part of the decision. We really believe there's a second chance opportunity to find good staff. We realise that people do not even want to talk to someone with a criminal record. They don't even ask why, they just shy away from it completely. I convinced upper management of ICB to give these guys a chance and it's worked out really well."

Waste Management Chief Executive Tom Nickels gave a similar response when asked about his company's involvement with Corrections:

"It started with our head of HR, Sharon Scott, coming to me and talking to me about the possibilities. We've got a number of skills gaps in our company that we're continually finding it harder to recruit for, and she said 'well, this might be an opportunity'. As we got talking, it just felt right. For me, it just seems like the sort of thing big companies should do. As New Zealanders, if we want the sort of society we do, it's our job to do something about that. If you think about the people who are coming out of prisons, if we as a society do not give them an opportunity, what other option have they realistically got? So it was coming out of two points probably. One was that we have skill gaps that we continually find hard to recruit for and, as a member of society, we've got a role to play in creating the society we want."

Ben Po Ching of B&H Builders described the process as "just another avenue where we can tap into another pool of resource of people who had skills already".

"I don't judge them in terms of their character, it's just the skills that I need. As long as they can swing the hammer or carry out a task that's given to them, I don't really care what they've done in the past. Some guys, they need to be given another chance. They're good people. If this can be used as part of their rehabilitation then I'm all for it."

Tom Compton went further, saying he felt grateful he was in a position to offer former offenders an opportunity he says most people wouldn't even consider. "We've got, as do most companies, a question in our job application which says 'do you have any convictions'. As soon as a company sees a yes, they'll bin their application but when I see yes, it's like an attraction for me and I feel compelled to dig a bit deeper and see where we can get these guys to fit in. I just think it's such a fantastic thing that we're doing in giving these boys an opportunity. They're not all ratbags … the majority of them do want to improve. It is definitely a social morality thing. I'm grateful that I can do it."

Similarly, Belinda Ritchie says: "A lot of people, I suppose, look at them and go 'we're not going to take you on'. But we're a big, big believer in giving them a second chance.

It's worked out very well. Obviously we can open the door. If they want to re-offend that's down to them but the ones that we have taken on haven't re-offended."

Work readiness and challenges

All the employers were asked whether they believed the candidates put forward for interviews were work-ready and whether they had appropriate support from Corrections at the time and following employment. Some employers also gave examples of challenges they and the staff they hired faced in making the placement work for both parties.

"We've had a few challenges once we've appointed people into roles," says de Wet of ICB. "Transport and licensing is always an issue. For our labourers to get to work, they need to have at least a restricted licence and reliable transport. Of the nine we've employed, three have left for different reasons. The other six are still here. One of the guys is ex-army and he has amazing skills that we saw from the beginning. We've advanced him, so he's a foreman now. He had driver licence issues to begin with, but he got it reinstated after a few months. Before he got it back we had to work around that, like getting someone else to pick him up, but he's worked out really well."

Po Ching of B&H Builders said while he felt part of the process, there were always things that could be done better, although he didn't elaborate. "It's all got to work out for these people. It's a second chance at life and it's an opportunity to learn new skills and develop themselves. That's rehabilitation right there in a nutshell."

Compton described former offenders as a highly motivated workforce. "They're desperate to get into the role. They are definitely motivated. They want to get into a role that they can work hard in and impress an employer, that's what I've found."

Nickels says that while an individual's motivation is one factor, there are others. "I think it's down to the individual who joins us, how well we have assessed them, how well Corrections has assessed them as being ready. It also comes down to the people around them – their workmates, their supervisor, the level of involvement and support and trust. I think they're all factors, but ultimately a fair degree of it comes down to the individual and whether they actually really do want to be rehabilitated.

"It's early days for us … and we haven't had perfect results so far. We've had some really good success and we've had some that haven't turned out like we would like. But actually that's no different to the general population when you're a big employer like us. Not everybody we put on turns out really well, as much as we'd like it to be the case. We're not deterred by that."

He didn't believe there was anything more to be expected from Corrections in terms of readying former offenders for post-prison employment. "We've been really impressed with the level of engagement from Corrections. It's been almost unexpected. Very positive is probably the best way to put it. They've been terrific."

Ritchie also says a close relationship with Corrections staff helps with any teething problems. "The ones who have come through to us have all definitely been prepped well and are prepared to work. I deal very closely with a Corrections probation officer. When he feels that there's someone that comes through, he'll send me the CV and then we will discuss everything and then he will then come in to the interview with the people. Then afterwards he'll follow up and if there are any problems I can get hold of him straight away. Corrections have been great."

De Wet agrees the support from Corrections has been good. "For employers, they've got this back-up that you have Corrections and they really jump if there's any problems, they just sort it out, it's incredible … it's just a phone call away. It's really great knowing you've got that support."

Changing lives

The employers were enthusiastic when describing the positive changes they observed in the workers they employed through Corrections and were generally certain their staff would not re-offend while they were employed.

"It's amazing to see them change, to see them getting their lives back on track, getting the children back, getting a stable home life, having money to spend on things," says de Wet. "You actually see them physically change. And they are tremendously loyal because of us giving them the opportunity and giving them support, and they know I really care about them."

Nickels says: "We can do things sometimes that can change the rest of people's lives and this is an example of that. It provides very positive feedback not only for our company but for those individuals involved. At a personal level it gives you a really warm feeling that you're doing something beneficial here, you're helping somebody."

Ritchie says the company has recently, for the first time, hired female former offenders. Two women have begun work with the company in the past few months. "They are both working out very, very well. Their lives are turning around. They're really happy, they enjoy coming to work. We're like a big family here," she says.

The workers

David* has worked for CV Compton as a mechanic since early 2016. He was deported from the US in late 2015 following his release from prison there. A New Zealander, he had spent 28 years in the US and was ordered to live in Auckland, away from his family in the South Island, when he returned.

"I was offered a programme through the Department of Corrections. They had a one-month course which if you took it you were able to get tickets for certain occupations and at the end of the course they would help look for a job for you. It was all basically health and safety, first aid, traffic control, forklift operations, working at heights and one or two other things."

He has remained crime-free since being back in New Zealand. "I had no wanting to go back to prison," he says.

Having a job, he says, gives him purpose. "It means having a stable living environment, a roof over my head, money to do the things I want to do and purchase the stuff I want to purchase. I'm extremely grateful to CV Compton for giving me a chance. Any chance I get I recommend taking the programme that the Department of Corrections has to get a job because a lot of offenders don't have jobs. It just adds purpose to your life and makes you feel like you're accomplishing something positive."

Hemi* has been a foreman for about six months and before that a labourer with ICB.

He left Auckland Prison in September 2016 after an eight-year sentence. Hemi, who has a partner and children, says he began serious offending at the age of 14 and cited his upbringing, associations, and the environment in South Auckland as factors in his lifestyle.

"I actually wanted a job. When I was on probation I heard there was an initiative that had started up where Corrections was trying to get guys like myself into work. The main thing for me was that my lifestyle needed to change. Everything that had happened to me in the past needed to change. I wanted that change. The first step was 'I need a job; I need to keep my mind busy'. I haven't spent much time with my kids growing up. I love my kids … they've always been there for me and the last thing I wanted to do was slide downhill.

* Not their real names

One of the major concerns I had looking for jobs and applying for jobs was that stigma attached to me. I know myself and I'm a highly intelligent person and I just wanted a chance."

Hemi says while he may not have appreciated it at the time, with hindsight he can see Corrections gave him rehabilitation and reintegration opportunities while in prison.

"When I look back on it now, on everything that was done to help me to reintegrate – more than anything else, they tried their best with programmes I was engaged in, trying to help me and upskill me. There's really some quite good programmes."

With employment, the links to his criminal past have diminished.

"For me, that ceases to exist. Old places, old mates, everything. I really love my job. For the first time it's something that I love doing. I've got people who employed me who've placed their trust in me. That trust from them is immense, they trust me to do my job and to do it unsupervised and give me a team."

Jennifer* recently began working with Ritchies as a cleaner. She is a mother and grandmother, which motivated her further to get into work and resume her former life following her prison term.

"My crime was very silly … I went away for that and I just knew that I was going to turn that sentence into a positive. I got qualifications that I was able to use when I came home … and I got my forklift licence. I did a full rehabilitation programme and I learned about behaviours that I had and had lived with not realising they were really choices and I could have made better choices. And that's what it's about now, assessing my situation, reassessing, moving forward and looking at the pros and cons. I'm not just jumping in and doing it just because I think that's what I should do but because I've weighed it all up and I can see where it's going to go or not going to go. It's been awesome."

Having a job has enabled Jennifer to "fit back into that slot of being mum, of being a positive member of society. It took away that shadow, that stigma of 'you've been to prison, no one's going to give you a job so just go home, rely on a benefit' … and I knew I was not going to do that. I know my family deserves better than that. I knew I'd worked hard enough to achieve better than that, so I did."

David*, a former white-collar worker, is employed by Waste Management as a heavy machinery operator following a stint in Auckland South Corrections Facility.

"The eight to 10 weeks when I came out of prison – you come out, you're on a bit of a high, you've got parole, but very quickly you realise sitting at home and doing nothing and living on a benefit is just a waste of time and is demoralising. For about eight to 10 weeks it was a miserable time in my life. Everybody is keen to read your CV, they're keen to interview and then up comes the criminal activity and history and you can almost see them glaze over.

"I said to [Corrections] 'if you can open the door to a few companies who are not averse I can get a job, I can guarantee. I'm not fussy. I will take what I can do and what's available'. A day later I had an interview with Waste Management and two other companies and Waste Management offered me the job when I interviewed with them three days later. Honestly, it was just a breath of fresh air. When I first started here and had my first week, it was like being reborn."

Summary

These perspectives are just a few among the 988 placements into employment since the This Way For Work pilot began. Each perspective contributes to the rich set of data the Department has been able to gather in order to strengthen and adapt the pilot as it has progressed.

The Department has two main areas of focus over the coming year for This Way to Work. Firstly, to develop the pre and post placement support offered by the Department in order to increase the sustainability of placements, which currently sits at around 66%. Secondly, to increase the profile of the pilot and its success stories in order to build on the changing discourse around hiring people with criminal convictions; it is important, it leads to success and it contributes to meaningful change in people's lives.

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* Not their real names

Extending the reach of the Duke of Edinburgh's International Award, Aotearoa New Zealand Hillary Award for youth in Corrections

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Author biography

Ashley Shearar returned to the Department of Corrections in 2016 after managing the Youth Policy team at the Ministry of Social Development. She previously held a variety of roles with Corrections, from working as a probation officer to leading the High Risk Response Team. Ashley completed her PhD at Victoria University comparing youth justice transformation between New Zealand and South Africa. She is passionate about improving outcomes for young people in the justice system.

> *"It's made me stronger both physically and mentally and it's made me appreciate the small things a lot more."*
>
> **A young man from a Corrections Youth Unit reflecting on his experience of the Award**

Introduction

The Department of Corrections recognises that to achieve a significant reduction in re-offending overall, it must improve outcomes for youth. The implementation of the Youth Strategy in 2013 marked Corrections' commitment to improving services and supports to reduce youth re-offending rates. Since then, a number of initiatives have been developed and implemented for youth in Corrections.

In addition to the services provided by Corrections, partnerships with external organisations play a significant role in the successful rehabilitation and reintegration of youth. Corrections' partnership with the Duke of Edinburgh's International Award, Aotearoa New Zealand Hillary Award (the Award) has continued to make a difference for a number of youth in Corrections and helped to increase engagement with the community.

About the Award

According to their Mission statement "the mission of the Award programme in New Zealand is to have young people, regardless of cultural, ethnic and socio-economic background, participating in an exciting, flexible and individually-tailored programme, to build skills, identity and self-esteem".

Young people across New Zealand from the ages of 14 – 25 participate in the Award programme. The programme offers three levels of achievement: Bronze, Silver and Gold. Each of the levels is made up of four key competencies which the young people need to complete, with each level becoming increasingly challenging. These competencies include skills development, community service, physical recreation and an "Adventurous Journey".

Youth working towards a Gold Award are also required to complete a fifth component, which is a residential project. This is described by the Award as "…undertaking a shared activity or specific course with people you don't know, where you will either: build on a talent you've developed in another section; learn something completely new on an intensive course; or do something to help others."

The Award is designed to offer young people a range of personal benefits such as enhanced self-esteem and a sense of achievement. It also provides people with many of the skills employers value, including; communication, reliability, decision-making, confidence, team work and leadership.

Delivering the Award in Corrections

The Award was piloted in 2016 in Corrections' two youth units located at Hawkes Bay Regional Prison and Christchurch Men's Prison. This pilot was made possible with the generous funding from a philanthropic sponsor. The initial focus was supporting the first two cohorts of young men to achieve their Bronze Awards. Since then, ongoing funding has enabled more young men in the youth units to achieve their Bronze Awards, as well as previous Bronze Award recipients to progress to their Silver and even Gold Awards – a significant achievement for youth in Corrections.

In 2017, the Award was extended to include the Auckland Region Women's Corrections Facility (ARWCF), with the first cohort of young women under the age of 25 successfully completing their Bronze Award in December that year.

Identifying eligible youth in Corrections

Sentenced youth up to the age of 25 years who spend at least six months in custody are initially identified as eligible candidates to complete all the components for a Bronze Award. Duke of Edinburgh Award staff meet with the young people to explain what the Award is about, the expectations from the participants and how they will be supported to achieve their competencies. Interested youth put themselves forward to become participants.

Each participant is provided with a book to record their activities against the sections. Corrections staff monitor the record book to confirm when individuals have met the requirements of each component to achieve the relevant Award.

Meeting the requirements in Corrections' custody

The Duke of Edinburgh Award scheme is committed to ensuring that all their programmes are delivered to a high standard internationally. Their staff have worked with Corrections to ensure that each site has been able to support youth to achieve the Award with integrity, despite the constraints of the prison environment.

Examples of skills development have included creative writing and developing tikanga skills such as kapa haka. A range of community service options have been achieved as well, including paintings for children in hospital; fixing pre-loved bicycles to provide a transport option for people released from prison; planting vegetables to supply to Women's Refuge; and serving as tuakana-teina[1], including teaching tikanga to peers.

Long distance running has helped many youth successfully meet their physical skills component, with regular morning runs recently culminating in a marathon being organised for young men at the Christchurch Youth Unit. In January 2018, a number of young men recently pushed their boundaries to complete the full 42 kilometre course within the prison perimeter, with others successfully completing half-marathons and 10km runs.

The Adventurous Journey has arguably been the more challenging component to deliver to youth in custody who are unable to go outside of prison. Creative solutions have been worked through at all three sites to date, including tramping with packs inside the prison perimeter, and identifying a location within the prison where the youth can undertake some further physical challenges as well as camp overnight. The youth have been electronically monitored during the Adventurous Journey to provide additional assurance around risk of absconding when outside of their usual units. Participants, Corrections staff and Award providers describe how this experience serves as a good opportunity for youth to open up about themselves, including their hopes and aspirations for their futures.

Support from experienced Award providers

To date, the Award has been implemented in collaboration with experienced providers: Joshua Foundation in Christchurch and Poniki Adventures in Hawke's Bay and Auckland. This has enabled us to deliver a quality programme, and for Corrections staff to get insight into what is expected for youth to achieve their competencies. The providers have worked alongside Corrections staff to support our participants through the programme. They have also worked more intensively with the youth during the Adventurous Journey component.

The involvement of the external providers has added value to the experience, which for the participants has included their appreciation for people coming from outside of Corrections to give their time and experience to support them. This was captured in letters written from the young men to one of the providers, with one of the young men writing:

> *I would like to thank you for the level of commitment you brought with you into prison. I really like how you treated us all the same as you would with people out in the community.*

Delivering the Award in a women's prison

Running the Award at ARWCF where there is no dedicated youth unit presented a new challenge for Corrections. A key difference was that the eligible young women could be identified from a number of units across the prison site, making it more difficult to ensure that staff across the site were aware of which young women were participating, that they understood the expectations and were able to support the young women through their competencies. It also meant that the young women had less opportunity to work together and support each other towards their competencies than if they were in the same unit.

The site responded to the need by identifying a key site representative who became responsible for communicating with the Award staff and the external provider and keeping the young women updated about key events and activities. The site also engaged key staff at the site who could help the women progress

1 The teaching relationship between an older person and a younger person.

through their competencies. This included participating with the young women on the Adventurous Journey, which also involved tramping around the prison perimeter and camping on site.

The partnership to progress the Award in a women's facility has provided useful insights, which can help to inform future deliveries to young women in custody, as well as possible expansions to other sites in both male and female facilities outside of youth units.

Benefits of the Award for youth in Corrections

The Duke of Edinburgh Award provides youth in Corrections the opportunity to receive an internationally recognised award which thousands of young people both in New Zealand and around the world are achieving at the same time.

A Youth Justice facility in Rainsbrook, United Kingdom, found that "the young people who achieved significant results in the Duke of Edinburgh's Award are much more likely to have developed a clearer sense of personal identity and of the direction they would like their lives to take in the future".[2]

Given that there is flexibility in how each of the sections is achieved, we have the opportunity to provide input on how activities can reinforce learning from offence-related rehabilitation programmes. For example, developing skills to manage harmful drug and alcohol use can contribute to the skills development section. The community service section can assist youth in custody to establish pro-social supports. The programme design can also support a tikanga Māori approach such as the application of Te Whare Tapa Whā[3] which strengthens life-style balance. The Award can help youth in Corrections plan for their future in the community by supporting employability and employment pathways, which has the potential to reduce re-offending.

The skills that the young people develop through all sections of the programme, including during the Adventurous Journey, can play a significant role in preparing them and equipping them for their release into the community. They also offer an opportunity for youth to make meaningful connections that can help to create a sense of comfort and familiarity with support networks prior to their release.

Benefits for staff working with youth in Corrections

The Rainsbrook programme review also found that participating in the activities provided staff with a "huge sense of job satisfaction, as they see young people they help achieve in areas the young people would not have formerly thought possible". They went on to say that "it also enables them to develop further their own skills base and equips them to impart new knowledge to the young people, relevant to their needs and abilities"[4].

During a workshop in 2017, Corrections staff in New Zealand reported it was "the best programme they had ever run" due to the amount of trust that builds up between Corrections officers and the participants.

Next steps

Following the successful delivery of the Award to youth in Corrections custody by external funding and providers, we are now working on an approach that will enable Corrections to deliver all the components ourselves. If possible, this would mean that more sites could deliver the Award to a wider group of eligible youth.

The approach involves identifying interested prison sites which have the experience or ability to deliver the Award. These sites would then be registered as Award units, with onsite Award leaders selected to support implementation, and ensure that youth are able to meet their competencies. Corrections staff would be identified as Award leaders based on their interest in working with youth, the energy to work alongside them, and the skill to motivate and encourage youth to succeed. They would be adequately trained to deliver the programme, with ongoing oversight and support from the Award.

While taking on this responsibility will help to extend the Award to more youth, one of the key benefits is the opportunity to connect youth with the community. To date this has essentially been through the input from the external providers, particularly during the Adventurous Journey. Prison sites will need to consider how best to make links with the community from their sites. While the Adventurous Journey is one option, the community service, skills and physical sections all lend themselves to finding creative ways to involve communities. Connecting with external service providers not only helps to enhance the experience for our youth but also helps communities to better understand the needs and challenges faced by youth in Corrections, and to play a role in helping them to overcome these challenges and to increase their sense of belonging.

2 The Duke of Edinburgh's Award Team Submission to the GSL Awards for Excellence – Rainsbrook Secure Training.

3 Te Whare Tapa Whā refers to the four dimensions of well-being: Taha Tinana (physical well-being); Taha Wairua (spiritual wellbeing); Taha Hinengaro (emotional well-being); Taha Whānau (family well-being)

4 The Duke of Edinburgh's Award Team Submission to the GSL Awards for Excellence – Rainsbrook Secure Training.

"I can now notice that if I need help, it's there – I just need to look."

A young man from a Corrections Youth Unit reflecting on his experience of the Award

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Women offenders: Another look at the evidence

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Author biography

Devon Polaschek is a clinical psychologist, and professor in the School of Psychology and the New Zealand Institute of Security and Crime Science, University of Waikato. Her research interests include understanding and preventing re-offending in serious violent and sexual offenders, family violence, psychopathy, desistance, reintegration and parole.

One of the few upsides to the increasing numbers of women serving sentences in western correctional systems is the increase in the amount of scholarly writing and empirical research about women offenders. Yet despite this improving evidence base, there still remain relatively few good research studies directed at understanding relevant characteristics of women offenders and designing and implementing effective approaches to exiting from these same systems. Perhaps the biggest increases are seen in articles that, without necessarily offering evidence to support their case, push back on the idea that findings for male offenders automatically apply to women. This concern is legitimate. Crime commission is still overwhelmingly a "man's game" (Salisbury & Van Voorhis, 2009; p. 541), making it difficult to collect data on large enough samples of women for robust investigations.

But it is also the case that the meta-analytic literature on "what works" with offending is dedicated to providing findings that can be used to allocate scarce resources to reduce reconviction for, say, 10,000 prisoners; an approach sure to cause outrage in anyone committed to the importance of individual differences. In this literature, gender, and often ethnicity, are treated as moderator variables, meaning that the overall findings are simply examined separately for women and men. The studies examined typically include relatively few women, and may themselves not have split out their results by gender. Consequently, we learn, at best, whether findings largely derived from research with men also apply to women. This is actually a very useful question, but it does not enable us to identify whether there are factors relevant for women that have not been considered with men, or often even whether common risk factors are more or less important for women than for men.

Progress may also have been slowed by the growing feminist scholarship in this domain. Prominent critiques are directed at the system itself, and even at whether women should be held responsible for their offending, given the purported effects of social inequality for instance. Kelly Hannah-Moffat, an accomplished sociologist, exemplifies this work. For example, she writes: "The actuarial logic of RNR[1]-inspired assessment gives priority only to those aspects of a woman's life that are 'empirically' [sic] shown to contribute to recidivism. This emphasis is problematic because it locates the problem of crime in the individual and diminishes the role that social and structural contexts play in women's criminalization" (p. 215, Hannah-Moffat, 2009), and "The foundational RNR model identifies 'promising targets for change'" (p. 33, Andrews & Bonta, 1994/2010) within the individual, precluding meaningful considerations of how social inequality shapes opportunities and choices, and how it is itself a risk to be managed (p. 37; Hannah-Moffat, 2016). Although important to a free-speaking society, such arguments are of limited value in a correctional setting where the issue of whether individuals will be held responsible, and of whether a particular woman's behaviour is in fact criminal, have already been settled.

The other major debate that emerges when reading the literature on women offenders centres on the non-criminogenic needs. There is a good argument to be made that addressing issues unrelated to offending, such as physical and mental health[2] is a fundamental human right, and a public good. But again, this can only be done in a system that is tasked with doing so. So, for example, in the US where key case law has dictated that prisoners must be provided with adequate healthcare, prison psychologists spend much of their time providing this care instead of working with offenders to reduce recidivism.

1 Risk Needs Responsivity
2 Mental health disorders can be risk factors for offending in specific cases. Overall though they are not (Bonta, Blais, & Wilson, 2014), and changeable risk factors for crime for those with mental disorders remain well accounted for by the "central eight".

Is "what works" for men relevant to women?

Much literature refuting the male-dominated status quo with regard to rehabilitation is, simply speaking, based on the idea that women are different to men. Given the apparent obviousness of this assertion, it is, perhaps, somewhat surprising that decades of psychological research shows women to be more similar to than different from men on a wide range of characteristics (Hyde, 2014), averaging about 84% overlap (Zell, Krizan, & Teeter, 2015). This research suggests that often such differences are exaggerated, or substantially in the eye of the beholder, implying we should be careful not to create or exaggerate differences through stereotyping and expectancy effects. This section examines the case for generalisation from the research literature on (mostly) men, for two of the important issues: risk assessment and treatment targets.

Risk assessment

The difference in the proportions of men and women involved in the criminal justice system as offenders is a very real one. One consequence of this difference is that most high-risk offenders are men, and most women are lower risk offenders. A salient question then, is whether and how to assess women's risk of future offending, and especially, whether existing instruments, built mainly from data on men are a good fit to women.

A recent review suggests the LSI family of tools (Level of Service Inventory-Revised [LSI-R]; Level of Service Inventory: Ontario Revision [LSI-OR]; Level of Service/Case Management Inventory [LS/CMI]) was found to be as effective with women as it is with men in distinguishing who will be reconvicted from who will not (Geraghty & Woodhams, 2015). The LSI scales are the best researched for women of the risk assessment tools, and are in use in New Zealand Corrections (see also Olver, Stockdale, & Wormith, 2014; Smith, Cullen, & Latessa, 2009). However, none of the studies in the Geraghty review addressed the issue of calibration: whether a particular score is associated with the same probability of recidivism for men and women. For instance, if a particular score was associated with a lower likelihood of recidivism for women compared to men, and this was not known, the tool is overpredicting women's risk. So further investigation is needed of this issue if we aren't to over – or under-manage women's risk relative to their male counterparts.

Dynamic risk factors for offending

A major concern with applying the RNR model to women has been whether or not dynamic risk factors for offending in men are equally applicable to women. Again, the LSI scales are particularly useful for addressing this question because they were developed by Andrews, Bonta and colleagues and therefore include measurement of the Central Eight criminogenic need areas. As I noted above, when scores on the central eight criminogenic need areas (antisocial history, peers, cognition and personality pattern, substance abuse, family/marital, school/work, and leisure/recreation[3]), are summed together, these "gender-neutral variables and their compilation into a total risk scale LSI-R powerfully predict offense-related outcomes for women" (p. 281, Van Voorhis, Wright, Salisbury, and Bauman, 2010). But the relevance of the individual risk factors has been examined less. Using LS/CMI data from five small studies (total *n*=354) Andrews et al. (2012) found that each of the eight needs individually predicted recidivism. Interestingly, each was more highly related to recidivism (i.e., more predictive) for women than for men, though this difference was only statistically significant for substance abuse. These results led them to suggest that for women, we should speak of the "Big Five" rather than the "Big Four": substance abuse is more important than for men, for whom it is only a moderate risk factor.

Is there a psychology of women's criminal conduct?

To consider the case for a "gender-responsive" (i.e., women-specific) correctional psychology requires an understanding of the strengths and limitations of the RNR approach. As I implied in the opening, the RNR model is at its most useful with resource allocation policy, service development, and broad design decisions. It is frequently misunderstood (see Polaschek, 2012) as much more restrictive and prescriptive than it is, and some of these misunderstandings are pertinent to women offenders.

