THE DELIVERY OF MENTAL HEALTH SERVICES WITHIN THE DEPARTMENT OF CORRECTIONS

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EXECUTIVE SUMMARY

TE ARA TIKA

This review describes the complex and often dynamic challenges of delivering mental health services within the New Zealand Prison system. Challenges which are typically unique to this setting - and which significantly impact on how care is provided, how services are accessed, treatments managed, relationships sustained, and ultimately what outcomes are possible.

Prioritising the need for security (over health service delivery) will mean that many of these challenges cannot easily be managed or amended. And in this regard, the tenants of operating a prison will inevitably frame the parameters upon which health services are delivered. However, the point of this review is not to simply itemise or elucidate these concerns – rather, to identify what enhancements are possible, where new opportunities for development exist, and how mental health outcomes for those in our care can be improved.

A particular feature of this approach has been to locate a comprehensive suite of pragmatic and sustainable recommendations. Recommendations which are aspirational and future focused, but which can be accommodated within existing structures, policies or processes. Likewise, recommendations that align with and support other strategic documents or departmental focus areas. The point being, that any developments must be cognisant of both the opportunities and immense challenges of providing mental health care to our prison population.

Many of these challenges will centre on these types of structural or logistical tensions. However, these are further exacerbated by a range of other socio-demographic and clinical confounders. Key to which is the assertion that the prison population does not mirror the community population. And in terms of mental health, these differences are often quite profound.

The most significant of which is the fact that the prevalence of mental ill-health will be measurably higher amongst the prison population. These issues are also likely to be far more acute, more complex, comorbid, more difficult to treat, result in poorer outcomes, and are more likely to have been catalysed by significant traumatic events. To this end, and while the challenges of delivering mental health care with a prison setting are immense, these issues will be significantly amplified when contextualised according to the type of people likely to require care.

In response, *Ara Poutama: The Department of Corrections* has over a number of years introduced a range of initiatives designed to better meet the mental health needs of prisoners. These have (on the whole) been well-received and based on good intent. However - the impacts and outcomes of these programmes have not always been as efficacious or enduring as anticipated. Oftentimes lacking the resource, infrastructure, coordination or integration required to support success. Or simply not being afforded with the time and space to truly determine effectiveness.

Over the past five years or so years, greater emphasis has therefore been placed on consolidating the Departments approach to the delivery of mental health services. To increase both the number and range of mental health supports available as well as the amount of resource provided. While these have led to enhanced levels of access, as well as improvements in the range and scope of care delivered - issues of coordination and consistency (across sites and within services) have remained. Likewise, a broad range of related concerns - structural, clinical, cultural, and organisational - have further impacted the type and quality of care provided.

In order to better understand these issues, and to ensure that the recommendations described within this review were fit-for-purpose and derived from good evidence, a comprehensive (mixed-methods) methodology was developed. This included reviews of the literature, interviews with experts, surveys, focus groups, hui, wananga, conference attendance, presentations, formal meetings with policy, strategy, and cultural experts, tohunga and rongoā practitioners, managers, clinicians, prisoners, whānau members, and special interest groups – including women, gender-diverse, and young people. As well – a number of site-visits (typically occurring over two/three days) were also organised and to ensure that more specific delivery issues and perspectives were captured. More detail about the methodology used for this review is outlined in the body of this report.

Given the broad scope of information and data collected - the analysis, organisation, and presentation of findings initially proved difficult. Notwithstanding, and as the process of review and data synthesis took shape, a number of seminal themes began to emerge. These emergent themes, however, were not always able to be clustered together or into a single inventory of ideas or concepts.

Eventually however, five broad categories or *Pou* were identified.