Today's RNR model is best thought of as a 15 principle-based empirical guide that tells us about a range of factors that are correlated with reducing reconviction. Successful interventions will contain or address more of these factors than less successful ones. But establishing empirically *how* the factors relate to recidivism is not part of the RNR model. Consider substance use. For some offenders it may be a risk factor because drug purchases take them into contact with other offenders (Arseneault, Moffitt , Caspi, Taylor, & Silva, 2000). For others, perhaps it reflects

3 The first four are referred to as the "big four" and the second four as the "moderate four".

binge drinking difficulties in the service of managing painful emotions, or their partner is pushing them to use drugs, leading to an addiction that they pay for by committing crime. We are all familiar with these and other mechanisms that may link substance abuse to crime. The RNR model does not specify which of these is relevant for a particular offender or group of offenders, leaving room for tailoring of programmes to the people they serve. It does not prescribe how change is best achieved with regard to the risk factor of substance abuse per se. All it says is that offenders who have contact with a service that is working to reduce substance use will be more likely to stay conviction free, all other things being equal.

Gender-responsive hybrid models understand women's offending as partially determined by unique risk factors (Van Voorhis, 2012), and argue that there are unique responsivity issues to address as well. Van Voorhis and colleagues are among those who have investigated whether the addition of women-specific factors to dynamic risk assessments might improve the accuracy of risk prediction (over the LSI scales alone), and by implication, the effectiveness of rehabilitation (Van Voorhis, Wright, Salisbury, & Bauman, 2010). Additional factors investigated for their relationship to recidivism included self-efficacy, parenting stress, housing safety, mental health and adult victimisation. However, though some were predictive with some samples, none was consistent across samples. Most of the predictive factors could be grouped under the Central Eight (Bonta & Andrews, 2016) anyway which may be why their predictive ability was limited or erratic (e.g., education and family support, anger/hostility, relationship dysfunction). In other words, again, gender differences may be more in the detail than in the general nature of the need. And as with more general purported gender differences, there is probably more overlap between genders than we might expect.

A later study (Bell, 2014) tested this idea of overlap by examining hypothesised women-specific and traditional gender-neutral risk factors in samples of women *and* men. She found that of seven gender-neutral factors, five predicted recidivism for men, and three for women. For nine women-specific risk factors, four predicted recidivism for women and three for men. Women scored higher than men on 12 of the risk factors overall, suggesting higher needs, but most were not related to recidivism. Current substance abuse, so strongly predictive for women in the Andrews et al. (2012) study, did not predict women's offending here at all.

So what can we make of this research? First, some specific aspects of risk factors may be much more prevalent in women than in men, but much of this detail lies below the surface of the broad categories of criminogenic needs in the RNR model. Research with women can be helpful in identifying and unpacking this specificity, which in turn may help with tailoring programmes to women. None of this constitutes evidence that women-specific risk factors lie outside the RNR model. Second, the women's literature remains small enough that we are at risk of making too much of the results of individual studies rather than waiting to see if those results replicate to different samples; very often they won't. Any single study of men's dynamic risk predictors is similarly unlikely to come out with the same pattern of results as a big meta-analysis summing many studies. We would not use one or two studies with men to say that the men's research literature is wrong. We need to be similarly careful with research with women. Third, we do need to know more about the specific forms of major criminogenic needs for women. For example, if women's criminogenic peers are more often their partners than for men, interventions to reduce this influence will be rather different than if the peers are fellow gang members.

What about trauma? Repeated exposure to traumatic events is common in the childhood lives of offenders, and for women, it is also concerningly prevalent in adulthood (Bell, 2014). The women offenders' literature on treatment is replete with programmes for "dealing with trauma", though often the actual processes by which this is done are not specified. This point is important insofar as we know that simply talking about traumatic experiences repeatedly can increase symptomatology for some people, and may not improve adult functioning; and in fact most trauma exposure results in little impairment to adult functioning. Further, traumatic exposure can have many consequences that are not limited to the criteria required for a diagnosis of PTSD. But PTSD is very elevated in prisoner samples (Briere, Agee, & Dietrich, 2016) including in New Zealand. Seventy-five percent of women in a recent study of New Zealand prisoners reported some form of mental disorder, with 40% meeting the criteria for PTSD in the previous 12 months (Indig, Gear, & Wilhelm, 2016). Treatment should be made available for these women, but it does not follow that such treatment will necessarily reduce criminal risk. In part this is because PTSD is simply a description of a particular cluster of consequences of traumatic exposure, with no assumption that they are functionally linked to offending.

Beech and Ward (2004; Ward, Polaschek, & Beech, 2006) outlined a model that is useful for linking risk factors to their possible causes, and clarifying different types of risk factors and how they interact. The model shows that major developmental experiences, especially in childhood or adolescence help to shape relatively stable psychological dispositions and it is some of these that constitute the dynamic risk factors clustered under the categories of the Central Eight.

Therefore, developmental factors (e.g., repeated childhood abuse) are only relevant insofar as they have led to *current* psychological dispositions that are themselves criminogenic needs. The mechanisms by which these experiences translate into criminal propensity are varied. For example, abuse may lead to global anger, and a sense that the world owes one a living, substance abuse, attachment difficulties, and negative cognitions about the self and others (Briere & Scott, 2015). Or it may compromise one's ability to get out from under the influence of criminal peers. Some of these mechanisms may fuel crime, but since adversity in childhood and adulthood is common for offenders, the influence of these types of factors – especially the historic ones – is already implicitly built into our models of criminal development. The mechanisms are the focus of treatment, regardless of how they were acquired, and treatment of the distress resulting from the events themselves will not necessarily affect these mechanisms, because over time they take on a life of their own (or in behavioural psychology terms, they are maintained by different factors to those that initiated them).

Responsivity

Is it the case that the gender differences are mainly attributable to responsivity issues? Responsivity refers to myriad different issues but is best thought of as an interaction between the person's ability to engage with the intervention and the intervention's ability to engage the person. Relatedly, sometimes what is really meant is the ability to engage with any change process.

The Indig study also found that 47% of women prisoners had experienced psychological distress in the past 30 days (cf. 27% of men). Women living in states of psychological distress or with untreated mental disorders simply may not have the energy to contemplate changes on risk factors. Change is hard for all of us. Routine activities in custodial environments will contribute to that stress. Particularly when sexual abuse is part of the history, both women and men may struggle to manage themselves safely when they are routinely strip-searched and subject to other intrusive experiences that trigger flashbacks, and where the presence and behaviour of other prisoners may activate a state of continuous hyperarousal and vigilance. If the therapy or programme occurs in such environments, the offender brings the consequences of this context into the treatment session.

Similarly, if women are worrying about the safety of children, or whether there is enough money to get through the next week, they are unlikely to prioritise "coming to group", and may not even have a feasible way to do so (petrol, childcare etc.). Ways to address the practical circumstances required to have the "headspace" to engage in personal change may be somewhat different for women, but these ideas mainly come under the category of "common sense"; in common with the state of responsivity research across the board, the research on responsivity factors for women is patchy at best (Bourgon & Bonta, 2014).

Recent interviews with Department of Corrections' Kowhiritanga facilitators (Kowhiritanga is a group-based rehabilitation programme for women) suggested that women's groups may need more time to develop a stable working culture, and that women often wanted to talk through issues at some length, as the material was being presented. Contrary to widely held beliefs, women are not generally more talkative than men (Mehl, Vazire, Ramírez-Esparza, Slatcher, & Pennebaker, 2007). But male criminals in group rehabilitation probably talk less than men in other circumstances. Male prisoners are generally mistrustful in groups, worrying that other men will take advantage of their sharing, and not wanting to be perceived as weak or needing help. So women offenders may require us to recognise the need to slow down group process when people are a bit more comfortable with the group environment.

Conclusions

The evidence base for women offenders remains small, but is improving in quality. However, robust evidence is swamped by agenda-driven writing that reveals stereotypic beliefs that crime reflects inherent badness in men and inherent illness and social disadvantage in women, and fundamental errors in logic, in understanding the aetiology of risk and its remediation, and the RNR model itself.

The overall picture suggests that the RNR model applies to women, but that women offenders may be more complex or more diverse to treat (i.e., reduce risk of re-offending) than men. To date, this complexity does not appear to come from greater criminal risk based on personal characteristics, or more numerous or complex, or "different-from-men" criminogenic needs. Rather, it may be coming from (a) higher rates of overall mental disorder (responsivity/non-criminogenic need) (b) higher rates of PTSD (both historic and recent), which may complicate any treatment that draws on past experiences, and may therefore require more individual treatment (c) greater responsibilities in the community (e.g., for children) that make focusing on treatment difficult (d) less control over some of the contextual conditions that facilitate change (e.g., more dependence on criminogenic partners, less ability to achieve financial independence due to childcare, less ability to be physically and emotionally safe due to family harm etc.), which in turn may lead to low self-efficacy for change, and in group settings at least (e) more comfort

with expressing emotions and opinions, and greater interest in communality, which may slow down the group process considerably.

Rather than using these potential differences as an opportunity to throw away decades of empirical research on in favour of untested or common-sense ideas, we would make more progress if we took all of the above into account in planning treatment responses to women offenders, and committed resources to investigating the effects. Many of these issues point to the importance of considering the whole person in our responses, and designing services accordingly.

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A brief history of Te Tirohanga units

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Author biography

Neil Campbell is of Ngāti Porou and Te Whānau-ā-Apanui descent and has held a number of positions within the Department of Corrections over the last 20 years. Until recently, Neil headed up the Māori Services Team that looks for innovations, partnerships and ways to make continuous improvements to achieve success with Māori offenders. He's now moved to a new role focused on organisational capability to work effectively with different cultures, including Māori.

In December 2017, Corrections recognised the 20-year anniversary of the first of its Te Tirohanga units, formerly known as Māori Focus Units.

The Department now has five such whare (houses/residences) around the North Island. The oldest is Te Whare Tirohanga Māori at Hawkes Bay Regional Prison.

The early years

Back in the 1990s, the concept of a "Māori Focus Unit" where things were done according to kaupapa Māori philosophy was pioneering. The idea came out of the minds of such Māori leaders as Sir Pita Sharples, Sir Norman Perry, and Kim Workman.

Every bold idea needs courage to drive it and that came by the way of Department leaders such as former Chief Executive Mark Byers, former General Manager of Prisons Phil McCarthy, former Hawkes Bay Regional Prison Manager Peter Grant and Corrections Kaumatua Des Ripi, the Department's most influential Māori leader of the day.

As with most pioneering expeditions, the track to be cut was a tough one. It required a change in attitude, behaviour and organisational culture that was somewhat before its time.

Early ventures into this territory started with the work of such people as Ana Tia, a volunteer who had tutored Māori in prison since the early 1970s.

Māori had understood from the outset that separation from one's cultural identity and the loss of associated beliefs, values and practices ultimately led to a compromised identity state. This in turn led to a very fluid sense of belonging. People felt "out of" rather than "in" the culture and developed confused and distorted cultural views.

To address those very issues, a dedicated space was established that would focus on residents' cultural identity as Māori men and what that meant.

The first steps were understandably tentative and continued what Ana Tia had begun.

Teaching men waiata, haka and the traditions of mihimihi and pepeha were foundation stones of those early environments. There was a high level of community and whānau involvement and inclusion, a distinctly kaupapa Māori operating philosophy and a structured day.

In 1997, the introduction of the Mahi Tahi programme saw the facilitation of a structured programme. This programme was the first of its kind and gave an in-depth look at the participants' Māori identity and history. Staff members also did sessions to deepen their understanding of Te Ao Māori. Mahi Tahi was well received by prisoners and staff and other programmes soon followed.

Mita Mohi's Mau Rakau programme was controversial in that it exposed the men to a Māori martial arts form. As with all martial arts, the focus was not on how to harm others but on the philosophy of balance of the mind, spirit and the body. It was a completely new way for men to look at their behaviour, attitude and thinking towards others and what it truly meant to be a warrior in the modern world.

As time passed it became obvious that the programmes we had were not going far enough to address the offending behaviour of the men. With this in mind, in 1999 Corrections introduced a programme to Māori service providers who took on the role of delivering it. This was a cognitive behavioural therapy programme that would come to be known as the Māori Therapeutic Programme and later, Mauri Tū Pae (MTP).

In 2003 the Ministry of Social Development's Social Report stated "Strong cultural identity is important for people's sense of self and how they relate to others. Strong cultural identity contributes to people's overall well-being."

And so began a period of opening more units, and refining the practices within the units. Over this period, four more units opened around the North Island; at Rimutaka Prison, Waikeria Prison, Whanganui Prison, and the then Tongariro/Rangipo Prison.

It would become apparent through feedback from participants, staff and service providers that more was still needed to develop these environments into effective therapeutic communities. However, it had been the right place to start.

Lifting achievement levels to an elite standard

In 2013, Corrections' Creating Lasting Change Year 3 document said "A new therapeutic model in our Māori Focus Units will be implemented nationwide to lift the achievement level of these units to an elite standard."

On the back of this statement the Department's Māori Services Team commenced work to change the way in which the units would operate. Our Te Tirohanga National Programme was designed to give greater consistency to the programme content within the units that were now referred to as whare.

The new programme introduced a phased model that provided a distinctive pathway and gave continuity to what was being learnt within each whare. It provided an opportunity for the tāne (men) to earn unit standards and qualifications as part of their learning experience. The phased approach also meant that tāne could enter the environments in cohorts of 10 that, for the most part, would complete the pathway together.

The first phase was foundational and included an induction process that would establish a whānau assessment and action plan, an offender plan, and preliminary programmes that addressed literacy and numeracy. This phase also included an introduction to tikanga and te reo Māori to assist the tāne as they progressed to phase two of the programme.

Phase two placed men on a medium intensity rehabilitation programme, Mauri Tū Pae. This programme addresses the offending behaviour of the tāne using distinctly Māori modalities, and increases whānau involvement and inclusion.

Phase three was designed to address drug and alcohol addictions at a tailor-made drug treatment programme in Whanganui.

Phases four through six concentrated on pre-release requirements and offered the opportunity for release to work initiatives, intensive reintegration planning and more whānau and community connectivity in preparation for pre-release centres. These include external self-care units and the two Whare Oranga Ake, New Zealand's unique open prison model that prepares and supports prisoners at the end of their sentence to move back into the community – currently at Hawkes Bay Regional Prison and Spring Hill Corrections Facility.

The six-phase approach meant tāne would remain within this therapeutic community for a period of 18 months.

A process evaluation of the Te Tirohanga National programme was completed in April 2015. It found that a strong and positive culture existed in all whare, with participants especially enthusiastic about the initial phases of the programme. Staff were supportive of the participants and appeared generally to be acting as positive role models, though there was some lack of clarity around staff roles. The anticipated involvement of whānau within the environments and in the programme in general was not occurring, partly because they were not being invited to participate in activities, and also because of restrictions on visitors such as those arising from the child protection policy and other operational considerations.

Following the evaluation, the programme was redesigned to a three-phase programme over nine months. The evaluation showed that the reintegrative phases would be more effective if the tāne had progressed to environments like the external self-care units or dedicated external reintegration spaces such as Whare Oranga Ake, so the reintegrative phases were moved outside the wire. Work was also done to ensure the operating philosophy of Te Tirohanga was more effectively embedded with both the programme participants and staff.

The future of Te Tirohanga

Many people over the last 20 years have questioned the effectiveness of kaupapa Māori-based environments inside our facilities. There have been a variety of views expressed from within Corrections and Māori communities alike. A common issue that continues to be discussed centres on how operational requirements and pressures impact the operating philosophy and kaupapa values of those environments.

At least one iwi is exploring the possibility of transitioning Te Tirohanga principles and programmes outside the wire so that these therapeutic communities and their associated kaupapa Māori operating principles can be managed by iwi themselves. This idea requires careful consideration of security issues, but it certainly provides a more connected pathway to reintegration initiatives such as Whare Oranga Ake. It will also mean greater and easier access for whānau to ensure increased involvement and inclusion within the rehabilitation space. There is merit in this thinking, which allows some of the most crucial features of the original design to be implemented effectively.

When looking at other therapeutic communities, the whānau-centric approach is what makes Te Tirohanga innovative. Wherever the programme is based, the inclusion of whānau, hapū, and iwi is critical to its success.

As with many kaupapa designed by Māori, the future invariably lies within the past. The future of Te Tirohanga may be yet another example of that thinking.

"I know our people": Exploring community approaches to gang member reintegration II

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Author's note: *The views expressed in this report are those of the author and not necessarily those of the Department of Corrections (nor do they reflect government policy).*

The formation, maintenance and transition away from gang-centred lifestyles are, first and foremost, community issues (Fleisher & Decker, 2001; Maxson & Esbensen, 2016; Pyrooz & Decker, 2011). Furthermore, the issues for men with gang affiliations leaving prison are complex and can include coming to terms with mental illness, the impact of age, and opportunities to participate in criminal activity (Tito & Ridgeway, 2007; Watkins & Moule, 2014).

Long-term desistance is best achieved through strategies that promote and sustain the individual's efforts to reintegrate into society as a law-abiding citizen (Thurber, 1998). As noted in Tamatea (2017), an individual's pathway through the New Zealand justice system involves a range of formal relationships that might include prison and probation officers, psychologists, programme facilitators, specialist helping professionals (e.g. substance abuse counsellors, sensitive claims treatment), educators/instructors/employers, case managers, spiritual guides (e.g. chaplains) and indigenous service providers. However, there are individuals and organisations that operate outside of the criminal justice arena that have been considered to impact on the attitudes, values, lifestyle choices, and behaviours of men who lead gang-centred lifestyles in the community.

With any behaviour change regime, the need for good models of practice and a sound theoretical rationale are vital. For instance, differential reinforcement may serve as a mechanism of change (based on behavioural principles) when addressing selection of peer group engagement. Despite a variety of programmes and initiatives that have been designed with principles in mind (e.g., Goldstein & Huff, 1993; Klein & Maxson, 2006), there are few gang-relevant *theories* that support decision-making with gang-affiliated offenders other than general models of offender management (e.g., Andrews & Bonta, 2010; Bonta & Andrews, 2016) or those models focused on young gangs in other jurisdictions where the conditions may differ (i.e., rural/provincial vs urban; Wood & Alleyne, 2010). In the absence of a robust theory of gangs to drive relevant intervention efforts (Tamatea, 2015), *practice-informed* approaches offer a source of potentially usable field knowledge to apply with individuals where gang involvement presents a barrier to offence-free and healthier lifestyle choices.

Continuing a series of articles on community practices with the gang community (see Tamatea, 2017), the current article explores the findings of a study that sought to uncover the approaches and experiences of community organisations who work with gang members in a rehabilitative capacity. A previous study (Tamatea, 2010) explored the experiences of gang members themselves.

1 This research was made possible by a Department of Corrections research evaluation grant. The author would also like to acknowledge the support of community probation staff who, through their constructive resources and linkages, helped to create positive research relationships with community providers who informed this work. The author would also like to acknowledge the support of Gary Gerbes, Glen Kilgour, Denis O'Reilly, Harry Tam, and Dr Nick Wilson, and – especially – the participants themselves, who shared their time and much of their experiences.

Consulting community service experts

The study explored the experiences and processes of community providers who routinely work with gang members with a view to clarifying the nature and purpose of their work, and gaining insights into their models of practice.

Guidance for best practice was taken from Waa, Holibar and Spinola (1998) who emphasise that:

1. diversity of stakeholders would be acknowledged
2. the study would seek to actively empower disadvantaged (i.e., offenders) and approached groups (i.e., community providers) with a view to being of benefit to them, and
3. the study would actively encourage bidirectional consultation with the stakeholders.

Due sensitivity was exercised when discussing and reporting on individual and/or group statements. Only the researcher knew the source of the comments, and possible identifying characteristics were altered in the final work to ensure confidentiality. However, because the work of some of the providers had achieved public attention, it was not always possible to ensure *complete* confidentiality. Some practices reflected a process of insights and workable solutions forged over long periods of time and some participants were reluctant to disclose "trade secrets", expressing concerns that their techniques may be misunderstood or considered out of context. As such, a superficial treatment of specific approaches is offered here to avoid misappropriating community expertise.

Participants

Participants were nominated by Community Corrections staff as part of a national survey (Tamatea, 2011) that invited respondents to identify the agencies and individuals that they endorsed. Consequently, participants were selected based on *confidence* and, by extension, presumed *effectiveness* in working with gang members. All contacted providers actively worked with gang members, either routinely as part of their practice (e.g., counselling), or directly with the gang community. The "effectiveness" of the agencies was defined in the survey by one or more of the following:

- reduction in gang/criminal associations
- increase in prosocial associations/support
- improved attitudes towards authorities
- increased reflective, self-monitoring, and independent decision-making
- increased consideration of consequences of their behaviour (reduced impulsiveness)
- more proactive about life choices (rather than assuming a "victim" role)
- improved management of substance abuse
- improved management of anger, hostility and/or other negative moods
- the agency assisting gang members to find employment
- the agency assisting gang members with establishing stable accommodation.

The completed sample involved 17 providers representing 10 services. The nature of the services varied greatly and included:

- community-based health care services
- prisoner-specific reintegration services
- individual counselling
- church-based community outreach groups.

Providers' roles included:

- service managers and team leaders
- field staff (i.e., healthcare providers)
- programme facilitators
- psychotherapists.

The participants were selected based on endorsements from probation officers. This implied that the agencies could deliver effective services that were relevant to dynamic needs and/or protective factors. However, there was no assumption made that the agencies explicitly addressed "risk" in the criminogenic sense.

Analysis

Thematic analysis is a data reduction and analysis strategy by which qualitative data are segmented, categorised, summarised, and reconstructed in a way that captures concepts of interest within a data set (Ayres, 2008; Miles, Huberman, & Saldaña, 2014). Themes are defined as patterns of experience typically derived from conversation topics, recurring activities, and meanings (Taylor & Bogdan, 1998; Tracy, 2013). As themes emerged, feedback was sought and obtained from the participants.

Processes, practices and problems

The findings are presented as they relate to the processes, practices, and problems faced by the participants. The primary categories include:

1. a description of the operational features of the agencies
2. intervention domains of relevance to offender reintegration
3. major challenges presented by gang members
4. broad descriptions of intervention philosophies and approaches.

The data is based on the summary notes taken at the end of each discussion.

Organisational features

To set a context, the basic interfaces between the participants, their services and clients were explored. Their referral processes and perceptions of their roles were of specific interest because these areas defined the scope of practice and the focus of the interventions.

Nature of contact

The contacts between service users and the participants varied:

1. intensive and short-term – especially if involved in health-based services that primarily targeted acute health issues
2. moderately intensive and intermittent – such as individual counseling or supported accommodation services
3. non-intensive and long-term community development programmes.

A number of the participants commented that, in the early phase of contact, gang members displayed "testing" behaviours (e.g., "puffing up", erratic attendance) which were likely designed to establish how "safe", tolerant and reliable a given service would be for them. These behaviours were observed in therapeutic environments where an element of personal disclosure was likely (e.g., counseling services), or activities that required behaviours considered to be outside of the repertoire of many members (e.g., making requests, applying for work). For participants who met with clients at their homes, the repeated contact was reported to have increased rapport via demonstrations of reliability, consistency, patience, and caring. In this regard, it was not unusual for some practitioners to report developing an attitude of perseverance with "hard-to-reach" individuals. For some other participants, long-term engagement offered opportunities for relationship development at a greater community level via several meetings where members of the agency would meet with members of a gang at a neutral and safe venue (e.g., marae). They held these repeated meetings to nurture a developing relationship between a gang chapter and their families where education and other essential services could be facilitated.

Entry criteria and referral sources

Most participants reported their service as having some broad referral criteria, with some stating that they had few exclusion factors save that of specific issues the agency could not accommodate (e.g., positive symptoms of acute mental illness). Furthermore, most agencies accepted referrals from a variety of sources, such as from the Courts, Corrections, other community-based health-care providers, and self-referrals. In community outreach efforts, membership of the gang – rather than a case referral – was sufficient.

Assessment of motivation (for behaviour change)

Very few of the participants formally assessed clients for motivation. Determining an individual's motivation for changing target behaviours (e.g., addiction, relationship skills) was noted to occur relatively informally as part of an overall health/intake assessment. Indicators for motivation ranged from modest in-session behaviour (e.g., returning to attend successive sessions), to reports from the individual's whānau and support people, to addressing cultural conceptions of intrinsic motivation, such as being tika and pono, as anchors in engagement.

Perception of role

Participants often saw themselves as having multiple roles that could be described as:

1. *clinician:* dealing with health-related concerns on a managed-care basis
2. *advocate:* offering representation for the individual when accessing resources (e.g., accommodation) or other services
3. *provocateur:* providing direct and sometimes challenging feedback to the individual about their behaviour in a safe therapeutic environment designed to mobilise the individual's own motivation
4. *kaitiaki:* acting in a "guardian" role to "walk alongside" the person on their reintegration process
5. *intercessor:* acting as an intermediary link between the gang and mainstream communities (e.g., outreach).

These roles covered tasks including:

1. directly challenging an individual's behaviour in an individual or group-therapy setting
2. providing access to resources (e.g., resource people in specific community or government agencies)
3. supporting the individual (and whānau) through critical life events (e.g., bereavement)
4. supporting the individual to engage in prosocial community-based activities (e.g., sports, education and recreation).

Acceptable outcomes

The expressed aims of service outcomes ranged from modest behavioural indicators (e.g., turning up to successive sessions, improved health) to improvements in broader lifestyle areas (e.g., increasing time out of prison, employment, quality time with whānau). Interestingly, gang-specific changes, such as withdrawal from associates or exiting from gangs, were largely regarded as a *consequence* – or lower priority – during engagement rather than as the primary focus of interventions. In some cases, the gang was conceptualised as a community that was

best encountered on its own terms (e.g., "tikanga gang" – see below, p70) with a view towards increasing educational opportunities for members' children, employment for adult members, and providing substance abuse programmes. In other words, while decreasing antisociality and gang involvement was seen as desirable across all participants, gang withdrawal itself was generally not considered to be a primary aim, but viewed instead as a natural outcome of clients meeting other goals.

Reintegration

The participants' approaches encompassed a range of life protective factors from offending. The categories that emerged from the discussions included: family and intimate relationships; work, education and accommodation; health and wellbeing; and relationships with the community.

Family and intimate relationships

A primary area of intervention across many of the participants' services concerned improving the quality of relationships between gang members and their partners, children, and wider whānau. Providing opportunities to reflect on close relationships and enhance attachments to others was a process encouraged by almost all participants. Indeed, it was a common observation that gang members actively sought to develop connections with their families. A suggested explanation was that this is an emotionally-driven reaction caused by having been separated from their whānau, sometimes for long periods. It was reported that many of the men who accessed these services were considered to have expressed a deep sense of whakamā (shame) in relation to the abusive or absent role they had played in the lives of their families. Furthermore, many of the participants commented that they would regularly attempt to assist their gang clients to attain a sense of perspective about their emerging roles as parents (or even grandparents), and what their continued involvement in a gang lifestyle may mean for their whānau. Discussing gang lifestyles as discrepant from – or even a risk to – families was a favoured strategy to address ambivalence about membership.

Most participants commented that many gang members who had accessed their service were unskilled or unaware of how to manage themselves in intimate relationships. Participants had observed a range of dysfunctional relational styles such as aggressive and abusive behaviour towards partners, or avoidant and anxious behaviour that was presumed to have derived from low self-esteem. Some participants suggested that gang members tended to reveal more difficulties in intimate relationships than other client groups.

With respect to wider social networks, some of the participants emphasised the importance of developing prosocial competence by bringing their gang clients into contact with prosocial groups, such as sports clubs or churches, or – in one case – welcoming members into their own homes as part of a wider whānau-style community.

Employment, education and accommodation

Some participants worked for organisations that had employment as a primary focus. They recognised that entering the workforce is a key reintegrative activity for offenders in general, but that it presents special challenges for many gang members who tend to eschew workplace values. In this respect, education about and socialisation into workplace culture, as well as sourcing opportunities for employment or marketable skills-based training was central to much of this work. Additional challenges involved attending to urgent and reactive issues, such as establishing adequate accommodation shortly after release.

Accommodation was seen as a major challenge for many gang members and was the primary function of one participant's agency that worked on a structured programme towards social integration. The "restorative social reintegration" approach of this agency involved forming long-term positive relationships in the community by means of attaining sustainable (i.e., affordable and livable) accommodation.

Health and wellbeing

Whilst several of the participants dealt with acute mental health, substance abuse and addictions needs, some agencies specifically targeted nutrition and physical exercise education. They aimed to promote lifestyle choices that would be incompatible with antisocial behaviour, especially sedentary and drug-using lifestyles fuelled by boredom and lack of structure. Encouraging lifestyle balance by engagement in sports was actively emphasised by those providers who had established linkages with community recreational clubs and facilities.

Community life

For most agencies, development of a prosocial outlook involved engagement in community activities that were alternatives to – or contrary to – gang life. For instance, agencies encouraged skill development for basic tasks such as making requests, asking for advice, and receiving support from organisations. Other agencies offered more intensive contact to assist gang members to make behavioural links with prosocial community living. For instance, one participant described the use of their family home as an environment for change.

Men would be invited to visit and observe other gang members preparing and participating in a meal with non-gang members. The therapeutic assumption was that these men need to observe alternative exemplars of how a "safe" place and a "family" might look. Another agency – a residential programme – had arranged a series of seminars by "inspirational speakers" that involved renowned personalities from the local community (e.g., council members, sports people, etc.). The rationale for these events was to expose the men to prosocial models from the community and promote engagement and dialogue between the gang members and the community. Lastly, one community group actively met with one gang chapter on a marae and, over time, developed a trusting relationship, assisted the children of the gang members into mainstream education, and offered life skills courses for the adults.

Primary challenges

Almost all of the participants encountered challenges that were indicative of broad operational barriers, and responsivity barriers experienced with gang members. Specific areas of difficulty or impediments to practice included:

Agency-specific factors: Operational barriers

Issues in this category were reflective of the economic context in which many of the participants' agencies existed, and revealed a range of systemic challenges that impacted on their ability to effectively work with gang members. These included relationships with other agencies, bureaucracy in larger organisations, and funding – particularly with smaller agencies.

Interagency relationships. Co-ordination with other agencies was seen as problematic by some. Many of the participants indicated that difficulties liaising with other agencies were reflective of gang members' experiences of thwarted efforts to access adequate services. Some participants enjoyed a positive and mutually beneficial relationship with probation services, others expressed perceived disconnection. This was a source of much frustration to these participants, particularly given their gang member clients were often serving sentences during the time of contact. One participant commented that long-term investment in the community is critical to developing effective partnerships and creating robust support that gang members can invest in as part of their reintegration process.

Bureaucracy. Though not a widely reported issue, participants from smaller agencies commented that they were most able to exercise operational flexibility with a minimum of "red tape" – a source of some frustration for other larger agencies. One provider commented that *"you need to be small enough to 'react'…because critical events happen frequently, and you don't always have the time to go through an endless chain of approvals to deal with them".*

Funding. Some of the organisations derived funding from District Health Boards, via contracts with other funding bodies, or as a result of goodwill from the community in the form of donations. Access to adequate resources such as appropriate staff, relevant training, and support for professional development appeared to be one of the biggest struggles for many of the organisations – often affecting their ability to maintain sufficient staff and accept referrals.

Gang-specific factors: Responsiveness barriers

While none of the providers held any illusions about the reality of working with offenders in general and gang members in particular, the following challenges were experienced near-unanimously: working with young members/prospects, gang members' perceptions of authority, and the related issue of gaining adequate trust.

Young gang members and prospects. Adolescent gang members and prospects were the most difficult sub-group to engage and motivate to change. This is not surprising given that many men join gangs in their adolescence and are likely to have a vested interest in creating (or furthering) their reputations and/or joining a collective that supports their behaviour and beliefs.

Authority. All of the participants commented that gang members typically have poor to hostile relationships with authorities, such as the Police, Courts, and the Department of Corrections. Some added that negative perceptions of mainstream institutions were likely generalised to include other agencies or services that they had been referred to or that were seen to have a visible relationship/linkage with these institutions. Consequently, developing rapport and therapeutic engagement was seen as a major challenge when working with (predominantly) men from communities that have a history of conflict with the "system" and a philosophy of rejecting mainstream society and its values.

Trust. Related to the above, establishing trust was seen as one of the most critical challenges for providers who routinely worked with gang members. Consequently, providers had developed a range of strategies and approaches to address responsiveness issues. These will be discussed next.

Addressing gang-specific responsivity barriers

The following "inventory" of approaches, philosophies and working models reflects the providers' learning from hard-won experience and investment in their communities. Some of the participants were reluctant to divulge specific techniques, so only broad outlines are offered here.

Safety considerations

Safety first. Basic idea: If leaving a gang is a priority, then the exiting member is likely to only make this move when conditions are favourable to them and their families. Although more of a cautionary consideration than an approach per se, the idea of "safety first" recognises the real and potentially far-reaching harm that can accompany the process of exiting from a gang. Indeed, it is not unusual for the very nature of exit rituals themselves to act as deterrents for leaving, with the effect of retaining group numbers, loyalty, and reducing ambivalence amongst members. For example, the rite of "handing in one's patch", may present very real hazards (e.g., group assault) in some gang chapters, but can also offer a visible and "respected" (by the gang community) pathway out.

Promoting relatedness

'Know our people'. Basic idea: Knowledge of "our people", such as the nuances of how specific communities function, can facilitate rapid and meaningful engagement and assist to address issues more directly. Early engagement is critical with gang members in therapeutic settings. Relationships with – and knowledge of – their home communities can be of value when attempting to form these relationships. To be open and direct about the gang/whanau relationship was observed to allow gang members to speak freely about their gang issues – an area that they come to challenge themselves about in time. One participant explained how they would address some of their gang clients in-session with non-ambiguous challenges to their behaviour and direct language. They would do this with selected clients whose whānau they have a well-established relationship *("I know their fathers, their uncles, and how they speak to them…they respond to it with me…I know our people")*. Such exchanges may be challenging, but are conducted in a spirit of caring.

Reducing difference. Basic idea: Reducing sub-cultural differences between people while enhancing similarities was considered a powerful approach to develop effective working relationships, and reduce two-way stereotyping (i.e., "gang member" vs "the system"). A sense of relatedness was presumed to create opportunities for gang members' confidence in the relationship to develop and set the conditions for change (e.g., working alliances). An example of this approach was that of "purposeful disclosures", where the participants would, as part of a *whakatau*, share significant aspects of their personal and family history with new gang member clients as a means of locating each other in traditional Māori concepts of connectedness (i.e., whakawhanaungatanga), but also in an effort to reduce perceived differences, recognising that all individuals have histories that include triumphs and achievements but also aspects of shame or disgrace.

Tikanga Māori. Basic idea: Creating connections in the world – Te Ao Māori, and the world "lived in" – promotes self-worth, a starting point for forming bonds based on trust. The citing of whakapapa was considered by some providers to help gang members understand "who they are" as gang members, as family members, and within other roles (e.g., vocational). Once these multiple realities were made explicit, effective working alliances and therapeutic aims were seen to be enabled, as well as developing quality connections with other services. Tikanga-informed change was assessed by some providers via observed lifestyle changes (e.g., to not "shit on the whare"). Some of the participants saw their role as a kaitiaki, and to "walk alongside" the person in order to develop empathy and try to "see their reality" as a useful frame of reference.

"Tikanga Gang"[2]. Basic idea: While some Māori men (and women who are affiliates) are gang members, this is no guarantee that Tikanga Māori processes are likely to be observed – or even respected. Furthermore, traditional practices may be observed in some contexts and situations, but may not be a generalised aspect of gang members' lives. "Tikanga gang" refers to gang-developed norms and practices that impact on daily living and critical incidents. Recognition of these principles was presumed to aid in the understanding of an individual's "gangness". For instance, a gang member's relationship with their children was seen to offer opportunities to catalyze change, by encouraging a health focus, rather than a crime-centric one. In addition, families were encouraged to change their environment by means of (literally) "changing the conversation around the dinner table" – disrupting dysfunctional or unhealthy discourse during family interactions by introducing positive values-based discussions as a normative experience.

Promoting empowerment

React vs Create. Basic idea: Gangs have typically emerged in part as a *reaction* to mainstream societal values, and many members join – in part at least – for this reason. Therefore, creating conditions for gang members to *react against* can be effective. Advocates of this view believed that introducing provocations to gang members' negative beliefs in a supportive, albeit direct, context could enable the men to participate

in and *create* their own reintegrative experiences. This approach means reintegrative experiences are not imposed, but that individuals attain a sense of ownership over their own change process. The primacy on self-determination and agency also recognised that mistakes may occur as part of this journey too.

Change vs exchange. Basic idea: Gang membership is part of an overall life process. However, people are inherently capable of caring for themselves, their families, and even their country. So, the main task of this model of practice is to restore the "memory"' of what this intrinsic ability to care "looks like" and facilitate people to embrace it. An advocate of this perspective explained that change is a process of discovery, rather than something that can be "taught". *Exchange*, on the other hand, involves a radical shift in the way some individuals think about themselves and imagine alternative and positive futures for them and their whānau. A central ingredient in this approach is to maintain the belief that change is possible. The process is then driven by the gang member themselves and opportunities are created to support informed and constructive decision-making in daily life choices.

Community outreach. Basic idea: Transitions from the gang to the mainstream community require long-term investment of the intervening agent in both. One participant described part of their service to assist individuals who have left their patches behind (for whatever reason) and want to support others who want to be "patch free". This was achieved by establishing prepared "target communities" – these groups involve ex-gang members who walk alongside existing members who have ambivalence about their membership or are seeking options to leave – in conjunction with "receiving communities", such as churches. When they are firmly established in crime-free living, former gang members and other ex-prisoners may form part of a Circle of Support and 'walk alongside' other offenders. These allied individuals are selected on the basis of prosocial lifestyle and demonstrated commitment. They are trained in the development of target communities and prosocial support, and are supported by the parent organisation. A parallel aim was to establish and maintain a non-judgmental environment for change and encourage the community to appreciate the relevance of helping gang members maintain change.

Closing comment

As can be seen, the range of practices and philosophies offered by the providers reflects an emerging body of field knowledge. One of the perennial tasks of any behaviour or lifestyle change process is *replacing* one system (i.e., of rewards, constraints, maintenance factors, etc) with another – no small feat given that many men and their whānau who live gang-centred lifestyles are likely to experience multiple problems. In this regard, gang members may be better treated as a group with specific needs – informed by sub-cultural norms, values, and practices – rather than as simply a "higher risk" group. This implies a targeted and *strategic* approach, but also realistic goals, such as promoting healthy relationships and values rather than simply focusing on extracting men from these communities.

Lastly, there is a need to recognise that gangs are a form of *community* with accompanying norms, values, processes and practices internal to those communities. Any behaviour change efforts with members of these groups would benefit from being "gang-informed". However, a workable *theory* of gangs that informs about function, susceptibility to join, structure (and variations), processes of entry and exit, and outcome issues has yet to developed beyond general theories of crime and desistance. Strategic interventions that are informed by gang cultures – in addition to theories of crime and desistance – are suggested as a constructive area of further research.

2 The phrase "tikanga gang" is attributed to Harry Tam, a gang member who has also worked as a policy advisor in various government departments.

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Effective rehabilitation through evidence-based corrections

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Executive summary

The Singapore Prison Service (SPS) adopts correctional research as a key strategy to inform policy and practice through Evidence-Based Corrections (EBCs). Local research is critical in contextualising overseas research findings for effective application by taking into consideration sociocultural and legislative differences between Singapore and other countries. In this paper, we share two examples of how correctional research aligns with the SPS's key strategies and guides correctional practices. The first study examines factors contributing to desistance from crime while the second study explores barriers that ex-offenders experience upon their re-entry into the community. The two studies showed that quality pro-social support is important in the reintegration and desistance journey of offenders. Furthermore, self-efficacy is needed for successful desistance, while a lack of employment is a key barrier to reintegration. Findings from such studies act as "feedback loops" that ground SPS's correctional practices in empirical evidence. This serves to ensure efficient resource allocation through targeted intervention, and enhance rehabilitation and reintegration efforts.

Introduction

Correctional research as a key strategy

The Singapore Prison Service (SPS) aims to enforce secure custody of offenders and rehabilitate them back into society as law-abiding citizens. Correctional research is a key strategy in achieving SPS's vision of inspiring everyone, at every chance, towards a society without re-offending. It contextualises international research for local use, aligning SPS practices with international standards. In addition, it provides evidence to enhance SPS operational and rehabilitative capabilities. By understanding and anticipating emerging correctional issues and challenges, correctional research helps determine the efficacy of new approaches for the Singaporean context.

Evidence-based corrections

Since the early 2000s, SPS has adopted evidence-based corrections (EBC) as part of its correctional research strategy. EBC is the body of research that informs correctional assessment, programming, release preparation, and community supervision. This paper shares two recent examples of how SPS correctional research informs practice. The first study examines factors important in desistance from crime, specifically self-efficacy and pro-social relationships. The second study addresses the reintegration barriers faced by ex-offenders in their desistance journey. Results from both studies not only informed rehabilitation practice in prisons, but also provided evidence in support of SPS's community corrections policy.

Facts about Singapore

Prisons	Two 8–storey prisons Total land area of 48 hectares
Incarcerated population	12,800 prisoners 221 prisoners per 100,000
Prison Staff	2,508 staff Ratio of 1 staff member: 5 inmates
2-year Recidivism Rates	2011: 27.4% 2012: 27.6% 2013: 25.9% 2014: 26.5%

Note: *Data correct as at end 2016*

Evidence-based corrections

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Self-Efficacy and Pro-Social Relationships on Desistance (2017)

Background

This study examined if and how individual self-efficacy and pro-social relationships helped offenders desist from crime. Desistance was defined as a change in identity, argued as crucial for long-term desistance (Maruna, 2001). Self-efficacy, such as hope and determination, is the desire and ability to act and bring about changes. Studies have shown the importance of self-efficacy for desistance (LeBel et al, 2008). Pro-social relationships refer to the quality and type of relationships an individual has in his social network. Satisfaction with relationships and marriage has been shown to reduce an individual's tendency to return to crime (Sampson & Laub, 2003).

Method

First, a survey was conducted on 78 male desisters in Singapore. They had been crime-free for an average of 8.3 years. Questionnaires measured their sense of self-efficacy, quality of pro-social relationships, and their identity (operationalised as criminal identity and generativity). Second, interviews were conducted for 44 of them to find out their desistance journey and how they stayed away from crime. Appendix A shows the list of questionnaires and interview questions used for this study.

Key findings

Table 1:

Correlation Results of Survey

Measures	Desistance measures	
	Generativity	Criminal Identity
Self-efficacy – General hope	.36*	-.27*
Self-efficacy – Meeting life goals	.43*	-.38*
Self-efficacy – Self-belief in desisting from crime	.32*	-.34*
Social relationships – family support satisfaction	.28*	-.32*
Social relationships – social support availability	.53*	-.30*

Note: ** p < .05. Correlational analysis were run to examine the relationship among variables*

- **Individuals with higher self-efficacy had a greater sense of desistence.** Participants who scored higher on measures of self-efficacy also scored higher on generativity and lower on criminal identity measurements (Table 1). This finding was corroborated by the interviews, where 40 out of 44 desisters had a language of self-efficacy when describing their desistance journey.
- **Self-efficacy facilitates motivation and taking action.** Participants' self-efficacy, which was key to their desistance, was seen in their motivation. Motivation included determination for change, having a goal, and the self-belief in their ability to change. Self-efficacy also facilitated an orientation towards taking action such as leaving drug friends or joining voluntary activities.

Motivation

"There were some who mocked me, but I persisted and stood my ground in what I believed in. This is a choice we made to stay clean" (Subject 28)

Taking Action

"When you work it out [by taking action towards change], you will see results. [If] you think [but take no action] sometimes [that] is deceiving." (Subject 19)

- **Individuals with strong pro-social relationships had a greater sense of desistance.** Participants who scored higher on measures of pro-social relationship support and availability also scored higher on generativity and lower on criminal identity measurements (Table 1). This finding was corroborated by the interviews where 43 out of 44 participants mentioned social relationships as important for their desistance.
- **Pro-social relationships trigger and maintain change** by providing encouragement and making crime costly. Some participants shared that the emotional support they received from people around them (e.g. family, prison officers) helped spur them to change.

Trigger Change

"When my son came to visit me, he shouted at me, because I promised him that I won't go into prison anymore … I realized that I hurt him so much… Yes, that was my turning point." (Subject 1)

Maintain Change

"But now…we have a family. Am I going to give up [that] just because of some fun things like [drugs]…?" (Subject 34)

Implications

Findings validated the SPS's current rehabilitation approach. Findings reinforce the notion that offender rehabilitation should be a multi-pronged approach addressing both individual capital, social capital, and the environment the offender is in.

Individual capital	Focus on self-efficacy for change, motivation, and behavioural commitment. Every interaction is seen as an opportunity to impact change.
Social capital	Strengthen social capital and capabilities through family interventions and community support. For example, the Yellow Ribbon Community Project[1], organised by community volunteers, reaches out to offenders' families.
Transformative environment	Create transformative environments with activities and processes that support and encourage behavioural changes. Transformative environments are specialised regimes which facilitate offender rehabilitation based on Therapeutic Community principles. Within prison, this can be done through engaging offenders not only during interventions and case review sessions, but also in daily interaction with prison staff.

Apart from studying the desistance journey of offenders, it is important to address barriers preventing the smooth reintegration of offenders upon their release. Addressing this gap, the second study sought to understand the reintegration barriers faced by offenders with and without drug misuse histories.

1 Started in 2004, the Yellow Ribbon Project is a community initiative in Singapore. It aims to create awareness of the need to give second chances to ex-offenders, generate acceptance of ex-offenders and their families in the community, and to inspire community action to support the rehabilitation and reintegration of ex-offenders into society. For example, the yearly Yellow Ribbon Celebrating Second Chances Award was initiated in 2006 to recognise ex-offenders for their efforts towards recovery and successful reintegration back to society. Other events include: Yellow Ribbon Fund, Yellow Ribbon Prison Run, and Yellow Ribbon Community Art Exhibition.

Reintegration Barriers of Offenders (2017)

Background

The transition from prison to community is often a challenging period for offenders. They commonly face reintegration barriers such as personal vulnerabilities, ex-offender stigma, and adjustment difficulties. If these barriers are not properly dealt with, offenders may fall into the vicious cycle of failed reintegration, re-offending, and subsequent reimprisonment. Existing literature highlights five reintegration barriers: employment (Wilson, Gallagher & MacKenzie, 2000), education (Fahey, Roberts & Engel, 2006), social support (Visher, LaVigne & Travis, 2004), accommodation (Richie, 2001), and finances (Western, 2002). However, none differentiated between different types of offences (e.g. robbery, drug, etc). As a large population of inmates in Singapore have histories of drug misuse, this study examined the differences in reintegration barriers between offenders with and without drug misuse histories in Singapore.

Method

Three-hundred-and-forty male offenders from Singapore were surveyed on their perception of the five reintegration barriers: employment, education, social support, accommodation, and finances. Participants with and without a history of drug misuse were surveyed. Details of questionnaires used to assess the five potential reintegration barriers can be found in Appendix B.

Key findings

- **Offenders with drug misuse as a criminogenic need faced higher employment barriers.** This was reflected as issues with physical and mental health due to the debilitating effects of drug use, issues with labour market exclusion, lack of human capital (relevant skills, knowledge and experiences) and past criminal records.
- **Offenders with drug misuse as a criminogenic need perceived more support from their families and significant others, but also had more family conflicts** as compared to offenders without drug use. This highlights that presence of support does not mean a lack of conflict in the family.

Implications

The study's findings impact correctional rehabilitation and reintegration practice during offenders' imprisonment and community supervision phases.

Market-relevant skill set	Equip offenders with relevant skill sets that meet market demands to improve employability. For example, the Singapore Corporation of Rehabilitative Enterprise (SCORE) offers offender employment assistance and partners SPS in providing rehabilitation services for offenders and ex-offenders.
Employment opportunities	Involve the community in offering sustainable employment opportunities to ex-offenders, especially those with drug histories. The Yellow Ribbon Project (YRP) has been actively raising community awareness on the need to give ex-offenders second chances and remove the stigmatising effects of imprisonment on their employment.
Family support	Equip families with skills to support offenders in their reintegration and rehabilitation. Courses such as conflict resolution will be essential to manage family conflicts which may serve as a trigger for re-offending.

Conclusion

The two studies on desistance and offenders' reintegration barriers support SPS's strategic priorities. Both studies showed that quality pro-social support is important in the reintegration and desistance journey of offenders. Furthermore, the desistance study highlighted the importance of self-efficacy for successful desistance, while employment problems were one of the key barriers for reintegration. Findings from these studies ground SPS's correctional practices in empirical evidence and highlight gaps in practice that can be addressed to improve rehabilitation and reintegration efforts. Overall, correctional research effort has contributed to evidence-based corrections approaches to offender risk assessment, intervention and rehabilitation regimes, operational capabilities, and inmate management. It also ensures that current and emerging trends are identified and localised. Correctional research findings are applied at the operational and policy level to support SPS's strategic priorities.

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Appendix A:

Questionnaire and interview questions used in the study "Self-Efficacy and Pro-Social Relationships on Desistance (2017)"

Questionnaires

Factors	Questionnaire	Source
Self-efficacy		
General Agency	Hope Scale	Snyder et al., 1991
Agency to Desist	Agency to Desist Scale	Lloyd & Serin, 2012
Social relationships		
Family Support	FACES IV Satisfaction	Olson, Gorall, & Tiesel, 2006
Social Support	Social Provisions Scale	Russell & Cutrona, 1984 in Hoven, 2012
Desistance	Loyola Generativity Scale	McAdams & de St. Aubin, 1992
	Criminal Identity Scale	Boduszek, Adamson, Shevlin & Hyland, 2012

Note:
Self-efficacy is also known as human agency. It encompasses hope, motivation, desire, determination, and purpose in life.
Social relationships refer to the availability and quality of support from one's social network.
Generativity is the individual's concern for and contribution to the next generation and community.
Criminal identity refers to an individual's identification as a criminal.

Interview Questions

1. What helped you to stay crime free?
2. Was there a significant decisive moment that led you to change?
3. After release, what were the steps you took to stay crime free?
4. Of all that we have discussed, which aspect was the most important contributor to your desistance?

Appendix B:

Questionnaires used in the study "Reintegration Barriers of Offenders (2017)"

Questionnaires

Factors	Questionnaire	Source
Employment barriers	The Perceived Employment Barrier Scale (PEBS)	Hong, Polanin, Key & Choi, 2014
Educational barriers	Perception of Educational Barriers Scale – Revised (PEB-R)	McWhirter, 2000
Social support	Social Support Survey (MOS-SSS)	Sherbourne & Stewart, 1991
	Quality of Relationships Inventory (QRI)	Pierce, Sarason & Sarason, 1991
Accommodation	1. Have you secured a place to stay upon release? 2. If yes, indicate quality of the accommodation in the 4 areas: a. Ownership b. Living space c. Satisfaction d. Residential mobility	
Finance	1. Do you foresee difficulties in paying for daily essentials after release?	

The parachute problem: Negotiating the ups and downs of Randomised Controlled Trial use in criminal justice settings

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Introduction

In 2003 the British Medical Journal published an article entitled "Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials" (Smith and Pell, 2003). The article attempted to summarise randomised controlled trial (RCT) evidence on the effectiveness of jumping out of aircraft with and without a parachute, in order to determine the effect of parachute use on bodily trauma and likelihood of death. The authors noted that the perception that parachutes are a successful intervention is based solely on observational study; while these studies have shown that non-use of a parachute can be associated with morbidity and mortality, they fail to meet the "gold standard" of research evidence. As such, a systematic review of randomised controlled trials on this subject was conducted, as the first step to establishing a more robust evidence-base.

Not surprisingly Smith and Pell's (2003) review failed to unearth any RCT studies, with the evidence "limited" to observational data. Strictly applying the tenets of evidence-based medicine, the authors concede that this knowledge is of insufficient validity to make sound causative claims about the link between parachute use and mortality. To resolve this problem the article concludes with the suggestion that "radical protagonists" of RCT methodologies should perhaps consider participating in a "double blind, randomised, placebo controlled, crossover trial of the parachute" to deliver a more definitive evidence base (Smith and Pell, 2003:1459).

While undoubtedly tongue in cheek, the article makes several important points that researchers, policymakers, and practitioners need to consider when assessing evidence-based needs. In particular, that sound causal knowledge is not always premised on whether RCT-knowledge exists. Rather, alternative methods can and do provide sufficient (or better) evidence about "what works", including in which contexts, and why. This observation is particularly pertinent to criminal justice research, where various obstacles often impede the successful application of RCT methodologies.