1. *Pou Arataki: Six Mental Health Principles*
2. *Pou Hinengaro: Four Mental Health Platforms*
3. *Pou Rautaki: Ten Mental Health Investments*
4. *Pou Kokiri: Five Mental Health Catalysts; and,*
5. *Pou Hua: Outcomes and Recommendations*

Each of the five *Pou* contain a summary collection of ideas, concepts, issues and opportunities which have been garnered from the research and review process. The first *Pou* - *Pou Arataki*, outlines the principles used to guide the review and especially the recommendations. The *Pou Hinengaro* focus on the various factors (often peripheral to service delivery) and which are required to support or sustain mental health and wellbeing within a prison setting. *The Pou Rautaki* are more specific and explore service and delivery related challenges and opportunities. *Pou Kokiri* describe investments which are required to maintaining quality and future growth. Finally, the *Pou Hua* is a summary of the key recommendations generated from the review and how these should be prioritised or actioned.

An abridged summary of each of the *Pou* and high-level recommendations are described below. Noting that considerably more detail and context is provided within the body of the report.

POU ARATAKI: MENTAL HEALTH PRINCIPLES

The Pou Arataki: Mental Health Principles were designed to help frame this review - and to ensure that the developmental opportunities, in particular, were guided by a suite of higher-level criteria. These principles were identified as part of various consultation and interview processes and in light of the desire to ensure that the review was framed in a manner which would ultimately drive change and improve the mental health and wellbeing of prisoners. In this regard, five review principles were identified.

While this report has been endorsed by the Chief Mental Health & Addictions Officer and Chief Māori Health Officer, further consultation will be undertaken within the Department of Corrections to decide whether, and how, each of the recommendations outlined in the report will be implemented, with an initial focus on progressing the priority investments.

Principle One: Transformational Change through Measured Investment

This principle is based on the idea that any recommendation is designed to improve the delivery of mental health services within *Ara Poutama Aotearoa* must be appropriately contextualised - to ensure a balance between what is desired, and ultimately what might be possible. The concern is, that unless the recommendations are appropriately framed and cognisant of the realities of delivering care within a prison setting, they are unlikely to be implemented – or fall well short of their expectations. This does not mean that significant innovation would not be possible, but that the recommendations generated from this review should be fit-for-purpose and consistent with broader departmental strategies, policies, and structures. Ultimately, supporting the current direction of travel as opposed to suggesting a pathway which is inconsistent, unrealistic or impractical.

Principle Two: Pragmatic Solutions

Principle Two, leads on from *Principle One* but draws greater attention to the need for solutions which move beyond philosophical or strategic reform, and towards initiatives and investments where the impacts were more immediate, pragmatic, and measurable. Further, that although issues and challenges would inevitably moderate progress, the focus should remain on the identification of solutions and opportunities rather than simply the elucidation of concerns.

Principle Three: Nuanced Approaches

One of the most frequently expressed issues to emerge from this review was the idea that established, community, or conventional approaches to the delivery of mental health services were ill-suited to a correctional

environment. And that the wholesale implementations of these models or theories would not bring about significant improvements in care. These frustrations were often viewed against the backdrop of implementing models, systems, or therapeutic approaches which were not optimised for a correctional setting. Likewise, initiatives that were not always cognisant of the unique mental health characteristics of the prison population and the extent to which these profiles impacted care. The ability to accurately and comprehensively reflect these realities would be key to the utility of both the review findings and the implementation of key recommendations.

Principle Four: Complexity and Diversity

Reviewing the delivery of mental health services within *Ara Poutama Aotearoa* presents a number of significant challenges. Many of these have already been described, and which are largely reflective of the multiple challenges of delivering health care within a custodial space. An added level of complexity exists, however, in that service provision is not uniform across sites. And while there will be operational guidelines, contractual arrangements, and policies which guide how services are delivered – the interpretation of these can be quite different. Further still is the idea that prisons do not always operate in a uniform manner, especially in terms of how mental health care is organised, and what access to staff, resources, and facilities is available.

The seminal point here, is that any review must appreciate and reflect this diversity and complexity. To avoid the risk that the recommendations may resonate with some but be of less value to others.

Principle Five: People Centred

Principle Five is unsurprising and was again a point emphasised throughout various discussions, hui, conversations, and more formal interviews. It was noted that while the review would likely bring about changes to the way in which mental health care was being delivered – the efficacy of these changes must ultimately be measured on the extent to which mental health outcomes for those in our care, have improved.