The rise of experimental research in criminal justice evaluation in New Zealand (and beyond)

Internationally, technological improvements in data capture, quality, and connectivity (such as New Zealand's Integrated Data Infrastructure) alongside the rise of public managerialist approaches to governance, have driven increased interest in "evidence-based policy" and the means by which we establish "what works" (Gelsthorpe and Sharpe, 2005; Hughes, 1998). Within New Zealand, the social investment approach exemplified this shift. Officially launched in 2015, the social investment approach involved using "information and technology to better understand the people who need public services and what works, and then adjusting services accordingly" (Treasury, 2017). As Treasury currently states on its website, "to make sure services actually deliver in practice, proposals being considered as part of the social investment

approach will need to deliver measurable results. Systematic evaluation of services will be a key part of this".

It is entirely reasonable to expect publicly-funded services and interventions to be rigorously evaluated; however, while not always made explicit, the requirement for "systematic evaluation" has often been narrowly interpreted as the need to incorporate RCTs within the evaluation design accompanying budget bids for new services (the trend has also been seen in other jurisdictions, see Sampson, 2010). This interpretation is based on an underlying premise about the hierarchy of social science methods, which assumes RCTs represent the apex of scientific inquiry, and a "gold standard" in evaluative outputs (Davidson, 2014). As such, it is widely believed that RCTs can and will provide the level of certainty necessary to direct policy decisions about which services to continue and/or expand, and which ones to cease.

What is an RCT, and why should we consider using RCTs in criminal justice settings?

RCTs seek to measure the effect of an intervention on an outcome by employing a random allocation process to treatment and control groups, thereby ensuring that any biases are equally distributed between groups. This, in turn, provides confidence that treatment was the cause of any observed difference in outcome, rather than some hidden confounding factors (Hollin, 2012).

RCTs have a long history within the science field and have played an important role in the development of medical knowledge. Although used to a far lesser extent in social science, where appropriate, well designed, and properly executed, RCTs can undeniably add value. As a variety of scholars have noted, RCTs represent a reliable method for making causative claims (Farrington and Welsh, 2005; Sampson, 2010; Weisburd, Lum and Petrosino, 2001); and as Sampson (2010: 490) suggests, experiments are "an essential part of the toolkit of criminologists" with "more, not fewer, field experiments" needed. We take no issue with this position: RCTs undoubtedly have value. However, where we take issue is with the application and appropriate use of RCTs, their presentation as a universal gold standard, and the over-extended claims that are made about their potential to lead evidence-based knowledge of "what works" (see Hough, 2010; Stenson and Silverstone, 2014).

Our argument is three-fold: first, and most fundamentally, if the term "gold standard" is appropriate at all, it refers to approach(es) that are most suitable to answering the question(s) at hand. In this sense, there is no singular "gold standard" (see Berk, 2005; Sampson, 2010; Grossman and MacKenzie, 2005; Gelsthorpe and Sharpe, 2005). To demarcate RCTs as a universal "gold standard", therefore, makes little sense, and may well be detrimental to the breadth and depth of the "evidence-based" environment. As Grossman and MacKenzie (2005: 520) argue, context is critical to methodological design and quality:

> *"To claim the RCT is a gold standard, is like arguing that since being tall makes for a good high jumper, it follows that a 6' elderly drunkard with a spinal injury is bound to be a better high jumper than a 5'11 Olympic athlete. All things are never equal, and one has to consider many factors other than, in this example, the person's height. Just as being tall is often a good property for a jumper to have, the property of being an RCT is often a good property for a study to have, but it does not follow that anything that is an RCT is better than anything that isn't."*

Second, while the term "gold standard" is often taken as a generic indicator of research quality, in fact this is a misinterpretation of a term that has a very specific meaning. Rating scales (such as the Scientific Methods Scale) from which "gold standard" language is derived, measure only one aspect of study validity: 'internal validity' (our confidence in assuming causation from findings). Even if RCTs do achieve the "gold standard" of internal validity, this is only one component of study validity; and RCTs' high internal validity is often obtained at the expense of other important aspects of validity (such as "external validity": our ability to generalise findings).

Third, even where we seek to understand causation and can agree that an RCT is (at least in principle) the best approach, in reality knowledge produced through RCTs is not necessarily more reliable, credible, or valuable than that produced through other methods. This is just as true in the medical arena as it is within social science (for instance, Bothwell et al, 2016). There is typically distance between textbook accounts of research methods and their application in the field. This is particularly true of RCTs, given the rigidity of their method and the stringency with which they need to be applied (to ensure internal validity), coupled with implementation difficulties associated with complex criminal justice settings. As Grossman and MacKenzie (2005: 523) state, we need to avoid scales whereby we assume that "even the most well-designed, carefully implemented, appropriate observational study will fall short of even the most badly designed, badly implemented, ill-suited RCT".

When should we use RCTs, and how?

Given increased interest in "evidence-based policy" and "what works", and given the central place of RCTs within this agenda (Davidson, 2006), it is critical that researchers, policymakers, and practitioners understand what RCTs involve and what type of evidence they are capable of delivering. The following sections discuss these issues.

"It depends on the context": understanding outcomes

RCTs seek to understand outcomes, and, as such, are an evaluative tool for answering "what works" questions. It should go without saying that they are therefore appropriate within this environment, but not necessarily others. However, even where our focus is "what works", we must take care in simply accepting the natural primacy of RCTs in establishing causation for a number of reasons.

While a perfectly designed and administered RCT may allow us to observe, with confidence, that a treatment affected an outcome, RCTs do not identify or elaborate the mechanisms within programmes that caused such an outcome to occur. Yet, in the event a programme is deemed to "work", an understanding of these "how" and "why" questions are critical to replication. Given the significance of "social structures" and "cultural processes" in shaping causation (and ultimately programme outcomes), this understanding is essential if we wish to transport experimentally-successful interventions to new settings or populations (Sampson, 2010; Hough, 2010). As Latessa (2018: 1) notes in respect of correctional programmes, "the challenge for those administering programmes is not 'what to do' but rather 'how to do it' and 'how to do it well'" (see also Pawson, 2013; Pawson and Tilley, 1997; Hope, 2009; Sampson, 2010; Sampson, Winship, and Knight, 2013).

In recognising this issue, some scholars have observed that the stringency of RCT design, and its necessary prioritisation of internal validity (that is, its ability to manage confounding variables) has been at the expense of external validity (that is, its generalisability to other places, contexts, or populations). As Berwick (2008) states, one of the great ironies of the RCT approach is that the stringency of its methodological approach ultimately strips this method of the context required to generalise and replicate successful programmes. Ultimately, this makes "experimental evidence an inflexible vehicle for predicting outcomes in environments different from those used to conduct the experiment" (Heckman, 1992: 227). For this reason Berwick (2008: 1183) labels RCTs "an impoverished way to learn".

Perhaps, a more positive framing of this limitation is Hough's (2010: 14) observation that RCTs are best conceptualised as a "starting point", rather than the end step of evaluative understanding:

> *"It is of great value for evaluative research to establish that something can work in reducing reoffending, but this is only the beginning of any serious evaluation. If a programme has been shown to be effective in one setting, the important next step is to identify the mechanisms by which this impact was achieved. The sort of evidence that one needs to search for this enterprise may be distinctly different from that which one needs to establish whether a programme can work."*

Consequently, understanding "what works" ultimately requires the use of a variety of methods (Clear, 2010). Elaborating this point, Latessa (2018) argues that outcome evaluation should be pre-empted by detailed intervention logic work (e.g. formative evaluation), and/or assessment of a programme's implementation (e.g. process evaluation) to ensure that application and fidelity issues are resolved. Such work is crucial as it ensures that a programme is at a suitable stage to justify and support timely and expensive outcome study (thereby reducing mid-RCT implementation changes that affect RCT methodology and quality of findings). Indeed, Latessa (2018) suggests that where programmes fail to meet set quality standards at this earlier stage, the considerable resources earmarked for outcome measurement (such as through RCTs) should be diverted into improving the service or intervention to better deliver desired outcomes (Latessa, 2018).

The presumed supremacy of RCTs in articulating "what works" also overstates the universality of this method in responding to all research questions that seek to understand causation. As Sampson (2010) notes, not all research that is interested in causation lends itself to the RCT method. For instance, criminologists are, and ought to be, concerned with macro-level causation and the development of causal mechanisms over long periods of time (sometimes even decades). In such situations, other research approaches, such as observation-based longitudinal studies (the Dunedin Longitudinal Study being one such example) offer better opportunities to assess causation. Indeed, much robust causal theory has emerged from the careful accumulation of observational studies, as opposed to laboratory-style experiments.

Ethics matter

Historically, one of the main areas of criticism levelled at RCTs has been the ethics of randomising treatment interventions (Braga et al, 2013). In response, a variety of authors have suggested that the increasing number of "ethically implemented" RCTs in criminal justice settings somewhat negates these concerns, and demonstrates that they are, for the most part, "based in folklore rather than facts" (for example, see Weisburd, Lum and Petrosino, 2001; Farrington and Welsh, 2005; Sampson, 2010).

The presentation of RCT ethics as "fact" or "fiction" is a superficial and unhelpful dichotomy. While recognising and accepting that it is possible to carry out "ethically implemented" RCTs in criminal justice settings, this does not reduce the relevance of ethical considerations. Rather, such considerations remain very much alive in debates about experimental social science methods. As Hollin (2012) states, RCTs should adhere to "the principle of equipoise": a term commonly used in medicine to denote the need for "genuine doubt and an absence of evidence" of effectiveness as a basis for research: "ethically, RCTs can only be planned and carried out where there is reasonable uncertainty about the effectiveness of an intervention" (Hollin, 2012: 238). To return to our initial example, given what we know from observational data about the relationship between jumping out of a plane without a parachute and the likelihood of physical injury, even if an RCT study produced more reliable causative knowledge, requiring some participants to jump out of a plane without a parachute to attain this knowledge is untenable for ethical reasons. Applying this 'harm minimisation' principle to the criminal justice environment, practitioners should carefully consider the strength of existing evidence in assessing the need for, and appropriateness of, RCT study before committing resources to this enterprise.

Impracticalities of blinding

In addition to ethical and theoretical issues, there are a broad range of practical obstacles that can either prevent the application of RCTs altogether, or undermine the validity of results. One of these is 'blinding' – a design feature associated with more rigorous approaches. There are different blinding options open to RCT designers: single blinding ensures that participants are unaware of whether they are in the treatment or control group, while double blinding removes this knowledge from both participants and administrators. Finally, triple blinding makes participants, administrators and researchers unaware of the group allocation of individuals. The purpose of blinding is to limit participant, administrator and/or researcher biases that can result from knowledge of how and where individuals are placed within RCT groups, and which can, in turn, undermine the study design and therefore its results (Hollin, 2012; Goldacre, 2008).

Blinding may be a relatively easy methodological task in simple medical settings (for example, where the treatment is a pill, and group participants are administered either the medication or an identical-looking placebo). However, its application is often considerably more difficult in criminal justice environments – such as target hardening initiatives to reduce burglary, specialist court services for victims, or treatment programmes for offenders (Hollin, 2008). In such circumstances, both those providing treatment and those receiving it are likely to be acutely aware of their groupings (Gelsthorpe and Sharpe, 2005).

The inability to blind a programme can impact on its delivery in ways that affect outcomes; for example, if randomisation procedures are properly adhered to and participants are asked to opt into the service or programme prior to treatment allocation, it is plausible to assume the effect of being denied treatment may have an impact on the attitudes and behaviours of those in the control group. Similarly, it may be difficult for those administering treatment to deny help to more promising cases, leading to flexible reinterpretations of randomisation procedures as trials progress (see Farrington and Welsh, 2005). Should this occur, considerable bias may be introduced into randomised experiments (Goldacre, 2008; Hollin, 2008).

Intervention volumes and the time lag for results

In addition to blinding, one of the most significant and insurmountable practical barriers to the implementation of RCTs in New Zealand criminal justice research is participant volumes (and relatedly timeframes). RCTs generally require large numbers, in both the treatment and control groups, to ensure that resultant analyses are of sufficient power to reliably infer causation. For example, in a situation where we might predict that an intervention will reduce re-offending by 5%, to achieve an 80% power result, sample sizes of around 1,500 participants would be needed for each of the treatment and control groups.[1] This is one of the reasons why RCTs work best in simple, high-volume intervention environments. In reality, few New Zealand criminal justice innovations are piloted at such high volumes. The simpler the initiative, the better, as any variation or bifurcation of the treatment group along the intervention pathway will effectively split the sample size of the resultant group, thereby reducing volumes and increasing the

1 Lenth, R. V. (2006–9). Java Applets for Power and Sample Size [Computer software]. Retrieved 19 January 2018, from http://www.stat.uiowa.edu/~rlenth/Power

time taken to achieve the numbers necessary for reliable analysis. As such, RCTs are less feasible in more complex social environments, such as those often found in criminal justice settings (Hough, 2010).

Without sufficient volumes, an RCT is likely to be lengthy, as the requisite numbers are gradually accumulated. These timeframes will be further extended to take account of post intervention outcomes. For example, should a trial intervention, with a focus on re-offending, take three years to accumulate sufficient volumes for analysis, analysis will then be delayed for a further 15 months to enable a standard re-offending follow-up period to be completed. Consequently, it may take up to four and a half years to obtain results. Such timelines are routinely seen in RCT research, but are often incompatible with the decision deadlines of policymakers. This further limits the scope and applicability of RCTs as an evidence leader; and as Clear (2010) argues, such delays also therefore have implications for the ability of RCTs to lead an innovative, future-focused vision of "what works".

Matching design with outcome need (ITT vs TR)

Information needs should be matched with the specifics of RCT design to ensure the required outcome information is obtained. Broadly speaking, there are two frameworks for RCT analysis: Intention to Treat (ITT) and Treatment Received (TR). These measure different outcomes. The purest approach to RCT analysis is ITT (Hollin, 2012). ITT incorporates all those allocated to the treatment group, regardless of their individual progress, while TR includes only those who receive treatment. Thus, within ITT analysis those who complete a programme, those who drop out, and, perhaps, those who do not even start a programme are all included in the "treatment" group. ITT analysis, therefore, measures the effectiveness of an entire intervention (broadly defined), and does so in a more "real world setting", where not all those who have access to treatment take it up (Grossman and MacKenzie, 2005).

Practically speaking, an ITT approach ensures that maximum numbers of people are included in the treatment group, enabling accumulation of the necessarily volumes for analysis in the shortest timeframe possible. Methodologically speaking, ITT ensures that the principle of randomisation (which is crucial to RCT claims to superior causative knowledge) is upheld. In contrast, TR analysis is restricted to those who received treatment: a sub-sample of the original treatment group. This approach is often favoured by practitioners and policymakers, since their focus is on understanding the impact of a programme on those who actually receive it.

Importantly, neither ITT nor TR is without limitation. ITT analyses may tell us only a limited amount about the effectiveness of the treatment in question (Hollin, 2012; Grossman and MacKenzie, 2005). In situations where there is a reasonable amount of treatment attrition (and the longer the duration of the programme or intervention being assessed the more likely this will be), combining the results of completers and non-completers may effectively cancel out the visibility of any positive treatment effect, or may even give the impression that a successful treatment intervention makes people worse. Moreover, ITT analysis does not explain why people dropped out of treatment, nor distinguish the degree to which this was a function of the intervention itself or merely a factor associated with the broader context surrounding it (Grossman and MacKenzie, 2005).

A TR model is also not without issue. In particular, by focusing only on those receiving treatment it is methodologically weaker than ITT owing to the biases inherent in its self-selecting sample. For example, if we were to take a TR approach to examining the effectiveness of a programme to reduce re-offending amongst recidivist family violence perpetrators, how likely is it that those who completed and those who did not complete the programme could be considered to be equally motivated to change their future behaviour? In presenting findings researchers will often provide both ITT and TR results. This is useful; however, it is important to note that doing so does not overcome all limitations, since the issues with each approach cannot simply be resolved through recourse to the other.

Slow knowledge

Owing to the problems with volumes and follow-up times, RCTs represent an extremely slow method of accumulating knowledge. While this is partly about the pragmatics of RCT methodology, such as case volume requirements, more fundamentally it is about the ability of the method to deliver knowledge that meets the needs of the "what works" agenda. In policy terms the "what works" agenda is about a desire to understand and select (from amongst the endless array of options available to policymakers) those initiatives or programmes which best achieve particular outcomes. However, RCTs do not answer this question; rather, RCTs test whether a programme or initiative can be seen to influence a desired outcome. Thus, while RCTs are often heralded as the mechanism for understanding "what works", this is a rather inflated claim. Even ignoring other limitations of RCTs, to the degree they inform policymakers about "what works", they deliver this knowledge extremely slowly. As Goldacre observes (see McManus, 2009: 52–3):

"Each RCT provides only one bit of information: 'yes' or 'no' to a single question. Just as one could climb a mountain by asking at each step which way to go, so RCT-based medicine is progress, but it's so very, very slow."

One of the approaches used to overcome this sluggishness is the systematic review of similar studies. However, as outlined elsewhere in this article, the inability of RCTs to examine or understand the mechanisms that cause a result, raises questions about whether, in doing so, we are "comparing apples with apples" (Hope, 2009: 130; Garg *et al*, 2008:255). And, beyond this issue, RCTs remain a relatively scarce commodity in criminal justice settings, which reduces the impact of summative analysis. For example, in an audit of RCTs published in one of the premier criminology journals – the British Journal of Criminology – between 1960 and 2004, Petrosino *et al* (2006) found evidence of only nine RCT studies, eight of which were published pre-1983 (see also Hough, 2010: 13). The commonality of null RCT results – those finding no significant difference between the treatment and control groups – and the publication bias in favour of only publishing significant results – is also an issue in this context (see Pawson, 2006; Stevens, 2011; Goldarce, 2008).

For some commentators, the delays associated with RCT knowledge production means they are "measures of desperate last resort when no better way exists to answer important questions" (Goldacre, 2008). Whether or not this is so, it is at least the case that RCT knowledge is unlikely to be the sole or primary evidence base for properly informed policymaking.

The policy limitations of narrow results

In addition to delays in knowledge production, the knowledge produced through RCTs is often of limited scope, which has implications for evidence-based policymaking. As Carr (2010: 8) points out, due to their narrow focus, experimentally-validated policies can ignore the wider context of interventions in ways that encourage adverse unintended consequences (see also Sampson, Winship, and Knight, 2013). Using the example of exhaustive "stop and frisk" by the Philadelphia Police Department (based on experimental evidence from a Kansas City initiative), Carr (2010) observes that what was not taken into account in the experimental research was the broader impact of this policy on racial relations between police and ethnic minorities (and therefore the ability of this experimentally-validated intervention to sustain crime reductions).

The implication of this issue to policymaking is clear: an intervention that has been experimentally shown to "work" in the respect of one specific outcome, in one place, and at one time, does not necessarily represent good policy or offer sustainable benefits in the long term. Of course, this criticism can equally be levelled at other methods; the difference though, is that other methods are not claiming "gold" status in respect of driving "what works" knowledge and improved social investment, and so are typically less "exclusive" in their approach (see Carr 2010; Sampson, 2010).

Conclusion

In his launch of the social investment approach in 2015, former Minister of Finance Hon. Bill English noted: "solutions to complex problems cannot be reduced to simple equations". As this article has demonstrated, the same maxim holds in relation to evaluations of interventions that target complex problems. In reality, establishing "what works" is difficult and often uncertain, with definitive results few and far between. While RCTs can undoubtedly make a useful contribution to our knowledge on intervention effectiveness, they are by no means problem-free and, even when appropriate and well-implemented, do not always deliver results that can be generalised. Nor do they provide definitive answers about why an intervention works or for which types of people or settings interventions work best.

RCTs may be an important part of the "toolkit", but they are simply that: "a part of", not a superior replacement to knowledge generated through other methods. While RCT results may appear deceptively simple, knowledge generated through this method (as in the case of all methods) has limitations, and requires careful interpretation (and, critically, this interpretation is not theory free). Even where RCTs are useful in providing some knowledge, evidence produced via other methods is both crucial to the successful implementation of RCTs and provides the broader context within which RCT results can be more meaningfully assessed. Most importantly, when it comes to questions of how something works and why (needed to successfully transport an intervention to other settings or populations), RCTs must defer to other methods.

Returning to the subject matter with which we began this article, when someone chooses to exit a plane with a parachute strapped to their back, between air and ground they will need to survey the fast approaching terrain and use their skills and experience to steer themselves towards a safe landing point. Like parachuting, conducting evaluation work well requires an ability to scan and negotiate the theoretical and methodological topography, sight and manage obstacles, and follow the right trajectory towards an appropriate "landing". This journey is often far from straightforward, and requires knowledge, skills, and experience. If in doubt, ask a researcher; don't jump out of the plane and hope for the best.

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Where New Zealand stands internationally: A comparison of offence profiles and recidivism rates

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Author biography

Marcus started as a policy adviser at Corrections in September 2017, and has been focused on how New Zealand justice settings compare to overseas jurisdictions. Before coming to Corrections, Marcus taught at the University of Canterbury while completing his masters in political science. His thesis analysed patterns of violence and the recording of atrocities in war-time Papua New Guinea.

Overview

The findings of this paper indicate that New Zealand's prison population is unusually skewed in terms of sexual and violent offenders.

Compared to 31 jurisdictions in the Council of Europe (CoE), the United States, and Australia, New Zealand's prisons have the highest percentage of sentenced prisoners convicted of violent (18.5%) and sexual (25.2%) offences. The reasons for this are beyond the scope of this paper and require further research. However, one reason might be that the majority (63%) of sexual offenders in New Zealand prisons are serving sentences greater than five years. These statistics underline the challenges of reducing the prison population, and the need for innovative approaches.

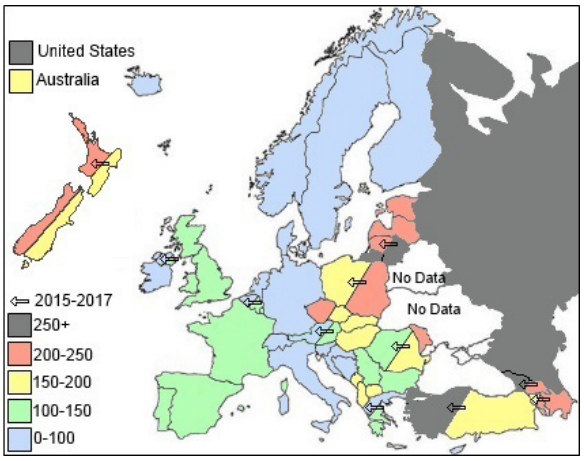
This paper also attempts to compare re-offending rates across jurisdictions. However, while Australia's re-imprisonment rates can legitimately be compared to New Zealand's, there is not enough data to draw any meaningful conclusions.

New Zealand's high imprisonment rate

With 197 prisoners per 100,000 population in 2015, as shown in Figure 1 below, New Zealand's incarceration rate far surpasses those of Western European countries. While English-speaking jurisdictions tend to have higher imprisonment rates than continental Europe, New Zealand stands out further with an imprisonment rate surpassing many of those in Eastern Europe also. By 2017, our prison population was 219 prisoners per 100,000, significantly higher than Australia (162) or England/Wales (145).

Figure 1:

International imprisonment rates 2015-2017



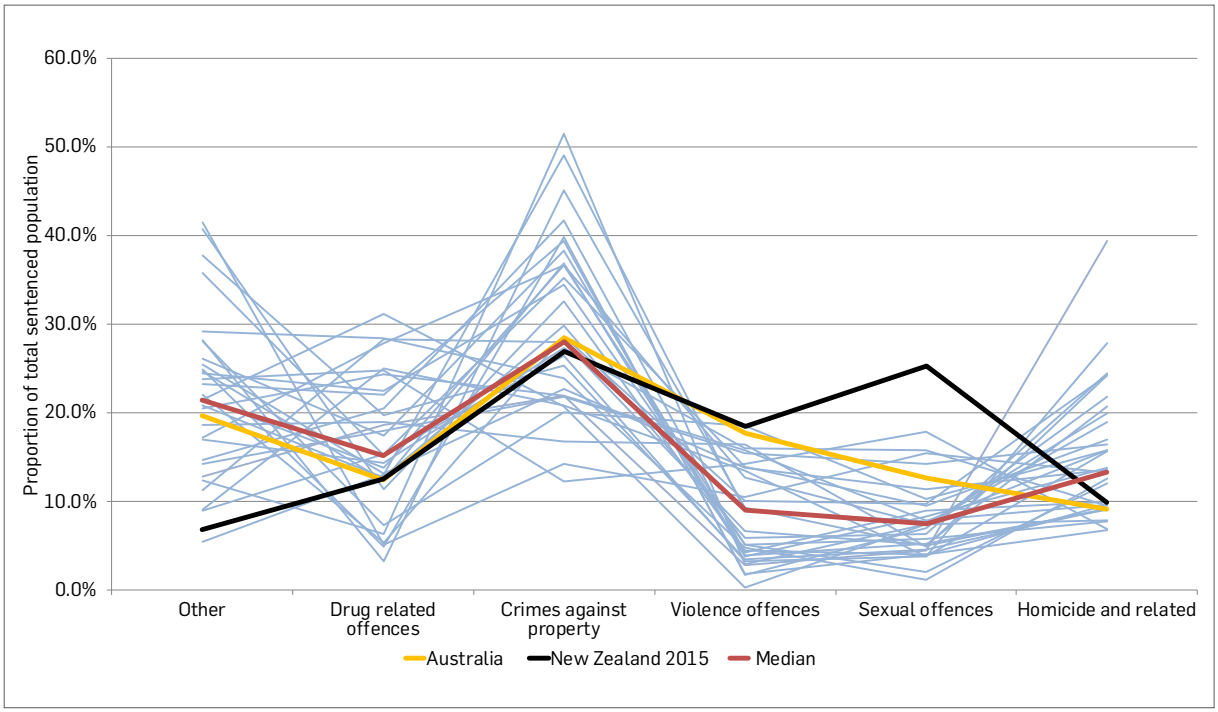
Comparing prison offence profiles with international jurisdictions

To understand why New Zealand's prison population is higher than other developed jurisdictions, comparative analysis of the factors that can influence the prison population is necessary. The following section examines one of those factors – our prison offence profile.

Comparative studies using criminal justice statistics are notoriously difficult to undertake, given the wide range of differences that exist across countries. However, a relatively recent CoE annual penal statistics report (Aebi, Tiago & Burkhardt, 2017) has been sufficiently standardised to allow legitimate comparisons between jurisdictions. It also includes a high level of detail and reliability, and so has been used as the main data source for this report. The CoE also constitutes the majority of the developed world.

Figure 2:

Overall composition of sentenced prison population by lead offence type 01/11/2015[1]



Together with New Zealand, it includes 76% of the OECD, 57% of high-income countries, and 80% of countries with high human development index scores.[2]

In the latest CoE data set (2015), 29 jurisdictions provided sufficient data on the offence composition of their prison population. This was supplemented with data from Australia and the United States. Combined with New Zealand, the data for 32 jurisdictions was examined.

A comparison of prison populations by offence type

Using the international data, Figure 2 below shows the overall breakdown (by percentage) of each jurisdiction's prison population by the lead offence type.[3] This is intended to provide a contextual overview of the different types of prison compositions. Figure 3 draws out select jurisdictions which characterise different types of prisoner compositions.

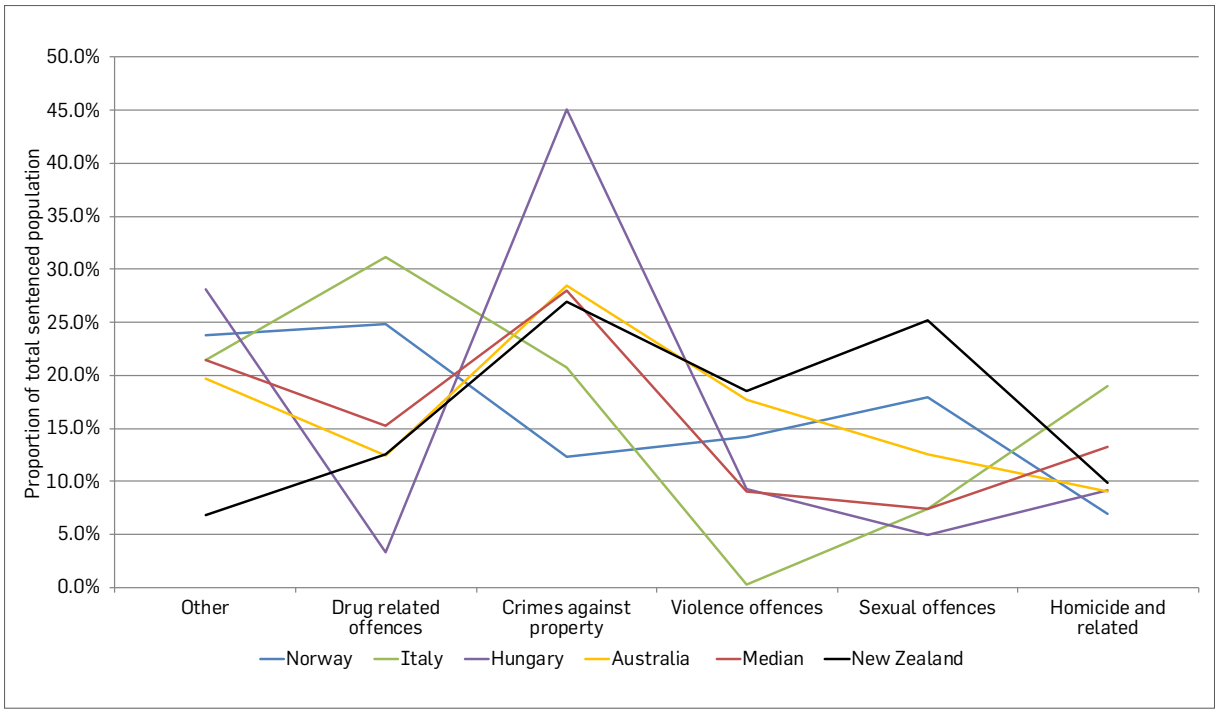
1 Data is provided in Appendix 1.

2 CoE includes 32 of the top 40 highest scoring countries on the IHDI.

3 Note that the six offence categories do not use legal definitions but have been validated for consistency (Aebi, Tiago & Burkhardt, 2017). The New Zealand and Australian data uses comparable categories based on the ANZSOC offence classification system. The classification of the US data is less certain.

Figure 3:

Archtypes of patterns within international jurisdictions prison profiles, 01/11/2015



Italy's offence profile is typical of jurisdictions with high numbers of drug-related offenders, who make up 31% of its prisoners. This is important as many jurisdictions have been able to target this non-violent cohort to reduce their prison populations. In the past, this has included mass amnesties in Georgia and Italy, decreasing technical violations and recalls in Texas, decriminalising drugs in Portugal, and increased correctional based drug treatment programs in Singapore (Ruggiero & Ryan, 2013; Helliwell, 2011; CSGJC, 2009; Laqueur, 2015).

Hungary's offence profile is characteristic of many countries in Eastern Europe, such as Latvia, Georgia, and Romania; 45.1% of its prison population was reportedly sentenced for crimes against property.

Norway demonstrates the profile of a jurisdiction that has already implemented successful reform. With fewer prisoners incarcerated for property or drug offences, 17.9% of its prisoners are on sentence for sexual offences. This is the second highest in the CoE. For similar reasons, Denmark has the fifth highest proportion of people sentenced for violence, while Finland has the fifth highest proportion imprisoned for homicide and related offences.

Australia is the jurisdiction most similar to New Zealand. While less pronounced than in New Zealand, Australia shows similar features with high proportions of sexual and violent offenders. This is also observed in England/Wales, and Northern Ireland.

Table 1 shows how New Zealand's offence profile compares to that of the other jurisdictions. Of all 32 examined, New Zealand had the highest proportion of violent offenders.[4] New Zealand prisons also contain a much higher proportion of sexual offenders than any other jurisdiction. They make up 30% more of the prison population than in Norway, and almost three times the median. Finally, when these categories were combined with that for homicide (and related offences) into one for all "interpersonal violence",[5] New Zealand still recorded the highest proportion of prisoners of this type.

4 This excludes burglary and aggravated burglary type offences in order to be consistent with the international data.

5 The offence categories (e.g. "interpersonal offences") are non-technical terms.

Table 1:

Proportion of prisoners by lead offence type (01/11/2015)

Offence category	Highest	2nd highest	3rd highest	Median for 32 countries included in sample
Violence offences	**18.5% (New Zealand)**	18.4% (Northern Ireland)	17.7% (Australia)	6.6%
Sexual offences	**25.2% (New Zealand)**	17.9% (Norway)	15.8% (England/Wales)	7.3%
Interpersonal offences	**53.6%[6] (New Zealand)**	46.6% (Albania)	46% (United States)	33.2%

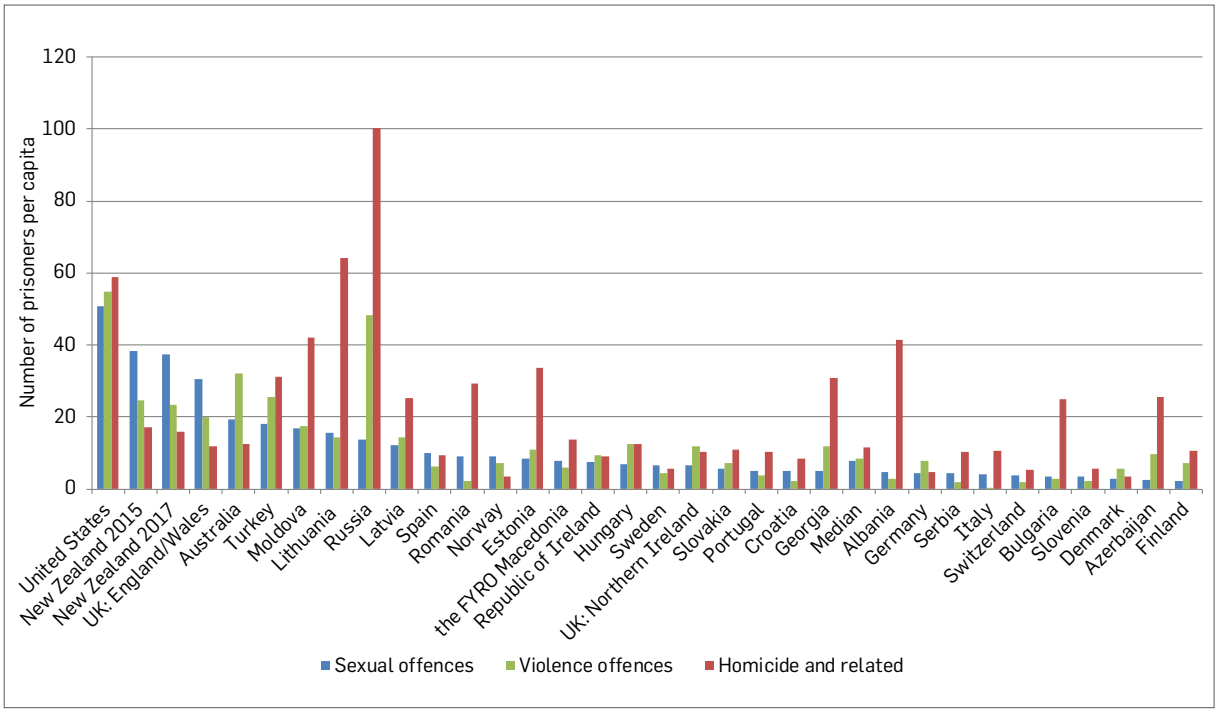
Comparing prison populations by per capita imprisonment rates

The results of Table 1 do not preclude the possibility that New Zealand has an offender composition driven by the same use of "prison as a last resort for the most serious offenders", as outlined above, in Finland or Norway. This possibility can be addressed by examining the data as a function of offenders per capita. Doing this shows it to be unlikely that we are similar to jurisdictions like Finland.

For every 100,000 people in New Zealand, 38.3 were in prison for sexual offences in 2015. In the Nordic countries this ranges from 2.1 to 9.2 per 100,000. Figure 4 depicts these per capita rates in more detail.

Figure 4:

Prisoners per capita by offence type 01/11/2015



6 The New Zealand figure is the total of: violence offences (18.5%) + sexual offences (25.2%) + homicide and related offences (9.9%).

Table 2:

Per capita rate of prisoners by lead offence type 01/11/2015

Offence category	Highest	2nd highest	3rd highest	4th highest	5th highest	Median
Violence offences	55.0 (United States)	48.4 (Russia)	32.2 (Australia)	25.7 (Turkey)	**24.5 (New Zealand)**	7.6
Sexual offences	50.7 (United States)	**38.3 (New Zealand)**	30.7 (England/ Wales)	19.5 (Australia)	18 (Turkey)	6.7
Homicide and related	100 (Russia)	64.3 (Lithuania)	58.8 (United States)	42.2 (Moldova)	41.4 (Albania)	12.2
Total interpersonal offences	164.5 (United States)	162.5 (Russia)	94 (Lithuania)	**80.2 (New Zealand)**	76.6 (Moldova)	30.2

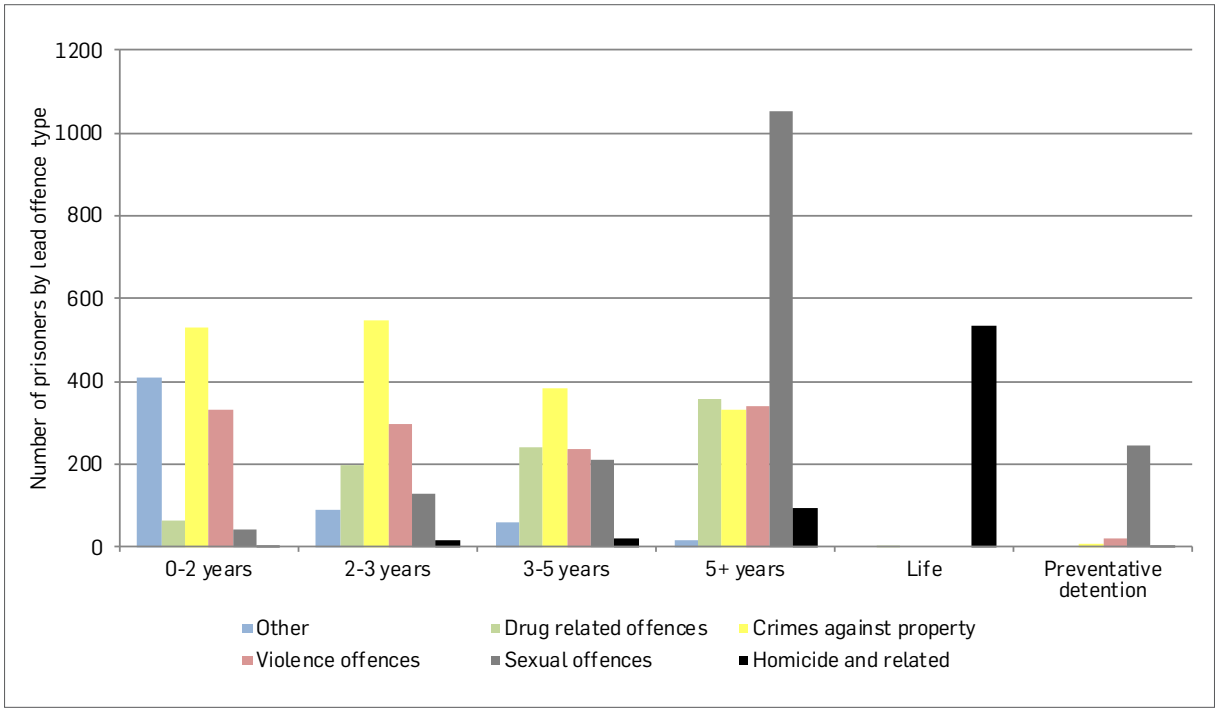
The divergence between New Zealand and the median number of sexual offenders is even higher in Table 2 than in Table 1, growing from nearly four to six times the median. Of all 33 jurisdictions, New Zealand has high proportions per capita of people imprisoned for sexual and violence offences. Only in regard to homicide and related offences do we rank lower, at thirteenth place with 17.3 offenders per 100,000.

The composition of New Zealand's prison population – a deeper examination

The data presented here do not explain why New Zealand has such high proportions of sexual and violent offenders. To shed further light on these findings, the mix of offence types by length of imposed sentence and throughput also needs to be examined. The following graph gives some indication of New Zealand's prisoner population via this lens.

Figure 5:

Snapshot of New Zealand prisoners by offence type and sentence length 01/11/2015



This graph depicts a snapshot of New Zealand's prisons on 1 November 2015. While comparative data for other jurisdictions is not available, Figure 5 helps to further contextualise the composition of New Zealand's prisoner profile.

The most notable feature is that those sentenced for sexual offending are mostly serving relatively long sentences. Of all sexual offenders in prison at that time, 63% were sentenced to more than five years.

Given such a high proportion of sexual offenders are in New Zealand prisons, and the fact that they are mostly serving very long sentences, two hypotheses present: that similar offenders in other jurisdictions spend less time in prison, and/or New Zealand has larger numbers of these offenders entering prison. Unfortunately, we do not have the data to answer these questions, however, these results cast some doubt on the idea that tough New Zealand sentencing practices alone are the cause. For this to be true sexual offenders serious enough to get more than five years in New Zealand would have to be diverted from prison in other jurisdictions, or would serve a sentence so short they would churn through the system without resulting in high prisoner numbers. More research is needed to answer these questions.

Comparing recidivism rates

An attempt was made to compare reconviction and reimprisonment rates across jurisdictions, to discover if these rates affect prisoner composition. However, attempting to compare these types of statistics is fraught with problems. Apparent differences in rates can arise due to the make-up of the cohorts, the length of time over which re-offending is measured, and the actual measure of re-offending itself. The lack of comparable data limits the usefulness of any comparison.

A project to standardise reconviction reporting by the CoE demonstrates how much small differences in reporting methods matter (Albrecht & Jehle, 2016). The study examined the recidivism statistics for Scotland, England/Wales, and the Netherlands. All three reported two-year reconviction rates. However, when their reporting practices were standardised the results changed significantly.

Appendix 1 provides some details on recidivism data in nine jurisdictions. This demonstrates high-level differences in methodologies to further demonstrate the inconsistencies that make comparisons problematic.

The only data identified that was comparable to New Zealand were the two-year reimprisonment rates of Australian jurisdictions, where significant effort to achieve methodological standardisation has occurred.

Table 3:

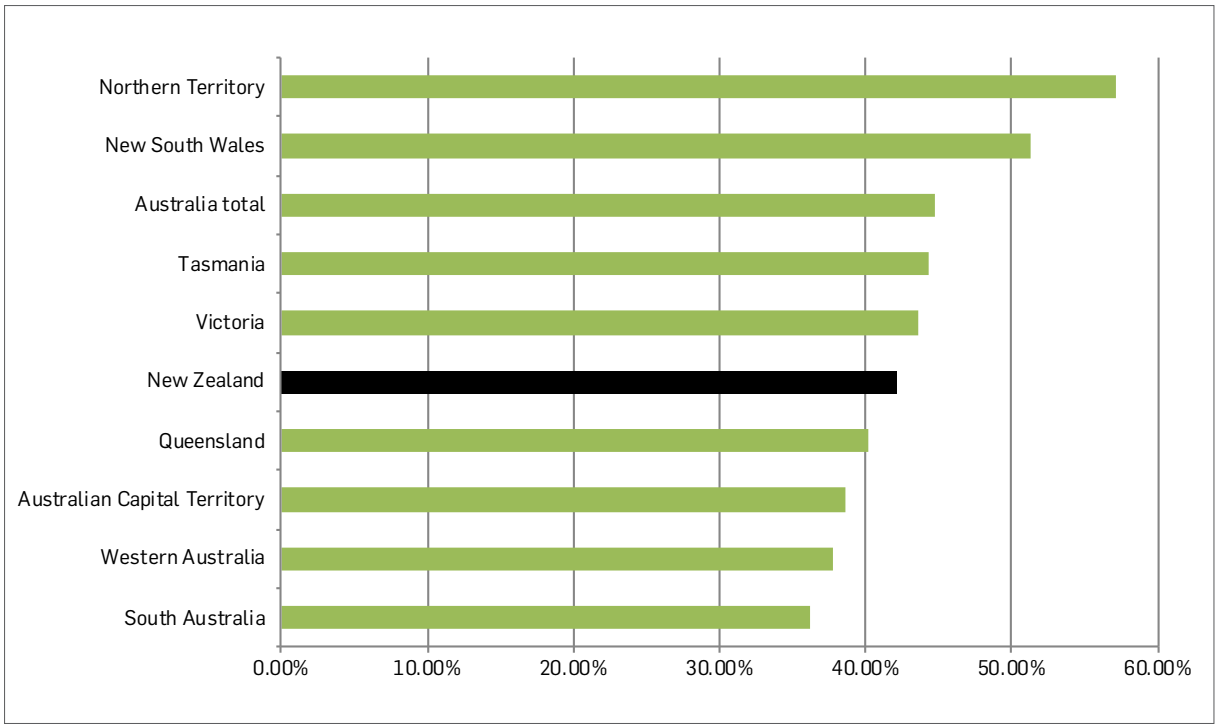
Results of the CoE standardisation program for reconviction data (2004)[7]

	England/Wales	Scotland	Netherlands
Original recidivism data	54.7% reconvicted	44.6% reconvicted	29.3% reconvicted
Adjusted recidivism data	**45.1% reconvicted**	**44.3% reconvicted**	**38.0% reconvicted**

7 Index cases are the original offences from which the "two years" is monitored.

Figure 6:

24 month reimprisonment rate of Australasian offenders released in 2013/14-2015/16



(Australian Government Productivity Commission, 2018)

Conclusion

The limited scope of this paper restricts the strength of the conclusions that can be drawn. However, from the evidence outlined, across the set of countries included in this analysis, New Zealand has:

- one of the highest imprisonment rates in the developed world
- the highest proportion (53%) of offenders in prison for interpersonal offences
- the highest proportion of sexual offenders in prison (25%)
- the second highest rate of incarcerated sexual offenders per capita (38 per 100,000 people)
- the fifth highest number of offenders incarcerated for violence offences per capita (24 per 100,000 people)
- a high proportion of sexual offenders serving long sentences (63% of sexual offenders in prison had sentences of five years or more), which may explain why they form a relatively high proportion of the total.

It must be acknowledged, however, that much of the available recidivism data are not comparable and what is available does not support firm conclusions.

With a high prison population rate, it is clear that some features of crime and justice in New Zealand are problematic. One of these areas is the disproportionate number of people in prison for interpersonal violence. Understanding what drives this requires more research. It may be due to the nature of our judicial settings, it could mean there is a concerted effort to tackle normally under-reported violence, or it may be as a result of some feature of the nature of crime in New Zealand.

Regardless, the high proportion of prisoners sentenced for violence offences means New Zealand lacks the same high numbers of non-violent offenders other jurisdictions (such as Texas, Portugal, Georgia, and Italy) have targeted to reduce their prison numbers. Therefore, policies from such jurisdictions may have limited transferability to New Zealand.

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Appendix 1: Percentage composition of jurisdictions prison population, 01/11/2015[8]

Jurisdiction	Other	Drug related offences	Crimes against property	Violence offences	Sexual offences	Homicide and related
Albania	12.8%	18.7%	21.9%	2.8%	4.5%	39.4%
Australia	19.7%	12.4%	28.5%	17.7%	12.6%	9.1%
Azerbaijan	29.2%	28.4%	23.9%	4.8%	1.2%	12.6%
Bulgaria	12.3%	6.4%	51.5%	2.9%	7.5%	19.9%
Croatia	24.7%	12.4%	36.8%	3.8%	8.4%	13.8%
Denmark	20.5%	24.4%	21.9%	15.7%	7.9%	9.6%
Estonia	11.3%	28.3%	27.9%	6.6%	5.2%	20.7%
Finland	18.7%	19.0%	16.7%	16.4%	5.0%	24.2%
Georgia	17.2%	27.8%	36.6%	5.1%	2.1%	12.1%
Germany	21.6%	13.8%	36.6%	12.7%	7.4%	7.8%
Hungary	28.1%	3.3%	45.1%	9.3%	5.0%	9.2%
Italy	21.5%	31.1%	20.8%	0.2%	7.5%	19.0%
Latvia	5.5%	13.0%	49.0%	9.0%	7.7%	15.7%
Lithuania	20.8%	12.7%	29.8%	5.9%	6.4%	24.4%
Moldova	22.0%	5.4%	28.6%	10.0%	9.8%	24.3%
Netherlands	35.7%	15.2%	26.4%	3.3%	3.8%	15.6%
New Zealand	6.8%	12.6%	26.9%	18.5%	25.2%	9.9%
Norway	23.8%	24.8%	12.3%	14.2%	17.9%	6.9%
Portugal	37.7%	19.7%	25.3%	3.5%	4.5%	9.2%
Republic of Ireland	25.4%	13.1%	22.7%	13.8%	11.3%	13.6%
Romania	24.9%	4.9%	39.8%	1.7%	6.9%	21.8%
Russia	9.1%	25.0%	20.8%	13.4%	3.8%	27.8%
Serbia	23.2%	22.0%	39.3%	1.8%	4.1%	9.6%
Slovakia	40.7%	11.4%	32.6%	4.5%	4.1%	6.7%
Slovenia	14.6%	20.5%	41.7%	4.2%	8.9%	10.0%
Spain	24.4%	22.5%	34.4%	5.1%	5.7%	7.8%
Sweden	41.4%	5.1%	14.3%	10.5%	15.4%	13.3%
the FYRO Macedonia	26.1%	17.4%	38.2%	3.9%	5.3%	9.1%
Turkey	9.0%	15.4%	35.2%	13.9%	9.5%	17.0%
UK: England/Wales	17.0%	14.4%	27.3%	16.0%	15.8%	9.5%
UK: Northern Ireland	28.0%	7.3%	20.1%	18.5%	10.3%	15.8%
USA	14.2%	18.0%	21.8%	15.4%	14.2%	16.4%
Median	21.5%	15.3%	28.2%	7.8%	7.4%	13.4%
Minimum	5.5%	3.3%	12.3%	0.2%	1.2%	6.7%
Maximum	41.4%	31.1%	51.5%	18.5%	25.2%	39.4%

8 Note this table uses non-legal terminology that may differ from that used in other reports or research.

Appendix 2: International recidivism rates and reported methodical differences[9]

Jurisdiction	Study period	Sample selection	Length of study	Re-offense criteria	Result
Netherlands (Research and Documentation Centre, 2016)	2010-2012	All adult offenders	2 years	A reconviction confirmed or logged with prosecution service or court. (includes pseudo reconvictions)[10]	25% reconviction
Austria (Statistik Austria, 2017)	2012-2014	All persons convicted or released from prison	2 years	Reconviction by Austrian courts	32% re-sentenced
England/Wales (Ministry of Justice, 2018)	2016-2017	All persons convicted or released from prison between January and March	1 year + (6 month follow up for case resolution)	Reconviction	29.6% reconviction
Scotland (Scottish Government, 2017)	2013/14-2015/16	All persons convicted or released from prison (not including breaches)	2 years	Reconviction (includes pseudo reconvictions), excludes group 6 offences	39.9% reconviction
Northern Ireland (Department of Justice, 2017)	2014/15-2015/16	All persons convicted or released from prison (1 financial year)	1 year + (6 month follow up for case resolution)	Re-offense committed in northern Ireland, excluding breaches	16.9% reconviction
Denmark (Statistics Denmark, n.d.)	2013-2015	Danish residence aged 20+ who have been released from prison or have been convicted	2 years + (1 year follow up for case resolution)	Found guilty under the penal code, road traffic act, or special law/ legislation	Relapse rate 47.7%
Sweden (Swedish National Council for Crime Prevention, n.d.)	2009-2012	Complete court sanction with legal force (includes youth)	2 years 3 years	Only specified as a relapse	Relapse rate 34% Relapse rate 40%
Australia (Australian Government Productivity Commission, 2018)	2013/14-2015/16	All released sentenced prisoners	2 years	Returning to prison, corrective services (including prison)	44.8% reimprisonment rate 53.4% relapse rate
Ireland (Central Statistics Office, 2016)	2010-2015	All released sentenced prisoners	3 years	Reconviction (match process)	45.1% reconvicted

9 Relapse rate is reconviction to a prison or community sentence only.
10 Pseudo reconvictions occur when a person is convicted of an offence that occurred before their first offence.