Principle Six: Culturally Framed

One of the most concerning and unfortunate connections between the mental health and corrections sectors is that both share remarkably similar levels of engagement with Māori. We know for example, that the lifetime prevalence of mental illness amongst the Māori population is more than 50%, and that the corresponding percentage of Māori within our prisons is greater still. Potential solutions to both these issues are complex, and well beyond the scope of this review. However, there will be a need to ensure that the recommendations from this review are consistent with the expectations of Māori. That they align with current strategies, policies, and initiatives – and further prioritise investments which enhance mental health outcomes for Māori.

POU HINENGARO: MENTAL HEALTH PLATFORMS

As described previously, the identification of themes, and the organisation of data, created a number of initial challenges. Largely due to the scope of the review and the diversity of perspectives shared. While the review had a particular focus on service delivery, many of the issues discussed (and solutions suggested) were not always connected to how care was provided. And more so centred on the various environmental or structural conditions which either impeded or promoted mental health and wellbeing. It was suggested that unless these factors were assessed (or at least contemplated) as part of this review – recommendations described were unlikely to achieve the outcomes anticipated. Or at the very least, significantly constrain what outcomes were possible.

The Pou Hinengaro: Mental Health Platforms were identified as part of this process. These are described in greater detail below:

Platform One: Environmental Catalysts

There is significant and long-standing evidence to highlight the various and often complex drivers of mental illness. These can include biological or physiological factors – a genetic predisposition, organic trauma, as well as a broad spectrum of environmental catalysts. For example, being victims of violence or abuse, as well as less obvious factors such as poor

housing, poverty, unemployment, disengagement from education, and an inability to access both formal and informal support.

Insofar as environmental conditions might precipitate or promote mental ill-health, there is significant evidence to support the idea that settings that restrict access to the natural world or are devoid of human contact are likely to have a negative impact on wellbeing. Likewise, are situations where opportunities for growth are limited, where aspirations for the future compromised, and where there is a lack of control over one's life and destiny. Compounding these issues further are negative interpersonal or relational confounders.

Engagements with individuals or communities which promote or cultivate fear, which are stress inducing, unsafe, or designed to promote mistrust, tension or aggression.

The unfortunate reality is that these examples and settings are common within a prison environment. And in the case of limiting choice or restricting movement, are in fact the foundations upon which these institutions have been established. As a consequence, this review identifies a number of recommendations designed to control for or mitigate the mental health impacts of these types of unique environmental stressors. While many of these issues cannot be addressed in any significant way – the point here is that a number of reasonable and pragmatic opportunities exist, and which warrant consideration for potential implementation.

Platform Two: Mental Health Training and Awareness

The delivery of mental health care is the primary responsibility of mental health specialists. However, opportunities to support and sustain mental wellbeing are far less restrictive, and nor will they be confined to periodic or formally scheduled clinical engagements. Further, and for the most part, clinicians are unlikely to have the most regular and sustained contact with prisoners. For these reasons, it makes sense to explore how custodial staff might be able to support mental health and wellbeing, outside of clinical settings, and in a manner which complement the activities of health staff. Some mental health training is already offered to custodial staff and there are existing initiatives currently underway aimed at increasing access for staff to mental health training (e.g., a review and update of the Corrections Officer Development Pathway[1] (CODP), the development of a learning & development pathway and support framework for custodial staff working in women's prisons).

However, the overall approach to training (especially in terms of mental health) is currently inconsistent, not always embraced, and could be more comprehensively framed to focus on signs and symptoms, common challenges, behaviours, and importantly - potential supports.

Platform Three: Mental Health Promotion and Education

Population-based approaches to supporting mental health and wellbeing typically emphasise the need for well designed, focused, and comprehensive education and promotion initiatives. Most often centred on raising awareness, building resilience, creating supportive environments, prevention programmes, peer support, stigma reduction and promoting overall positive mental health. The relevance of these theories and approaches will be significantly compromised by a multitude of situational challenges. And to the extent that many community-based mental health promotion and education programmes will seem entirely out-of-place within a prison setting. Nonetheless, the fundamental principles and broader objectives of mental health promotion and education are likely to ring true in any setting. The seminal consideration, however, will be to ensure that these are applied and interpreted in ways which are both meaningful and relevant. A number of recommendations relevant to these opportunities are described within this review.