Enhancements transform Office of the Inspectorate

Janis Adair
Chief Inspector, Office of the Inspectorate, Department of Corrections

Author biography

Janis has been Chief Inspector since July 2017. Born in Northern Ireland, Janis spent seven years as a nurse in the British Army. She then joined the Police and spent 15 years in Hampshire, where she worked in the Criminal Investigation Department, dealing with drug investigations, major crime, and a stint as second-in-charge of the anti-corruption unit. In 2004 she came to New Zealand and has worked for the Commerce Commission, the Independent Police Conduct Authority and the Office of the Ombudsman. Before joining Corrections she was in the UK working on the Independent Inquiry into Child Sexual Abuse.

Mā te titiro me te whakarongo ka puta mai te māramatanga

By looking and listening, we will gain insight

(Office of the Inspectorate whakataukī)

In early 2017 the Department of Corrections' Inspectorate was significantly enhanced. It moved from being primarily complaints focused to having a wider mandate, including carrying out inspections of prisons to ensure that prisoners are treated in a fair, safe, secure and humane way. Our work aims to be influential, credible and highly persuasive and ultimately supporting Corrections' goals of ensuring public safety and reducing re-offending.

The Office of the Inspectorate is a critical part of the independent oversight of the Corrections system, and operates under the Corrections Act 2004 and the Corrections Regulations 2005. It has a team of inspectors who carry out inspections and investigations. The Inspectorate, while part of the Department, is operationally independent which is necessary to ensure objectivity and integrity. Long-established functions of the Inspectorate include the investigation of prisoner complaints that have not been resolved at a lower level, the investigation of all deaths in custody, the review of Visitor Prohibition Orders, and special investigations. Inspectors also investigate complaints from offenders subject to community sentences.

Background

The role of prison inspectors is firmly enshrined in legislation and Office of the Inspectorate staff have a detailed knowledge and understanding of Corrections' core business while remaining independent of operational business and management. Inspectors have unrestricted access to all staff, facilities, information, documentation, files, records and property under Corrections' care or control.

New Zealand prisons have had inspectors since 1880, when the first Inspector was appointed in response to concerns about the state of the colony's prisons. Since then, the role of Inspector has been consistently restated by successive legislation (under various names, such as Visiting Justices and Inspectors of Penal Institutions). When the Department of Corrections was established as separate from the Department of Justice in 1995, the Inspectorate became part of the Department of Corrections.

The Office of the Ombudsman also handles complaints from prisoners, is formally advised about investigations into deaths in custody and serious incidents involving prisoners, and carries out its own programme of prison inspections.

The environment in which prison services are delivered in New Zealand has seen rapid, fundamental change in recent years. The number of prisoners has increased to levels not seen before, straining capacity and requiring the expansion of some facilities and more use of double bunking. New Zealand's prisons are arguably subject to more public and political interest and scrutiny than at any time in history. The report into allegations of organised prisoner on prisoner fighting at the Mount Eden Corrections Facility[1] thrust the Inspectorate into the public arena in a way that had not happened before.

Changes to the Inspectorate

These developments and their impact on the risk profile of prison services have changed expectations of the Inspectorate. Although its core focus remains – of carrying out investigations and reviewing complaints as set out in the Corrections Act 2004 – a need was identified for a cycle of risk-based, in-depth, "free, frank and fearless" prison reviews. These reviews are

1 http://www.corrections.govt.nz/resources/strategic_reports/chief_inspectors_reports_into_circumstances_surrounding_organised_prisoner_on_prisoner_fighting_fight_club_and_access_to_cell_phone_contraband.html

intended to provide greater assurance that prisoners are being treated fairly, safely and humanely, and that emerging risks and good practice are identified early.

The Inspectorate Enhancement Project, initiated by the Department of Corrections, included a new prison inspection framework, strengthened transparency and accountability arrangements, increased Inspectorate staffing and funding, and signalled more open communication. The new Chief Inspector was appointed and staffing was increased, both in number and skill base, to reflect the new functions. The Office of the Inspectorate was repositioned within Corrections to sit within the Office of the Chief Executive, so it was separate from the operational side of the Department.

The Inspectorate has developed a performance framework, setting out our vision, mission, values, priorities and action areas. To hold ourselves to account we have adopted performance measures, based on the timeliness of our reporting, which will be included in the Annual Report. We have adopted the values of respect, integrity, professionalism, objectivity and diversity to guide and inform our work.

Prison inspections

The new prison inspection framework was based on research into international and national best practice. The operations of Her Majesty's Inspectorate of Prisons in the United Kingdom (HMIP UK), Queensland Corrective Services, and the Western Australia Office of the Inspector of Custodial Services were reviewed. The Department also consulted other New Zealand government agencies that perform similar types of inspections, including New Zealand's Education Review Office (ERO).

The prison inspection programme involves an inspection at each of the 18 prisons across the country within a 20-month time frame. Prisons are assessed against a "Healthy Prisons" framework, based on the UN's original Standard Minimum Rules for the Treatment of Prisoners. The Office of the Inspectorate has updated the framework to meet the standards of the new UN Standard Minimum Rules for the Treatment of Prisoners, adopted by the General Assembly in December 2015 and known as the "Nelson Mandela Rules".[2]

Prison performance is assessed under four guiding principles:

- **Safety:** Prisoners are held safely.
- **Respect:** Prisoners are treated with respect for human dignity.
- **Rehabilitation:** Prisoners are able, and expect, to engage in activity that is likely to benefit them.
- **Reintegration:** Prisoners are prepared for release into the community, and helped to reduce their likelihood of re-offending.

The four principles reflect that the purpose of the prison system is to protect society from crime, both during imprisonment and after release, and they also highlight the potentially competing demands that are often placed on prison staff and management. As well as four principles, the healthy prison standards require inspectors to consider nine specific areas of prison life: reception and admission, first days in custody, escorts and transfers, good order, duty of care, environment, health, rehabilitation, and reintegration.

The prison inspections are intended to provide a robust, strength-based, risk-driven "window into prisons". They will identify innovation and good practice and give early warning of emerging risks and themes. The reports are written to broadly focus on the prisoners' journey – from arrival in prison through to rehabilitation and release.

In 2017, inspections were carried at Manawatu, Auckland, Hawkes Bay, Waikeria, Invercargill, Auckland South, Rimutaka and Spring Hill prisons. So far this year, inspections have been carried out at Mt Eden, Northland, Otago, Tongariro, Christchurch Women's and Christchurch Men's prisons. The reports are published on the Inspectorate website (www.inspectorate.corrections.govt.nz) for reasons of transparency and to promote trust and confidence in the Inspectorate. The first two inspection reports (into Manawatu Prison and Auckland Prison) were released publicly in February 2018 – a milestone for the Inspectorate – and the third one (Waikeria Prison) in May.

Death in custody investigations

The process for investigations into deaths in custody has also been updated. All deaths in custody in New Zealand prisons are investigated by the Office of the Inspectorate and the reports to the Chief Executive are submitted as evidence at a subsequent Coronial inquiry.

Investigations of deaths in custody are proportionate to the circumstances of each case. Comprehensive investigations are carried out into unnatural deaths and those where serious concerns have been raised. Natural deaths are generally investigated with a focus on the adequacy of access to, and the provision of, medical care. Investigations are informed by health and other experts, as required.

The Office of the Inspectorate now proactively contacts the nominated contact of each person who dies in custody, setting out the Inspectorate's role in investigating the death and reporting to the Coroner. The family is kept updated about the investigation.

2 https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf

At the conclusion of the investigation, the next of kin can request a copy of the report which is released subject to the Coroner's approval and the Official Information Act.

What next?

Along with the new responsibilities comes a changed ethos in the Office of the Inspectorate, and more visibility and accessibility. With a wider focus, the Inspectorate aims to demonstrably add value to Corrections' assurance processes. By taking a broader lens over the operation of prisons in particular, the Inspectorate aims to lift awareness about what is happening at sites and work in partnership with the Department to bring about continuous improvement.

The long-term aim of lifting and sustaining standards and strengthening the rehabilitation pathway, is to help promote a prison system which has more engaged prisoners, a reduced potential for violence and a reduction in re-offending.

The journey to achieve a safer and healthier workplace

Mike Cosman
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Author biography

Mike Cosman is an Independent Member of the Corrections Health, Safety and Wellbeing Risk Governance Group. He has worked in health and safety as a regulator, policy maker, manager and consultant for the past 39 years.

This article looks at the history of occupational health and safety legislation and practice, principally in the UK and New Zealand, and considers how a modern day Corrections environment, with all its inherent risks, can still function safely and legally for the benefit of staff, offenders and the wider public.

Historical context

Recognition of the need to keep work and workers healthy and safe is not new. Indeed, the earliest known reference comes from the Bible and even acknowledges the importance of safety in design. *"When you build a new house, make a parapet around your roof so that you may not bring the guilt of bloodshed on your house if someone falls from the roof."* (Deuteronomy 22:8)

The earliest powered corn mills were dangerous places. A fatal accident to a child in 1540 was reported (HM Chief Inspector of Factories, 1936):

> *"a yonge childe… standing neere to the whele of a horse myll… was by some mishap come within the swepe or compasse of the cogge whele and therewith was torne in peces and killed. And, upon inquisition taken, it was founde that the whele was the cause of the childe's death, whereupon the myll was forthwith defaced and pulled downe."*

Industrial health and safety legislation originated in the early 19th century in the UK, where the Industrial Revolution started, when the exploitation of workers –particularly young children – became so obvious that there was a moral crusade, led by Sir Robert Peel, to put in place minimum standards, and a mechanism to enforce them. The first legislation was An Act for the Preservation of the Health and Morals of Apprentices in 1802.

Early entrepreneurs, a number of whom were Quakers, such as Titus Salt, Cadbury and Lever Brothers, took a more holistic view of their workers, recognising that poor housing, sanitation, lack of education and inadequate time for rest were both unhealthy and bad for business. (Eves D, 2014)

Figure 1:

The risks of work (artist: LS Lowry)

In 1840, New Zealand was one of the first countries in the world to have legislation around working hours with the passing of the 8-hour working day legislation, following a campaign by carpenter Samuel Marsden. We continue to celebrate his achievement on Labour Day – even if that luxury is one many of us no longer enjoy.

Industrial health and safety legislation continued to grow in first world countries, largely around particular topics or industries and most often in response to a scandal or campaign. Occupational health was an important area as industrial diseases were rife – but often associated with a single occupation – watch dial painters (radium poisoning), miners ("black lung" or pneumoconiosis), cotton workers ("brown lung" or byssinosis), asbestos workers (mesothelioma) and quarrymen (silicosis). Lead poisoning was a particular risk for women workers due to its effects on the unborn child. Not surprisingly the life expectancy of workers in industrial cities was relatively short.

The 20th century was the era of major industrial disasters Aberfan (coal tip collapsed on a school), Flixborough and Bhopal (chemical plant explosions), The Herald of Free Enterprise (roll on, roll off ferry capsized), King's Cross (railway station fire), Windscale, Three Mile Island and Chernobyl (nuclear

explosions), more recently, Piper Alpha and the Gulf of Mexico (oil rig explosions) and, locally, the Brunner and Strongman coal mine explosions.

Figure 2:

Explosion at the Pike River Mine

Regulatory responses to these disasters typically sought to regulate for the precise mechanism that had caused the harm, which in many cases was a rare combination of circumstances unlikely to be widely replicated. The political response demonstrated concern and appeared to result in action although it was more often addressing symptoms rather than underlying (or root) causes.

Risk management

It was only in the 1970s that it was recognised that workplaces are dynamic systems with multiple influences and moving parts, and that addressing just one element of the system was unlikely to be effective. The influential report from a committee led by Lord Robens in the UK (Robens et al, 1972) challenged thinking globally and led to the first piece of systems, risk and performance based health and safety legislation in 1974. Even then the toll of death and disaster continued for many years as legislative reform globally embraced a wider range of industries and major industrial hazards.

The change in thinking was radical. Health and safety no longer belonged to the regulator who set detailed prescriptive standards that were invariably out of date and acted as a dead hand on innovation and improvement. Instead, employers had to take responsibility for their own risks and work out the best way of managing them in their particular context, following a set of simple principles and process steps.

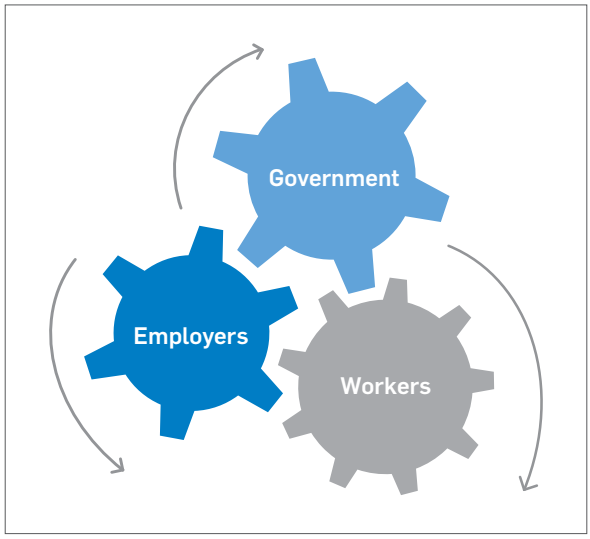
Those who had earlier complained about the inflexibility of the old approach demanded clear instruction from the regulator about what to do so they could "tick the box" to compliance. A "first principles" approach to risk may be liberating, but it also requires more advanced knowledge and skills on the part of employers to work out, and if required, to defend their choice of risk controls.

Worker participation in health and safety

Worker involvement in health and safety was another important new concept. The idea that managers don't have all the answers and that workers might have insights and experience that could contribute to a safe workplace was seen as threatening by many and as an excuse for more union power. However, despite considerable opposition at the time, the notion of a tripartite approach to health and safety (workers, employers and government) is still recognised globally (International Labour Organisation, 1981) and nationally as the right one and has been reinforced in the Health and Safety at Work Act 2015 (HSWA).

Figure 3:

Tripartite approach to health and safety



Crown immunity

Many public sector activities were exempted from detailed regulatory scrutiny to a greater or lesser extent by virtue of Crown immunity. This either exempted certain types of organisations from the application of the legislation as a whole or meant that they could not be prosecuted or fined in a criminal court[1]. In 2016, most Crown immunity was removed under the HSWA, although there are provisions and reserve powers to exempt certain Defence operational activities and anything prejudicial to the security and defence of New Zealand.

1 Health and Safety in Employment Act 1992 S.3, Crown Organisations (Criminal Liability) Act 2002

Pike River, the Independent Taskforce and the HSWA

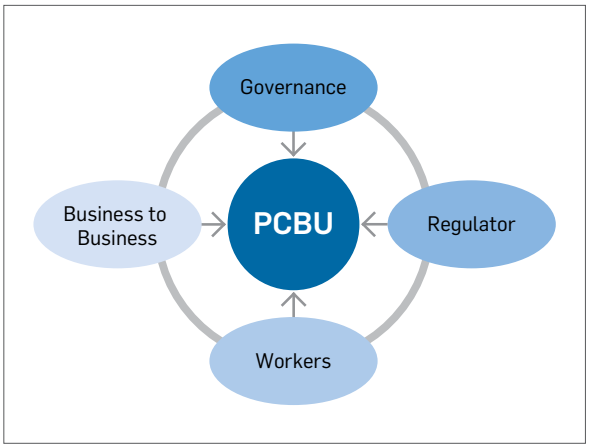
As noted above, many changes in health and safety legislation have happened in response to disasters that raise public, political and media awareness of an issue that may have otherwise gone unnoticed outside the local or specialist communities. So it was with Pike River. The disastrous explosion that killed 29 men on the West Coast in 2010 was the first such tragedy in New Zealand in the era of social media and satellite communications. As a result, its impact was felt very widely within hours of it happening and it continued to unfold under the relentless eye of the media. It continues to do so up to this day, most recently with the Supreme Court finding that there were significant flaws in the decision to drop charges against the mine manager in exchange for insurance payments to the victims' families.

The government response was to establish a Royal Commission to look into the local circumstances of the disaster, quickly followed by a wider review of health and safety in New Zealand by the Independent Taskforce on Workplace Health and Safety, of which the author was a member. The Taskforce findings (Jager et al, 2013) showed conclusively that the fundamental risk based approach to health and safety was sound, but that New Zealand had failed to put in place sufficient supporting infrastructure and mechanisms to enable it to work effectively. Its report emphasised the need for more effective accountability, motivating and knowledge levers and made a series of recommendations to government. The government response was swift and positive[2]. All the recommendations were accepted and work began to reform the regulator (leading to the establishment of WorkSafe NZ as a dedicated Crown Entity) and the regulatory framework, to emphasise the missing elements.

The new legislation was largely based on model law developed in Australia in the early 2000s. It reflected the complexity of modern work and working practices with a much higher degree of flexibility about when, where and how work is performed, multiple levels of contracting out and increasing collaboration around particular projects.

The Person Conducting a Business or Undertaking (PCBU) is the primary duty holder and is accountable for the impact of its work on any worker (regardless of how they are engaged, including volunteers) and on others over whom it has influence and control.

The new accountability levers that influence the PCBU, and that have been strengthened under the HSWA, are governance, the regulator, workers and their representatives and others in the supply chain. Together these influences are designed to hold the PCBU accountable, internally and externally, for meeting its duties.



Health and safety in Corrections

Corrections is fully subject to the Act and has the same duties and responsibilities to its staff, contractors, volunteers and others – including offenders who are "other persons" whose health and safety should not be put as risk from work carried out as part of the business or undertaking[3]. The only specific exemption is that the Act clarified[4] that prisoners carrying out work in prisons have no rights to worker engagement, participation and representation.

The majority of the critical risks with the potential to cause death or irreversible harm to Corrections workers and others (including offenders) arises in the operation of the core prison and community corrections systems. Those in the criminal justice system are tasked with dealing with people who are considered to be a threat to society by virtue of their actions and behaviours. Whilst a manufacturer can decide to no longer use a toxic chemical, Corrections cannot refuse to look after a convicted murderer or sex offender.

This makes clear interpretation of the statutory qualifying phrase "as is reasonably practicable" vitally important.

2 Working Safer http://www.mbie.govt.nz/info-services/employment-skills/workplace-health-and-safety-reform/document-and-image-library/working-safer-key-documents/safety-first-blueprint.pdf

3 HSWA S.36(2)
4 HSWA S.15

It is defined as *"that which is, or was, at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters, including–*

a. the likelihood of the hazard or the risk concerned occurring; and

b. the degree of harm that might result from the hazard or risk; and

c. what the person concerned knows, or ought reasonably to know, about–

(i) the hazard or risk; and

(ii) ways of eliminating or minimising the risk; and

d the availability and suitability of ways to eliminate or minimise the risk; and

e after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk."[5]

Importantly, doing all that is reasonably practicable in a particular situation does not mean the risk has been eliminated or that harm can never occur. It is also context specific – so that which may be reasonably practicable in one circumstance is not automatically the same elsewhere.

In the author's experience, health and safety issues within Corrections were, historically, largely seen as operational, with "OSH" really only applying to office based risks, ACC accreditation, rehabilitation and return to work. The Department's Creating Lasting Change strategy was introduced in 2011, and included a commitment to increasing staff safety and continuously improving the way staff work safely with offenders. The introduction of the strategy, along with serious incidents such as the death of Jason Palmer at Spring Hill Corrections Facility in 2010 and the serious assault of another staff member in 2012, represents a turning point for Corrections. This led the Department to establish an Expert Panel on Staff Safety to look in depth at issues of violence, particularly within prisons. The panel comprised the former Commissioner of Police, senior public and private sector prison executives from Australasia and the author (as an independent health and safety expert). It looked at the causes of violence and how the regime in prisons could inadvertently contribute to this. It considered representations from injured corrections officers, and unions, as well as reviewing international literature to inform its findings.

A comprehensive three-year programme of work was developed as a result that included a wide range of measures focusing on staff capacity and capability, infrastructure, intelligence, offender management and oversight[6].

Most importantly, Corrections adopted a system-wide approach that considered and addressed the causes of violence, and emphasised responses to violent incidents that mitigated the impact on staff and offenders. This shift in focus from accepting that violence is endemic in Corrections to one where the environment and regime itself can either precipitate or reduce the propensity for violence was profound and strongly aligned with Corrections' overall objective of reducing re-offending, rather than simply incarceration.

This change in thinking has also influenced the broader culture in prisons, including the recruitment and training of corrections officers with more of an emphasis on communication skills and interacting with offenders in a way that builds trust and respect and hence anticipates and defuses potential flashpoints.

Good governance practice

A key criticism of the Pike River Coal Company by the Royal Commission was the lack of leadership from the Board. They stated that,

> *"The board did not verify that effective systems were in place and that risk management was effective. Nor did it properly hold management to account, but instead assumed that managers would draw the board's attention to any major operational problems. The board did not provide effective health and safety leadership and protect the workforce from harm."*
>
> **Royal Commission 2012**

Even before the Taskforce reported, the Chief Executive of Corrections identified the challenge associated with public sector departments not having a formal governance structure that could perform the kind of functions the Royal Commission had signalled. In particular, the single point accountability of the CEO to the State Services Commissioner and the Minister did not provide for the kind of detailed scrutiny and oversight that boards typically provide.

The establishment of the Corrections Health, Safety and Wellbeing Risk Governance Group (HSWRGG) in 2013 was an innovative move by a public sector department to create a health and safety governance structure comprising the CEO, the Executive Leadership Team and independent members. It anticipated the

5 HSWA S.22

6 See http://www.corrections.govt.nz/resources/strategic_reports/annual-reports/annual_report_201415/part_a/public_safety_is_improved.html

legal changes in the HSWA and explicitly recognised the need for a strategic approach to the wide range of health and safety issues within Corrections.

Four years later, Corrections was recognised as inaugural winner of the Safeguard Best Board Level Engagement in Health and Safety award. As the Deputy Chief Executive, Corporate Services noted *"For us this was an acknowledgement from our peers that we were in fact achieving excellence in our leadership of health and safety. The award has provided us with the motivation to continue to innovate and strive to create an even safer and healthier workplace."*

Since receiving the award, Chief Executive Ray Smith has been asked by the State Services Commissioner to take a functional lead role for the public service in health and safety. The governance model developed by Corrections is now being widely adopted by other departments.

Risk management

A key first step for the HSWRGG was to establish the risk profile. Where across the various functions in Corrections could people get seriously harmed or killed? Inevitably, the historic focus had been on operational safety issues, in particular violence. However, more detailed scrutiny revealed a diverse landscape including fleet safety, quad bikes, infection risks, prison industries, facilities maintenance, major capital projects and mental health.

Each of these risks required detailed assessment to determine the context, who was at risk, how harm might occur, the current controls to reduce the likelihood and consequence of harm and the effectiveness of those controls. Although offender risk assessment is an integral part of Corrections operations, the same tools and skills were not necessarily being applied to identifying, assessing and managing health and safety risks.

Success in health and safety is often hard to measure other than by counting how many people get hurt. However, in one case in 2017, a decision made by the HSWRGG could be directly linked to harm being prevented. Corrections has a very large fleet of around 1,700 on and off-road vehicles and plant, including tractors, cars, prisoner escort vehicles and vans. A review of the vehicle related risk identified that some vans were up to 20 years old and had poor survivability devices (seat belts, air bags, crumple zones, etc.). Significant capital investment was agreed and a programme of upgrading commenced. Not long afterwards, a van containing a Corrections driver and eight offenders was involved in a head-on crash with a private car, the occupant of which tragically died. None of the occupants of the 3-month old van suffered major injury, something that would have been almost inevitable if the vehicle had not been recently replaced.

Overlapping duties

A major set-back occurred in 2014 when there was another death, this time of an offender serving a community work sentence. The offender was working at a local church when a log rolled onto him. WorkSafe NZ investigated and the court ultimately found that Corrections had failed to take all practicable steps to protect the offender from harm through the planning and monitoring of the agency placement. Even though the agency was in charge of the offender at the time, the court felt that Corrections had not done enough to assess the capability of the agency to manage health and safety and to verify their systems and processes.

The subsequent investigations caused Corrections to look very broadly at its sphere of influence, a new concept linked to the primary duty under HSWA to *"ensure the health and safety of workers whose activities in carrying out work are influenced or directed by the PCBU*[7]*"*. This duty is qualified in relation to multiple overlapping PCBUs by requiring each person to discharge their duty to the extent to which they have the ability to influence and control the matter[8].

In many instances Corrections works with, or contracts, a range of service providers to perform functions on its behalf either within its own premises or in the community. This can include facilities management (Spotless), monitoring services (First Security), privately operated prisons (SERCO), offender management programmes (NGOs, iwi and other providers), Police, court staff, other parts of the criminal justice system and a diverse range of other services.

Given this shared responsibility for managing the risk, ensuring the process for the engagement and monitoring of service providers is fit for purpose, and can be evidenced as such, is crucial. In many cases, contracts did not clearly reflect the respective roles and responsibilities of the parties or make provision for regular health and safety reporting or review. Work on understanding and managing overlapping duties is still underway and is probably one of the most complex challenges ahead given the scale and complexity of the issue.

Is Corrections there yet?

Workplace health and safety is not something that can ever be ticked off as done. The risks to Corrections' people are constantly changing and understanding of what "good looks like" continues to evolve. Challenges from stakeholders including unions, the Ombudsman, Human Rights Commissioner, WorkSafe NZ and others regularly lead to reviews, whilst prison and community-

7 A PCBU is the Person Conducting a Business or Undertaking. Ref; HSWA S36(1)(b)
8 Ref HSWA s33(3)(b)

based practice leaders are constantly looking for ways to enhance their service delivery.

For example, rapid growth in the prison muster put significant pressure on infrastructure and led to an increase in double bunking. For probably the first time such an important operational decision was subjected to independent health and safety scrutiny to ensure there were no unintended consequences that might impact on prisoner or staff health and safety. A similar review in response to a complaint looked at prisoner restraints (seat belts) in single-cell escort vehicles.

On-going evaluations are reviewing the effectiveness of recent measures such as on-body cameras and enhanced stab resistant body armour in reducing the incidence and severity of injury. Meanwhile, ground-breaking work has been done to develop fatigue management tools to support better rostering decisions.

A lot of this development has taken place in the prison environment, which, by its nature, is tightly controlled. By contrast, work in the community often takes place in private homes away from the safety infrastructure of colleagues and cameras. Often the main tool in the probation officer's safety toolkit is their ability to dynamically assess the situation in front of them informed by intelligence they have gained from previous contact and sharing with other agencies (RiskTec, 2014).

Advances in technology can help (stay safe apps or remote monitoring) but fundamentally good health and safety is about a state of mind – sometimes described as "chronic unease" (Hopkins, 2009). Put simply, chronic unease is the opposite of complacency. It is a healthy scepticism about what is seen and done. It is about enquiry and probing deeper, really understanding the risks and exposures and not just assuming that because systems are in place everything will be fine. It is not just believing in what the statistics appear to say. It is about resetting an organisation's tolerance to risk and responding accordingly and continually questioning whether what is being done is enough.

The thought process of a leader therefore changes from *"We haven't had an incident, we are doing so well,"* to *"Is there anything we're overlooking and what else do we need to do?"* (Business Leaders Health and Safety Forum, 2018).

The potential for very serious harm to occur within the Corrections environment, whether from a quad bike overturn, fire, riot, disease outbreak, operating machinery or a fall from height, is ever-present.

The Business Leaders Health and Safety Forum, a group of over 350 chief executives, states that, *"Health and safety is not something that is done to us, it's about applying individual and collective knowledge and skill to analyse problems and develop solutions that integrate safe working into 'how we do things around here'"*.[9]

Is Corrections there yet? No. Is it well on the way with its journey and does it have a clear sense of where it is heading? The evidence suggests it is and it does. Only time will tell.

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9 http://www.zeroharm.org.nz

Performance on the Physical Readiness Assessment

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Author biography

Alan has worked in sport and exercise for more than 40 years, having held positions at the University of Otago, Massey University, and the University of Manchester. He is a life member and former Deputy Chair of Sport and Exercise Science New Zealand and a former council member of the International Society of Biomechanics. Alan has developed occupational fitness assessments for Fire and Emergency New Zealand, and joined Corrections in March 2013 to design and develop the Physical Readiness Assessment (PRA). Following the national roll-out of the PRA in April 2017, Alan took up the role of Moderator to monitor PRA delivery and performance standards.

Introduction

Tests of physical fitness for duty are common in correctional jurisdictions throughout the world because they assure employers and staff members that they able to keep themselves and their colleagues safe in physically demanding situations. For example, several Australian state jurisdictions have fitness tests for both recruits and serving officers, as do both the English and Scottish Prison services.

Fitness tests generally fall into two types: tests of general fitness using established elements that might be performed in a commercial gym, and occupationally related tests that use simulations of tasks actually carried out by corrections personnel. Of the international fitness tests investigated prior to development of the Physical Readiness Assessment (PRA), two stand out as being very similar to the final form of the PRA because they are substantially simulations of frontline duty:

- Correctional Officer Physical Aptitude Test (COPAT) used by Alberta Correctional Services
- Fitness Test for Ontario Correctional Officer Applicants (FITCO) used by Ontario Correctional Services.

The design and development process used for the PRA was based on that used by Jamnik et al (2010) to develop FITCO.

Structure of the PRA

The PRA is designed to provide an indication of the occupational physical performance of frontline custodial staff. However, the PRA also indicates the general level of fitness of participants because performance in some elements of the PRA is dependent on aerobic and anaerobic fitness and muscular strength and endurance.

The elements of the PRA are based on the need for any assessment of occupational fitness to reflect the actual requirements of satisfactory performance in the job. Therefore, the PRA is based on a scenario that reflects a typical sequence of events in a corrections officer's day:

> *"A corrections officer is walking from one unit to another to conduct a search. The search is undertaken and during the search an emergency 'Break – Break – Break' call is received. The corrections officer runs as quickly and safely as possible to the scene of the emergency and has to use physical force to restore order. Once order is restored, the corrections officer notices an unconscious colleague, and so removes him/her to a place of safety for others to take over care. Once the emergency is dealt with, the corrections officer walks back to the original unit".*

The PRA is composed of six elements; a 300m maximum speed walk, a simulated search, a simulated emergency response, simulated spontaneous C&R, simulated rescue, and a 300m recovery walk. The time for the walking and running sections and the total time taken are recorded and generate scores. The simulated C&R score is determined from measurement of the maximum sustained horizontal force as a percentage of body weight. The five scores generated are combined to produce the overall score, which is used to place staff in one of three performance zones; red (well below average), amber (below average) or green (average or above). This approach is a more appropriate measure of fitness to undertake the role than a simple pass/fail criterion because it places an individual in the population of corrections officers and also allows the individual to target training to specific elements that may be causing them issues.

PRA Performance Standards

Data from a sample of serving corrections officers were used to develop the scoring system shown in Table 1. Analysis of the raw data confirmed that the individual element scores and the overall score were approximately normally distributed and so a scoring system based on standard deviations was appropriate.

The overall score for the PRA is determined as follows:

- if there are no scores of 1 or 2, the overall score is the rounded average of the individual scores
- if there is one individual element score of 1 or 2, the overall score is either 2 or the rounded average of the individual scores, whichever is lower
- if there are two or more individual element scores of 1 or 2, the overall score is either 1 or the rounded average of the individual scores, whichever is lower.

For those staff members returning a result in the red zone, the Department has contracted two external providers of support programmes to assist staff to return to the green zone. The programmes are tailored to the needs and preferences of the individual client and may include supervised gym sessions, supervised pool sessions, nutritional advice, physiotherapy, or any other intervention the provider recommends. All costs are met by the Department, including the cost of an initial medical examination to rule out any clinical factors that might have impacted on PRA performance.

PRA performance data

From 1 April to 20 December 2017, 2,023 custodial staff members (1,521 men and 502 women) aged between 18 and 72 were rostered to complete the PRA. Of those rostered, 210 staff members (162 men and 48 women) chose to defer the PRA for up to 12 months. Deferment was made an option prior to the introduction of the PRA because it was felt that some staff members might need more time to prepare. Staff had been encouraged to try out the PRA on a no-consequences basis so that they had an indication of their level before undertaking the PRA. However, staff didn't have to provide a reason for deferring, and we should not assume that those who deferred would not have performed satisfactorily. Some of those candidates who deferred have subsequently undertaken the PRA and have returned a result in the green zone.

Of those staff members attempting the PRA, 31 men and 12 women started but did not complete the PRA, which resulted in 1,770 complete results. Many of those not completing the PRA stopped because they experienced an injury or other discomfort, but it should not be assumed that they would have returned an unsatisfactory result if they had completed the PRA.

Table 1:

The PRA scoring system based on z-scores

z-score	< = – 2	< = – 1.5	< = – 1	< = – 0.5	> – 0.5 < 0.5	> = 0.5	> = 1.0	> = 1.5	> = 2
PRA Score	1	2	3	4	5	6	7	8	9
Description	WELL BELOW AVERAGE		BELOW AVERAGE		AVERAGE	ABOVE AVERAGE		WELL ABOVE AVERAGE	

Figure 1:

Distribution of scores broken down into age groups.

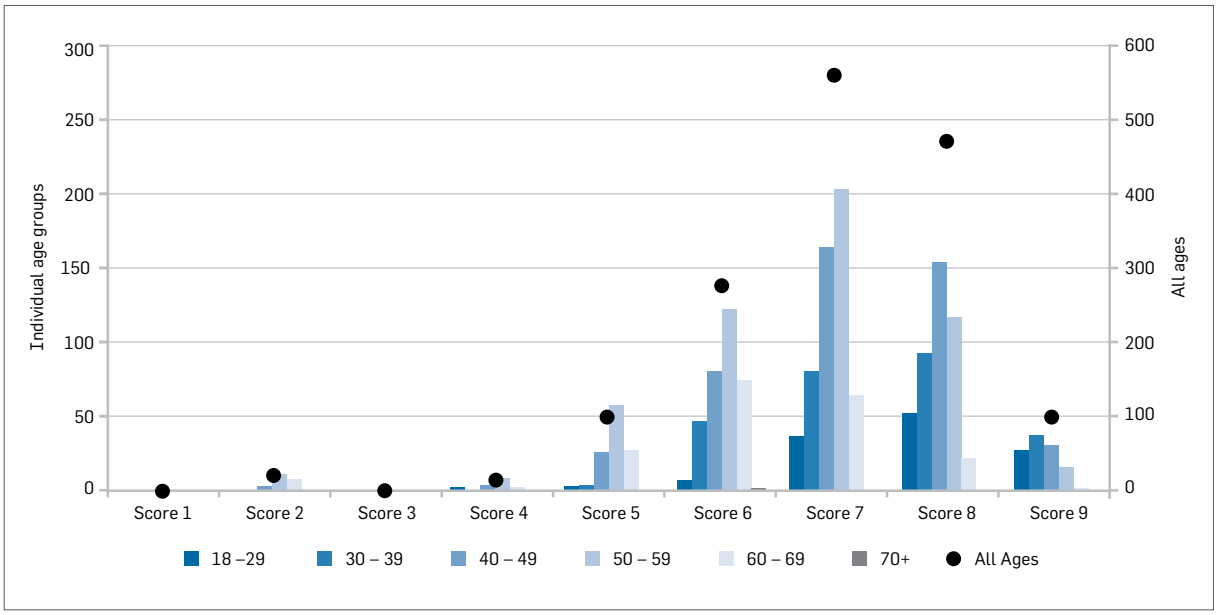


Figure 1 shows the distribution of scores for the 1,770 participants broken down into 10 year age groups. The distribution was expected to be approximately normal with a mode of five. However, the mode for all age groups taken together and the age groups less than 60 was seven, whereas for the age groups over 60 the mode was six.

Figure 2:

Distribution of overall scores as %age of sample split at age 60 compared with the expected normal distribution.

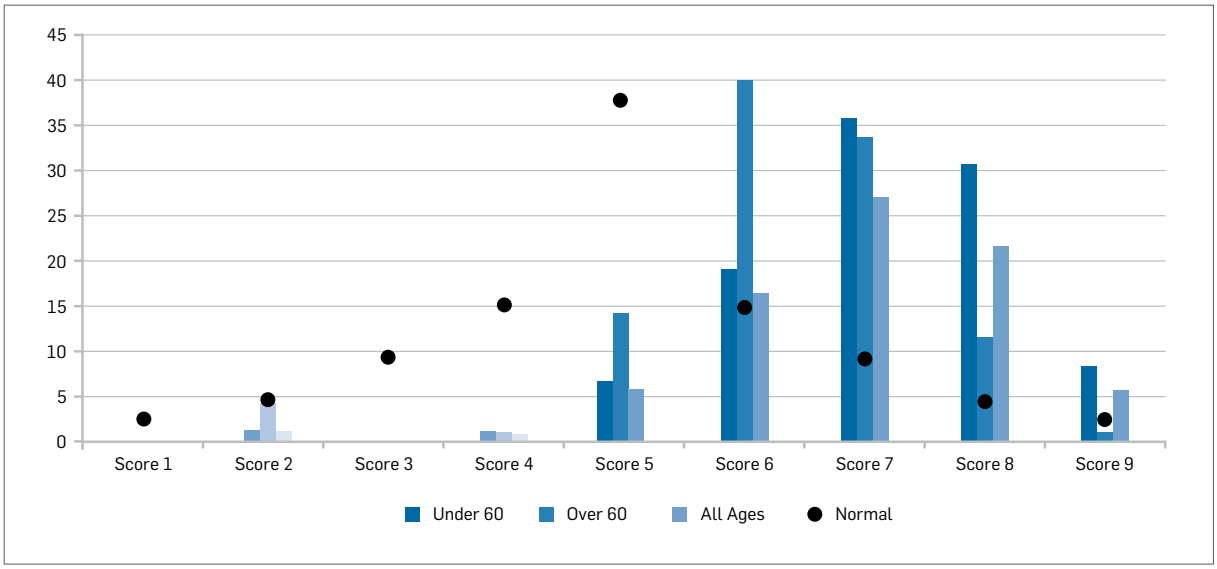
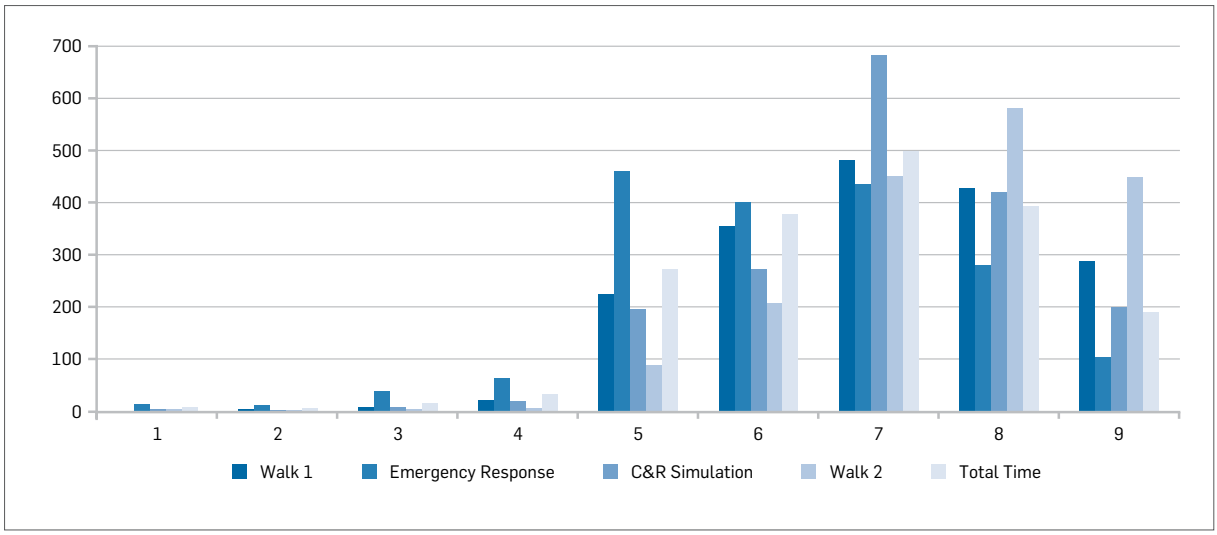


Figure 2 illustrates that the distribution of overall scores for all age groups was substantially better than the expected distribution derived from the initial study data. It appears that the actual mean of the measured data, which are used to derive the scores, is about one standard deviation better than the mean estimated from the initial study data. Figure 3 confirms that this is the case for all elements of the PRA although the Emergency Response element is rather different from the rest.

Figure 3:

Count of participants in each score for each element of the PRA.

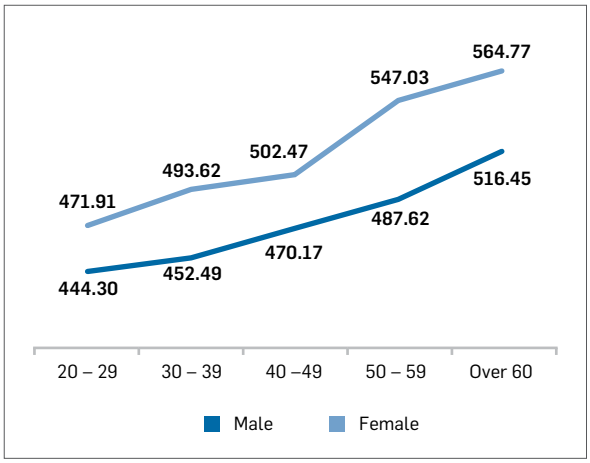


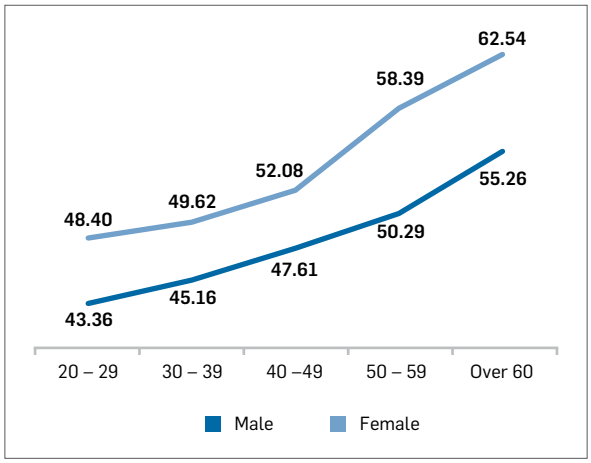
Age and gender effects

Because the PRA currently requires the same level of performance for all ages and both women and men, a two way ANOVA[1] was carried out, with age group and gender as factors. The analysis revealed significant main effects and interactions ($p<.001$) for the total time for the PRA, the C&R simulation result, and the emergency response time. Participants were grouped into those under 30, 30 to 39, 40 to 49, 50 to 59, and over 60. Figure 4 indicates that women were significantly slower than men ($p<.001$) by about 10% for the whole PRA and about 20% slower than men in the emergency response and that both genders slowed down with age.

Figure 4:

Mean Total Time for the PRA and Emergency response time split by age group and gender.



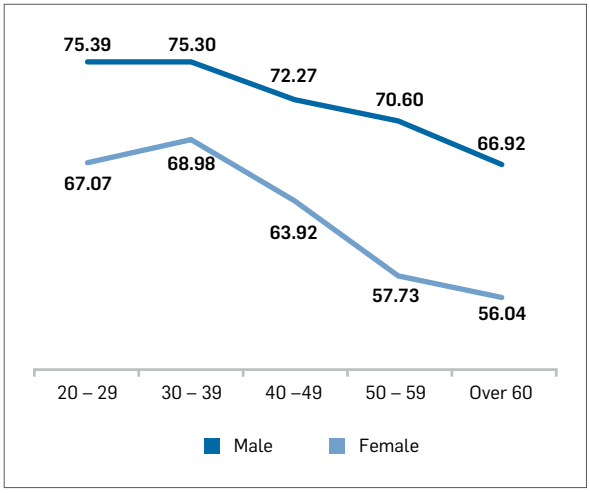


1 Analysis of Variance (ANOVA) is a statistical method in which the variation in a set of observations is divided into distinct components that indicate if the group means of the dependent variables differ.

Similarly, Figure 5 indicates that women produced significantly lower forces ($p<.001$) than men by about 10% of body weight and that the difference tended to increase slightly with age.

Figure 5:

C&R Simulation result as % of body weight split by age and gender.



All the measured elements show a small weak association with age (R^2 from 0.04 to 0.16): the mean for the timed elements increases by about 0.4s per year for individual elements and 2s per year for the total time, while the mean for the C&R Simulation element reduces by about 0.3% of body weight per year. The rate of change with age differed between men and women most notably in the Emergency Response, the C&R Simulation, and the non-timed elements (see Table 2). It appears likely that the Simulated Rescue element is the major source of the difference in the untimed elements because performance is dependent on absolute strength.

Table 2:

Mean rate of change of element data with age in seconds per year for timed elements, and % body weight per year for the C&R Simulation.

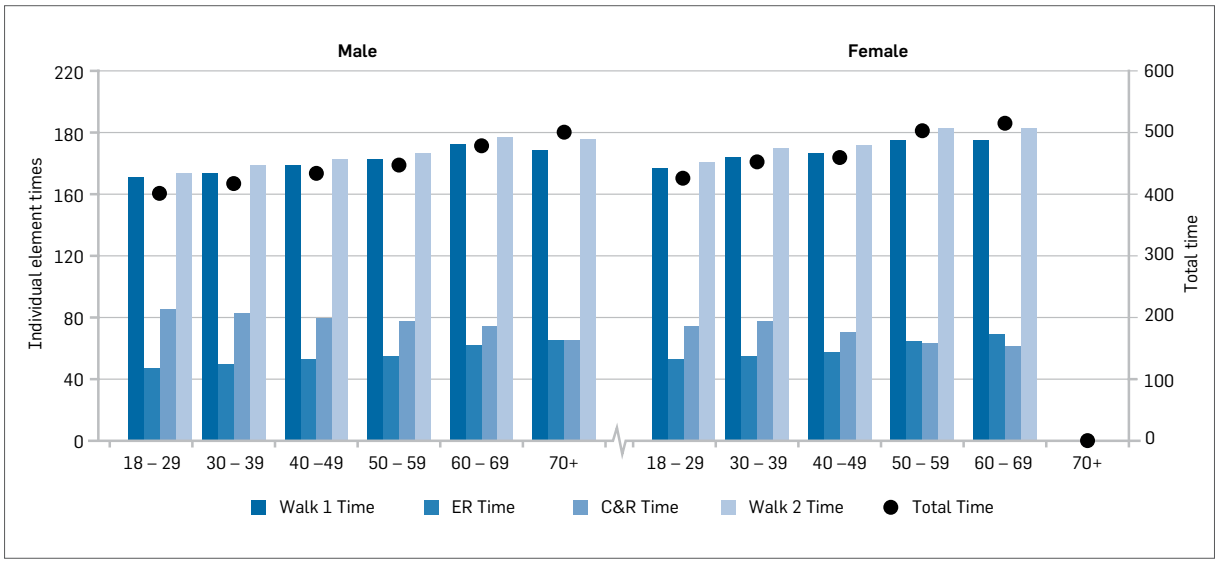
	All	Male	Female
Walk 1	0.47	0.47	0.48
Emergency Response	0.33	0.31	0.42
C&R Simulation	-0.29	-0.26	-0.44
Walk 2	0.45	0.44	0.54
Total Time	2.03	1.89	2.71
Non-timed elements	0.79	0.68	1.27

Figure 6 indicates that the rate of change of element means is reasonably consistent across age decades with small differences between men and women. In general, the rate of change is slightly greater for women than men. For example, the mean total time for the PRA increased by 18.9s/decade for men and 27.1s/decade for women, 8.2s/decade faster than men.

The small reduction in performance with increasing age is reasonably consistent across age groups. However, the rate of increase in individual elements is so small (generally less than 5s/decade in the timed elements) that introduction of age related scoring could unfairly discriminate between candidates. For example, a 59 year old taking 209s for walk 1 would score 4, whereas a 60 year old taking the same time would score 5.

Figure 6:

Mean element data split by age group for male and female participants.



In the timed elements, women returned a smaller spread of data than men, with a greater mean time (between 6.2s and 10.2s on individual elements and 42.7s overall) and a slightly smaller standard deviation (see Table 3). In the C&R Simulation, women, on average, produced horizontal forces 10% of body weight lower than men with a slightly smaller standard deviation (1.3% BW).

Table 3:

Differences between male and female data on the timed or measured elements of the PRA.

		Min	Max	Mean	Std Dev
Walk 1 (s)	Female	134.1	229.2	172.3	16.4
	Male	111.0	265.8	164.2	16.3
	Difference	23.1	-36.6	8.1	0.1
Emergency Response (s)	Female	32.8	90.7	54.6	10.1
	Male	28.7	111.0	48.4	8.7
	Difference	4.1	-20.3	6.2	1.4
C&R Simulation (% BW)	Female	36.5	143.3	64.5	13.5
	Male	34.9	125.9	74.5	14.8
	Difference	1.6	17.5	-10.0	-1.3
Walk 2 (s)	Female	134.5	282.1	176.1	26.9
	Male	113.0	339.4	165.9	25.6
	Difference	21.5	-57.3	10.2	1.4
Total Time (s)	Female	382.2	826.4	515.8	82.2
	Male	325.6	855.9	473.1	72.4
	Difference	56.6	-29.5	42.7	9.8

Conclusions

Most custodial staff performed considerably better than expected on the PRA, both in individual elements and the PRA as a whole, which indicates that most staff are fitter than might be expected from the initial validation study results. The low number of results in the red zone (well below average) appears to be a consequence of both the generally higher standard of fitness and, possibly, the substantial number of deferrals and incomplete PRAs (11.9% of those rostered to complete PRA).

The differences in the means between male and female candidates on all the timed or measured elements is about half a standard deviation (ranging from 0.38SD for Walk 2 to 0.67SD for the C&R simulation). The difference is sufficiently substantial to warrant a more detailed analysis once the whole cohort of custodial staff has completed the PRA.

When the whole cohort of custodial staff has completed the PRA once, the available data will allow a more detailed analysis specifically aimed at clarifying any age or gender related differences. Until that time the performance standards should remain unchanged.

It is especially pleasing to note that most members of the custodial staff exceed the minimum standard of physical readiness required to cope with the physically demanding aspects of their role, ensuring that the safety of both staff and prisoners is not compromised by any deficit in staff fitness. It is also gratifying to see the benefits of the support programme; to quote one staff member:

> *"I thank the department for helping me become a healthy version of me. Good for me, great for my family and more importantly I am more able to assist my work colleagues in a time of need."*

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Across the Tasman: A reflective practice journey

Paula Frawley
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Reflective Practice Leader, Department for Correctional Services, South Australia

Author biographies

Paula started at Corrections in September 2005 as a probation officer and progressed to the senior probation officer role in 2010. In June 2011, Paula was selected for the newly formed position of practice leader and has continued in this role to date. Paula uses the models and frameworks that underpin reflective practice to enhance staff ability to learn from their experiences and thereby build their professional competence.

Gina joined the Department for Correctional Services (DCS), South Australia, in 2008 and has held a number of positions, including community corrections officer and senior case manager. In mid 2015, she joined Central Office to review DCS Enhanced Community Corrections service standards. Gina was recently appointed to the role of reflective practice Leader, the first such role in DCS South Australia.

Introduction

In August 2016, the State Government of Australia unveiled a strategy to improve community safety and address re-offending – Reducing Re-offending 10% by 2020. This article explains how reflective practice supports DCS South Australia's vision for a safer community by protecting the public and reducing re-offending.

Reflective practice is the process of thinking about our experiences and enhancing practice based upon this reflection. Research shows that reflective practice is central to learning as it allows professionals to develop a critical understanding of their own practice, along with developing the necessary skills, knowledge and methods to achieve the best outcomes for their clients (Maclean, n.d.).

In New Zealand, sentence management is conducted by probation officers in the community, and case managers in the prison environment. Their daily interactions are "packed" with exposure to different cases and decision making requirements, all of which provide learning experiences. However, the benefits of the learnt experiences are lost if we do not take the time to "unpack" them through reflection. Reflective practice sessions provide an avenue for practitioners to come together and discuss certain aspects of a case or practice topic at the micro level. This discussion should draw on individual and collective experiences and feelings about practice and allow practitioners to grow their understanding and application of practice (Vuorre, 2012).

It's crucial to clearly communicate the reasons for reflective practice, and ensure everyone involved agrees to those reasons. Trust, transparency and safety are vital, and it is imperative that reflective practice is not intertwined with disciplinary or performance management processes. Good reflection requires a questioning approach which takes into account cultural contact and explores a range of alternatives and approaches. There should be a structure, but no pre-determined outcome (Vuorre, 2012).

Staff are the focus of reflective practice and are responsible for their own practice development. Reflective practice support is provided through group and individual reflective practice sessions and through mentoring, coaching and "in the moment" assistance by practice leaders.