Platform Four: Coordination and Integration

It has already been noted that for a number of years *Ara Poutama Aotearoa* has sought to implement strategies, policies, and initiatives designed to improve the delivery of mental health care within prisons. While these have been largely welcomed – and have successfully improved access to care, and the range of treatment options available - these gains and opportunities have not been universally felt. With significant variations in how care is provided, accessed, supported, and organised. This in spite of the fact that various guidelines, procedures, protocols, and

1 The Corrections Officer Development Pathway is the initial learning programme for all new Corrections Officers and Offender Employment Instructors.

parameters have been developed in order to ensure the safe and consistent delivery of care. There is a risk that an overly prescriptive or regimented approach to how services are delivered (in order to promote consistency) will constrain innovation and negatively impact the ability to nuance service provision. However, the greater risk is that care (and the quality of care) remains inconsistent, haphazard and variable. Further, that an inefficient system of care takes root and is accepted as conventional (or best possible) practice. Addressing these issues will play a significant role in ensuring that care is delivered in a more consistent and organised manner, that efficiencies are maximised, and that resources are applied in settings where they are most needed.

POU RAUTAKI: MENTAL HEALTH INVESTMENTS

While the *Mental Health Platforms* describe a range of environmental and structural drivers of mental health (at least for *Ara Poutama Aotearoa*) they do not sufficiently highlight service delivery challenges and what options for enhanced care are possible. The *Pou Rautaki* are designed for this purpose and are centred on ten key Investment areas. These are summarised below:

Investment One: Therapy within a Prison Setting

One of the more profoundly obvious (and frequently raised) issues to emerge from this review is that conventional or established therapeutic models of care are ill-suited to a correctional setting. For reasons already described, a carceral environment will limit the extent to which most therapy options or interventions can be applied. Restrictions will be placed on how and when therapy is administered, to what extent, in what situations, and according to parameters or timetables that are not always governed by health need or best-practice. Yet – the expectation is that clinicians can intuitively amend their practice or reinterpret their training to accommodate these types of environmental restrictions. Further, without due consideration as to the impacts on care, the outcomes possible, and the veracity of what is being delivered.

While many of the challenges of delivering care with a prison cannot easily be resolved, and notwithstanding the efforts of clinicians to nuance or amend practice – more is needed to discern, review, and evaluate best practice and options for care. Likewise, what bespoke models, suited to this setting, can be developed, validated, and evidenced.

Investment Two: Women in Prison

The idea of developing a more bespoke approach to the delivery of mental health services has been a recurring theme throughout this review. There are a number of reasons for this and which are often linked to the fact that prison environments will be highly dissimilar to community settings. The mental health issues will be more complex, more difficult to treat, and to have far more restrictive treatment and care options. The demographic and cultural profile of the prison population is likewise unique, and again calls for approaches to care which are dynamic and responsive enough to reflect these challenges.

Part of this dynamism will be to introduce programmes of care which leverage cultural frames, especially for Māori, and given that Māori make-up a disproportionately high number of inmates. The idea being that culturally inspired approaches will help in creating treatment options that are more resonant and engaging – and ultimately, more efficacious. Extending these ideas beyond the need for culturally inspired programmes, is the notion that a number of gender-specific issues also exist and which likewise call for approaches to care which are similarly nuanced. Approaches which are mindful of the unique challenges faced by women in prison and the manner in which these impact the delivery of care and the outcomes anticipated. Further still, how non-clinical staff are trained, and what more focused health promotion and health education opportunities, specifically for women, can be explored. Detail on these recommendations are contained within the *Investment Two* section of this report.

Investment Three: Cultural Catalysts

Understanding the multiple connections between culture and wellbeing formed a significant part of this review. Notwithstanding the fact that these ideas have been promoted (and largely accepted) for at least 30 years – the extent to which cultural platforms have been used to support the mental health and wellbeing of Māori within *Ara Poutama Aotearoa* has yet to be maximised. This review identified a number of examples of best practice, both historical and contemporary, and

where culture had been successfully used to garner outcomes which would not have hitherto been possible if not for these types of interventions. Likewise, various other Māori focused initiatives, policies, services, training and larger programmes of work. Yet, the possibility of expanding and further refining these investments holds significant potential – especially in the mental health space.