Why South Australia implemented reflective practice

In 2016, the Department for Correctional Services (DCS) appointed the reflective practice leader to create and implement a Community Corrections Statewide Reflective Practice Framework. The DCS wanted to strengthen the services available to staff, so the position was responsible for facilitating clinical support and supervision to staff to promote evidence based case management and therapeutic services.

The Reflective Practice Framework creates a collaborative and challenging approach to managing those on sentence. It empowers staff to make professional decisions, builds confidence, and assists with case analysis and planning.

The New Zealand contribution

The New Zealand Department of Corrections recognised the importance of reflective practice when introducing it in 2012, following a pilot. The main driver of reflective practice was the newly established role of the practice leader. The practice leader was solely focused on developing, leading and supporting professional practice.

New Zealand's reflective practice framework is based on the Gibbs model of reflective practice. This cyclical model is comprehensive and easy to apply in a correctional setting.

In August 2015, DCS executives visited the New Zealand Department of Corrections to exchange practice expertise and knowledge. New Zealand shared their reflective practice *Leadership Framework and Guidance*. This was tremendously valuable in assisting with the research and development of South Australia's Reflective Practice Framework. A strong link has been developed between New Zealand and South Australia and further collaboration and shared learning will continue.

Collaboration

The South Australian framework has also been based on the Gibbs model of reflective practice. It was recognised that support from an experienced New Zealand practice leader would benefit the introduction of reflective practice in South Australia. In August 2017, Paula Frawley was invited to be a guest speaker and facilitator at the DCS inaugural reflective practice workshop held in South Australia. The workshop introduced reflective practice concepts to managers who would be co-delivering the reflective practice sessions with their practice leader Gina Roberts. The initial workshop was followed by a reflective practice roadshow to all 16 Community Corrections Centres in South Australia. Throughout October 2017, around 140 staff attended these sessions.

The roadshow included:

- an interactive session with Paula, enabling DCS staff to hear about the journey of implementing and continuing to develop reflective practice in a corrections environment
- a discussion of any staff concerns and how these could be mitigated
- a video recording of a team reflective practice session in action.

Similarities and differences between South Australia and New Zealand

Similarities in group reflective practice sessions

The process and concepts underpinning group reflective practice sessions are very similar because the issues that face our staff and the people we work with are universal. Staff identify their individual learning and practice needs and how best these can be met. Reflective practice sessions are led by staff, with support and guidance from reflective practice leaders. Groups in both organisations have identified the importance of establishing a strong team kawa reinforcing the essential principles of trust and respect. This creates a safe space, so staff feel respected and can get the most benefit from every session. Finally, staff in both organisations show great commitment and enthusiasm to developing practice that improves outcomes for those in our care.

Different jurisdictions

South Australia and New Zealand have significantly different staff numbers requiring different resourcing models for facilitating reflective practice. In New Zealand, the Department's approximately 80 practice leaders support reflective practice delivery to 1,090 probation officers and 290 case managers on a fortnightly basis. In South Australia, reflective practice sessions are co-facilitated by Gina Roberts and the manager at each of the 16 Community Corrections Centres on a bi-monthly basis. Reflective practice is still developing within South Australia's Corrections and they look forward to the potential growth within the reflective practice space (Roberts, 2017). An evaluation of the first 12 months of the implementation of the framework is underway, with a report due towards the end of 2018.

Conclusion

Reflective practice is central to learning as it allows probation professionals to understand and develop their own practice to achieve the best outcomes for their clients. The spirit of reflective practice does not change, whether a session is being delivered in New Zealand or South Australia.

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Practice note: Identifying and managing the effects of traumatic brain injury

Issued by:
Chief Psychologists' Office, Department of Corrections

Introduction

This practice note is intended as advice to frontline staff to help identify and manage the possible effects of traumatic brain injury (TBI) among offenders. It is common for TBIs to go unreported and to escape medical attention at the time of occurrence, especially if they occurred during illegal activity. Such injuries have the potential to widely impact upon individuals' wellbeing and behaviour. In a Corrections environment, the impact of TBIs can present in behavioural and management issues that require an informed approach.

The imprisoned population has a higher incidence of TBI than the general population (Farrer & Hedges, 2011). Research has identified that 63.8% of New Zealand male offenders have sustained a TBI across their lifetime, with 32.5% of these having experienced multiple injuries (Mitchell, Theadom and Du Preez, 2017). Sustaining a TBI in childhood has been shown to increase the possibility of imprisonment in adulthood (Schofield et al., 2015). This relationship indicates that, for a number of offenders, a TBI will have preceded their sentence.

The Department is working closely with the Accident Compensation Corporation (ACC) and the Ministry of Health (MoH) as part of the Traumatic Brain Injury Strategy and Action Plan 2017 – 2021. This future work will include increasing understanding of the prevalence of TBI in the offender population, and developing strategies to identify and treat offenders with TBI.

Alongside the close working relationship with ACC and MoH, the Laura Fergusson Trust has been running a pilot programme at the Christchurch Men's Prison Youth Unit since November 2017 to identify young men coming into the youth unit with a suspected history of head injury. The Trust's project aims to determine whether each young person is registered with ACC, and to consider what formal support would assist youth with a history of head injury to manage this injury. This support may include trying to become registered with ACC if they are not already. Laura Fergusson Trust will be providing an evaluation of their work at the end of the pilot scheduled for June 2018.

How traumatic brain injury may affect the behaviour of offenders

The behavioural changes associated with a TBI are varied and will depend on the site, cause, intensity (e.g. open vs. closed head trauma), frequency, and duration of the injury (Maas et al., 2017). The male prison population aged from 15–34 years, as well as the elderly (65 or older), are most likely to have suffered a TBI, with even greater rates observed among Māori (Feigin et al., 2013). Traumatic brain injury has been associated with higher rates of violent behaviours (Williams, Cordan, Mewse, Tonks & Burgess, 2010), younger age of offending and a greater likelihood of re-offending (Williams et al., 2010). However, TBIs often go unrecognised by sufferers, and offenders are unlikely to have presented to emergency departments at the time of the injury (Haines, 2016).

Given that offenders may be imprisoned well after sustaining a TBI, it is particularly important to be aware of the long-term effects. The following points highlight some of the changes that may be seen (Schoenberg & Scott, 2011). These changes may negatively impact on an offender's capacity to engage in programmes, and to self-manage their behaviour appropriately within a correctional environment.

Generalised impairments

Generalised impairment (difficulties that affect a range of brain functions) is commonly associated with blunt force trauma to the head. Injury is most commonly of a mild form that shows up in both acute and chronic symptoms. A mild injury is sometimes referred to as "concussion". Concussion symptoms include headache, nausea, inability to concentrate, low mood, fatigue, and irritability. To be diagnosed with concussion (technically known as "acute mild-traumatic brain injury"), the individual also needs to have experienced around the time of injury: (1) loss of consciousness; (2) loss of memory before or after the trauma; and/or (3) a change in mental state (i.e. dazed, confused, disorientated). It is possible for a person to have experienced a brain injury even if they did not lose consciousness.

Some individuals experience generalised symptoms for a long period of time, developing what is known as post-concussion syndrome. This is also known as chronic mild-traumatic brain injury. It is most common in the year following the injury but can persist longer – particularly when multiple injuries have been experienced over time. Long term symptoms can include difficulties with attention, memory, learning, fatigue, depression, anxiety, sensitivity to light and noise, dizziness, and headaches.

A decline in memory and learning capacities can show up as difficulties engaging in programmes, or difficulties consolidating the skills taught in programmes. Ultimately this can contribute toward an apparent lack of behavioural improvement or change and/or generalisation of skills. Difficulties with attention and concentration can impact upon an individual's ability to maintain focus on a task; this may be conceived as the offender being deliberately defiant and unwilling to comply with instructions and/or a lack of achievement within and after programmes.

Specific impairments

The front and side parts of the brain are particularly vulnerable to injury, which will produce specific difficulties, namely:

- Hearing impairments resulting in difficulties hearing instructions.
- Language difficulties resulting in difficulties finding words, comprehending what others are saying or meaning, and expressing what they want to say.
- Slowed processing speed with information resulting in delayed understanding and reaction to information (e.g. being spoken to and reacting).
- Emotional regulation difficulties which may be observed in fluctuating moods, such as irritability, acting childish, or showing little emotion.
- Behavioural regulation difficulties resulting in impulsive behaviours, being socially inappropriate, having difficulty shifting their thinking or "letting go" of an issue, and over-reacting – sometimes aggressively.
- Disorganised thoughts and behaviours resulting in difficulties planning, talking about those plans, and acting in a logical manner. They may appear "all over the place".
- Apathy resulting in a lack of drive or enthusiasm which may also impact on willingness to engage in programmes, and poor awareness of the needs and feelings of others.

Identifying offenders with traumatic brain injury

Consider the possibility that an offender may be experiencing the ongoing impacts of a traumatic brain injury if the symptoms listed above have been observed. This is particularly the case if there is a reported history of head trauma or diagnosis of traumatic brain injury on file. Self-reported history, information on file, or even a positive response to the question *"Have you suffered a head injury that put you in hospital?"* on the SDAC-21 can be indicators that traumatic brain injury may be contributing to the observed behaviour.

Practical accommodations for offenders with traumatic brain injury

Mild symptoms may be adequately supported within the structured and consistent prison environment (most recover within six months). Severe symptoms, such as behaviour disinhibition, can be more difficult to understand and manage appropriately (Haines, 2016). Tips to assist frontline staff in managing offenders with traumatic brain injury:

- If attention and processing speed difficulties seem to be an issue, be aware that the person can become overwhelmed with information quickly – particularly in a pressured or stressful situation. Present single instructions in a simple form and allow offenders sufficient time to process information before giving further information.
- For memory and learning difficulties, repeat information frequently, provide reminders, encourage offenders to ask questions. Write down routines and instructions and if you note that an offender is having difficulty remembering, provide the answer before they give the wrong answer. This can also help offenders to retain information in programmes.
- When approaching an offender presenting as aggressive/irritable, communicate the rules in a clear and direct manner, avoid evoking conflict, and break down instructions into single clear statements.
- For ongoing fatigue and other physical symptoms, encourage offenders to communicate their needs, keep to a schedule, and to take opportunities for short periods of rest and sleep during the day.
- Encourage the offender to learn the signs of needing to slow down (e.g. feeling overwhelmed, frustrated/irritable, angry, tired etc), to identify what they need (e.g. clearer or written instructions, a rest), and to adapt their daily routine if possible.

Further information is available from a range of providers

There are a number of resources available that provide more information about brain injury. These resources also include information about helping individuals with brain injury manage their symptoms, and how to respond to difficult symptoms and behaviours. Two major New Zealand resources can be accessed through the following links:

Brain Injury Association: https://www.brain-injury.org.nz/html/resources.html

Accident Compensation Association: https://disability.acc.co.nz/useful-resources/traumatic-brain-injury-tbi/

Additional information is also available by accessing the resources in the references section.

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World Congress on Probation: Report from the Chief Probation Officer

Darius Fagan
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Author biography

Darius has worked for the New Zealand Department of Corrections since 2001. He started his career as a probation officer and believes in the important role probation officers can play in helping offenders change their lives. As Chief Probation Officer, Darius is passionate about designing practice that adheres to evidence-based concepts that can be practically applied by officers in their day to day work.

The World Congress on Probation is administered by the Confederation of European Probation (CEP) which launched the first world congress in London in 2014.

The third world congress was held in July 2017 in Tokyo and was attended by over 400 people from more than 40 countries – including New Zealand. The theme was "probation and the role of the community", with a particular focus on community volunteers. Community volunteers play a significant role in the work undertaken by probation services and in a number of Asian jurisdictions the work of community volunteers is a dominant feature.

Japan has a goal to reduce the prison population by 20% by 2020 and to make the country the safest in the world. The role of the community and community volunteers is identified as being key to achieving this, and this goal will surely resonate with New Zealand and international audiences.

The use of volunteers is most prominent in Japan where people on parole are supervised by 1,000 professional probation officers and over 40,000 volunteer probation officers or hogoshi. The service is largely focused on support and reintegration, and volunteer probation officers will do this by inviting people to their own homes for tea or meals, as well as meeting in restaurants and cafes or other community locations. There are probation centres which are largely used to deliver programmes or training and supervision for the hogoshi.

Field visits

Before the congress there was the opportunity to undertake some field visits to understand the Japanese system in more detail. I was able to visit the Tokyo City Probation Office, a reintegration hostel for women, and a local probation office in Ota city.

Tokyo City Probation Office

The Tokyo City Probation Office is the centre of probation in the region where research, analysis, planning and some specialist treatment is undertaken. The office measures performance related data and supports the planning and co-ordination of probation officers and hogoshi across the city. While at the Tokyo City Office we were able to meet and chat with programme facilitators of a successful sex offender rehabilitation programme. They referred to the programme as a "super compact programme" which delivered sex offender treatment in five two-hour sessions spread across 10 weeks.

Women's reintegration hostel

Next we were taken to a women's reintegration hostel in the Shibuya District of downtown Tokyo. At the visit our hosts were quick to point out that this hostel was a mere 20 minute walk from the residence of the Japanese Prime Minister. The hostel had actually been visited by the Prime Minister in 2015, the first time this had occurred in the 130 year history of rehabilitation in Japan.

The hostel was home to 20 formerly imprisoned women and provided accommodation and reintegration services. Links were also made to local employers. Most of the women had their own rooms although there was one shared room which was used if the hostel was full. At the time of the visit all of the women were out at work. The money they earn remains under the control of the hostel and is given to the residents when they request it "for good purposes".

One interesting feature of the hostel was a recently introduced robot called Pepper which was programmed to encourage communication and expression of feelings. The robot could ask someone basic questions, such as "how are you feeling?", and tell people about the weather or the news. It is programmed through facial

recognition software to recognise feelings and respond to these by playing games or dancing. The general idea of this was that it was a sort of mindfulness robot which might help cheer someone up or take their mind off problems.

Probation office in Ota City

The probation office in Ota City, an outlying suburb of Tokyo, was primarily used to support the hogoshi in the local community. Here we were able to ask hogoshi some questions to find out more about who they were and how they worked. One was also the Mayor of Ota City. Their motivation for fulfilling the role was to help people and to provide a civic service to their city.

The volunteers have a unique way of working in that they would see people on probation in local restaurants or invite them to their own homes. One of the volunteers talked about how she had been running a group programme for eight juveniles from her small apartment. She said that there had been times of tension and fights between the youths, but that generally things went well and that the provision of a simple meal was greatly appreciated and helped to ease any tension.

The staff at the office in Ota City were particularly pleased with their connections to local businesses as the area is a thriving industrial and transport hub being located near one of Tokyo's main airports. They valued the growth in the area as it provided employment opportunities for people on probation through partnering with local businesses.

The congress

The congress was held over two days and guests were officially welcomed by the Honourable Yoko Kamikawa, Minister of Justice in Japan, through a video message. There followed a number of keynote speeches, plenary discussion panels, special speeches and a large selection of workshops from probation jurisdictions all over the world.

Keynote speeches were delivered by:

- Dr. Frank Porporino, T3 Associates – Developments and Challenges in Probation Practice: Is there a way forward for Establishing Effective and Sustainable Probation Systems?
- Prof. Peter Raynor, Swansea University – Effective Probation: The Past, Present and Future of Probation Research
- Prof. Todd R. Clear, Rutgers University – Imagining Community Justice Values and Probation Practice
- Tomoko Akane, Ambassador for International Judicial Cooperation of Japan – Future of Probation: Asian Experiences and the Role of the Community.

All of the keynote speeches were very future-focused and inspired a lot of optimism in the role that probation has to play in reducing crime and forming community connections for people who have been incarcerated or involved in crime. More than one keynote speaker noted that probation should not be seen solely as another form of correctional control or a cheaper alternative to the high costs of incarceration, but a service that can support and guide people to lead productive lives as good citizens.

Frank Porporino laid out a potential framework for changing probation systems to be more aligned to the ethos of crime reduction. His framework included an emphasis on mobilising support networks, changing inequality and promoting fairness, greater involvement of reformed ex-offenders, and more public engagement and involvement in supporting people to reform.

Peter Raynor provided a detailed history of how evidence has shaped and changed probation practices over time. He then reflected on this and proposed potential priority areas for future research to ensure that probation practices continue to evolve in an informed way. In particular, he proposed research in the areas of skills implementation, learning from ex-offenders, how successful policies gain support or legitimacy, and how to understand, measure and compare different approaches across the world.

Todd R. Clear delved further into areas raised by Frank Porporino and linked these to a set of core values for community justice. The values are based on a report from the Harvard Series on Community Corrections which could be used to offer a framework for a new vision for community justice.

Tomoko Akane provided a unique perspective from her understanding of the Japanese justice system and her previous role as a prosecutor. She highlighted some of the unique features of the Japanese probation system, use of volunteers and the wider role of community in the work. Her ideas centred on the importance of community and she stressed that the integration of people in the community requires strong collaboration between families, employers and the wider community.

Workshop sessions

A wide range of workshop sessions was available and these were grouped into themes. I concentrated on attending the presentations on evidence-based theories and practices, offenders with special needs, and development of policies and practices. Some of the workshops presented ideas or trials that were in the very early stages of development and did not yet have enough evidence behind them to be considered conclusively effective or applicable to NZ. However, there were some interesting highlights, such as

Innovative Approaches to Reducing the California Prison Population, Expectation for Community Corrections in Lay Judge Trials, and The Entre Program: A Community-based Treatment Program for Violent and Gang-affiliated Adult Offenders.

Innovative Approaches to Reducing California's Prison Population

This presentation was delivered by two probation chiefs from two counties in California: Sonoma and Calaveras. It focused on the impact and innovation brought about by Assembly Bill 109 (AB 109) which de-federalised a number of crimes. This legislation effectively pushed 40,000 cases away from the state prison system and into the county probation system. It also reduced the numbers subject to federal parole.

In Sonoma County, the injection of extra cases and funding into the county probation system was seen as an opportunity to realign and update the service to modern evidence based practices. This included: introducing motivational interviewing, new evidence based risk and need assessments, a new offender guided case plan approach with S.M.A.R.T. goals, and a structured sanction and incentives policy.

The new approaches started to be implemented from 2014, and early analysis shows that there has been an impact in reduced use of jail as a sanction for violations, reduced revocations to prison for felony probationers, reduced recidivism, and a reduced crime rate in Sonoma County. This is quite an achievement as there was some nervousness initially about a rising crime rate if more serious prisoners were managed on probation.

Expectation for Community Corrections in Lay Judge Trials

Since 2009, Japan has been trialling "lay judge" panels to preside over serious criminal cases. A lay judge panel is comprised of three professional judges and six community members. Since the trial started, these panels have dealt with 2.5% – 3% of criminal cases, or 11,768 cases in total. The lay judge panels process all aspects of the case including fact finding, victim submissions, the trial, and sentencing. The cases covered a wide range of crimes from murder to drug offending.

Evaluations have found that compared to standard bench judges, lay judge panels tend to make greater use of suspended sentences, and also to impose probation conditions more frequently with the suspended sentences. When decisions and statements made by judges at sentencing were analysed, it was found that lay judge panels placed a greater emphasis on rehabilitation. They gave more weight to individual circumstances such as age, and there were clear themes of compassion and hope for perpetrators to reform.

The Entre Program

The Entre Program in Sweden targets gang-affiliated adult offenders. It is one of 14 programmes available in the Swedish prison and probation service. On average, Entre takes 22 sessions to complete over an eight month period. It is designed for men, but a small number of women have also completed it.

The programme is based on Risk Need Responsivity principles and focuses on six themes: relations and associates, attitudes and values, aggression and violence, identity and self image, alcohol and drugs, and practical social situations. The interesting thing about this programme is that it is designed to work flexibly based on the needs of the individuals or group being treated. The dose, length, focus and intensity can all be adjusted depending on the cohort.

The programme was still in pilot at the time of the congress so full results were not available. There had been the usual issues with community treatment such as re-arrest, non-attendance, and aggression in sessions. Anecdotal feedback was available from staff and participants who were optimistic about behaviour changes that had been observed in those who stuck with the programme.

All of the resources for these sessions and all the others are still available on the congress website.

http://www.moj.go.jp/HOGO/WCP3/program/index.html

Closing remarks

As always, the World Congress inspired a lot of ideas and reflections. It is particularly interesting to see how countries that have relatively new probation systems go about setting them up and what they focus on. If there was one consistent theme, it was that probation services will struggle if they remain anonymous and don't strive to achieve community support and buy-in to their work. This was deemed particularly important in helping communities to understand their role in supporting reintegration and gaining practical help such as employment.

The congress closed with a handover ceremony from Japan to Australia. The next Probation World Congress will be held in Sydney in 2019.

Book Review: *Parental Incarceration and the Family: Psychological and Social Effects of Imprisonment on Children, Parents, and Caregivers*

Joyce A. Arditti
New York University Press, 2012, ISBN: 978-0-8147-0512-4

Reviewed by Dale Warburton
Senior Policy Adviser, Department of Corrections

Reviewer biography

Dale Warburton joined the Corrections Policy Team as a Senior Policy Adviser in November 2017. He has previously held policy roles at the Ministry of Transport and Ministry for the Environment.

Set in a US context, *Parental Incarceration and the Family* summarises a wealth of literature to argue that imprisoning parents has wide and significant implications.

The book is presented uniquely by supplementing overviews of research with, at times, emotional anecdotes from the author's own qualitative research to examine the effects of parental incarceration on family relationships, wellbeing and outcomes.

As the title suggests, the book not only examines the impacts on prisoners who are parents, but also how the imprisoning of a parent affects their children, their parents and other family members.

Separate chapters are devoted to highlighting the breadth of impacts on mothers and fathers who are imprisoned. This provides an opportunity to reflect on how impacts can differ between a mother's imprisonment and a father's imprisonment, and highlights gaps in research. While numerous impacts are summarised across the two chapters, the most prominent are; difficulties in maintaining their parent–child relationship while in prison, particularly if there are geographical or visitation barriers, rebuilding familiar relationships after release, and navigating if the non-imprisoned partner has found a new partner.

The book continues with a chapter dedicated to the impacts of imprisonment on families and children and offers a reminder that a prison sentence is not only punishment for the offender, but can have significant, and extensive, impacts on their families.

Literature covered in the book argues that the effect of a parent's imprisonment can manifest itself in many different ways. In addition to traumatic separation there are economic impacts from lost income, psychological impacts, and behaviour changes by children. When extended family are required to take over as primary caregivers, the impact ripples further than just the immediate family. Impacts on children can extend further, with the author highlighting research that suggests having an imprisoned parent can lead to a higher chance of a child being imprisoned themselves. In summary, the life path of the remaining family, and in some instances the extended family, is severely altered.

In the final chapter, the author turns attention towards policy implications, with a particular desire for policies to take into account the broader implications of parental imprisonment. While the author does not explicitly set out a range of policies to reduce the impact, a framework for considering the effectiveness of potential policy options is developed. The inference from this framework is that imprisonment is a reflection of the socio-economic conditions within society, and while policies or procedures can be implemented to try to maintain familial ties during imprisonment, social policy reform that addresses social and racial inequalities would have a greater impact by reducing the frequency of imprisonment.

Although no silver bullet is offered, the author argues that policies need to better account for the effects of parental imprisonment, and urges readers to use the framework provided to undertake further research.

In New Zealand, the Department of Corrections has taken steps to reduce the impact of parental imprisonment. Mothers with Babies Facilities allow approved mothers to live with, and care for, their infant child on prison land. Mothers and Bonding Facilities provide opportunities for imprisoned mothers to feed and bond with their baby on a daily basis in a safe and suitable environment. Whānau days in prisons provide opportunities to maintain or establish family relationships in a culturally appropriate manner. Audio-visual technology allows virtual visits as an option, which is especially useful when distance to, or cost of visiting, the prison is a barrier for visitors.

With regard to further research, a natural extension to the body of work could be to quantify the expected financial cost of the broader impacts to society of imprisoning a family member. Research that quantifies the expected societal cost of a prison sentence could provide a useful contribution if there was an opportunity to discuss changes to the sentencing regime, particularly in light of a shift toward more evidence-based investment practices to social service provision.

Book Review: *Dress Behind Bars: Prison Clothing as Criminality*

Juliet Ash
New York: I.B. Tauris (2010), ISBN 978-1-85043-894-6

Reviewed by Sophie Beaumont
Intern – Women's Strategy, Department of Corrections

Reviewer biography

Sophie joined the Corrections Women's Strategy team as part of the 2017 Summer Intern Programme. She completed her MA in Criminology at Victoria University in 2017. Her research focused on how women are depicted in women's magazines and discussed trends found in images within the context of rape culture in New Zealand. Sophie contributed to a range of work for the Women's Strategy team, including researching and drafting an options paper on clothing within women's prisons.

Dress Behind Bars: Prison Clothing as Criminality explores the different iterations of prison uniforms, internationally and across genders, from the late nineteenth century to the time of publication (in 2010). Ash takes the perspectives of those who have worn the clothes and those who have issued them and contextualises them in historical movements of both punishment and reform.

The book presents both an anthology and a critique of historic and modern prison clothing. The first four chapters are focused on the past, giving insights into the uniforms (or lack thereof) from the late-1800s up to the 1990s. The fifth chapter focuses specifically on uniforms within English prisons from 1950–1990, chronicling prison dress through post-war clothing rationing to the model of non-compulsory prison clothing for women (introduced in 1971) and men (introduced in 1991). Contemporary prison clothing is covered in the penultimate chapter and an overview and analysis of current practices from around the world is given. The book concludes with an analysis of media portrayals and art made by people in prison that captures their perceptions of identity within an institution.

The text draws from a multitude of international jurisdictions, though it does tend to reference models from the United Kingdom most frequently. This is understandable given the author is based in the United Kingdom and it is where the majority of the first-hand information about prison clothing has been collected.

Particularly interesting are the links the author makes between attitudes towards crime within society and prison clothing. The book shows that with periods of reform, uniforms in prisons become more in line with regular clothing and when jurisdictions swing towards highly punitive mentalities prison clothing becomes an overt symbol of this. Insights and analysis like this reflect the criminological undertones of the text and make the book a good resource for those involved in decisions around clothing/property in prisons. A key takeaway for all Corrections staff is that the mind-sets driving projects are reflected in what is delivered and this has the potential to inhibit, rather than enhance outcomes for people in prison.

The overall message of the text is that clothing goes far beyond the literal; it is framed as an expression of individuality, key to shaping and maintaining one's identity. The importance of recognising and being responsive to the more abstract needs of those in prison is meaningfully highlighted. It is a good read and recommended for anyone interested in prison clothing or more general change within the prison environment.

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