But which will be contingent upon a more structured, well resourced, and integrated approach. The specific recommendations attached to this investment area are provided in considerably more detail within the relevant section of this review. However, it is important to note here that there are a range of opportunities to further strengthen the relationship between culture and mental health that might only be possible within a prison setting. This must therefore be viewed as a priority for future investment.

Investment Four:
Workforce Development

It should come as no surprise that workforce issues have been identified as a major challenge to effective service delivery. These are concerns which have been highlighted elsewhere and are not confined to the corrections or health sectors. Nevertheless, workforce-related concerns were expressed throughout most (if not all) of the interviews, discussions, hui, and presentations. Many of the concerns raised were not always confined to mental health care, or the delivery of health services. Rather, more general conversations as to the lack of staff throughout *Ara Poutama Aotearoa* and the corresponding impact on the ability to provide treatment in a timely, ongoing, and sustainable manner. Solutions to these problems are complex and cannot be resolved quickly or simply.

Investment Five:
Workforce Retention

Investment Five was deliberately delineated from *Investment Four* in that workforce recruitment and development issues were measurably different from the challenges faced by the existing staff. Five main areas of concern were identified. The first was that working within a prison environment (for many) lacked appeal and was logistically challenging. Second, opportunities for growth and development appeared limited. Third, was that clinical engagement and the administration of care was both frustrating and cumbersome – but oftentimes a reality of working within this setting. Fourth, many of the contracting arrangements were perceived as lacking security and therefore made it difficult to both entice and retain staff. Finally, more lucrative (and arguably less demanding) roles could be secured elsewhere.

It is therefore proposed that a formal and comprehensive workforce retention strategy be developed which will usefully consider;

1. *Options to mitigate and account for workplace challenges*
2. *Growth and development pathways and opportunities*
3. *Strategies for mitigating clinical and environmental challenges*
4. *Ways to create certainty and security in terms of contracting and service delivery; and*
5. *Staff remuneration options as a means to retain staff*

Investment Six:
Logistical and Resourcing Challenges

Logistical or care delivery challenges were frequently raised by those spoken to. Most often, these were concerns raised by clinicians and with respect to the frustrations many experienced when attempting to provide timely and effective care. While it was noted that to some extent these challenges were unavoidable (and more broadly reflective of the difficulty providing health care within a prison) many of the issues experienced were simply related to structural, environmental, or resourcing factors.

These included the lack of therapeutic spaces, their overall condition, their suitability/confidentiality, time limitations/constraints, access to therapeutic resources, continuity of care and unexpected transfers, how non-clinical staff were deployed or accessed, the impact of security classification on access to mental health support, and issues surrounding when and how medications were administered. Opportunities to mitigate these challenges are again complex and are detailed within the relevant section of this review. Suffice to say that an integrated and system-wide approach, where both resources and information is shared, will be imperative.

Investment Seven:
Roles and Responsibilities

The effective delivery of mental health care requires input and support from a wide range of teams and

professions. The ability of these teams to operate in an integrated and coordinated manner will be key to ensuring that the benefits of this type of approach are maximised. Further, that care is delivered in a way which meets the diverse needs and expectations of those in our care. While the efficacy of this approach is well considered, a large number of those spoken to raised concerns in terms of how these theories were applied in practice. How care and support was organised, the extent to which needs were being met, and how both clinical and non-clinical roles were coordinated to bring about mutually supported mental health outcomes. Having a clearer and more coordinated approach to how teams and professions work with and alongside each other is needed. In order to maximise therapeutic outcomes and to also ensure that time and resources are used to best effect. While this does occur on some sites, it is less evident in others. A more detailed description of the strategies required to address these issues are outlined within the Investment Seven section of this report. Finally, a priority recommendation is to implement a more sophisticated approach to the allocation of staff/FTE. Detail on this new approach is provided within Investment Seven.

Investment Eight: AoD and Mental Health

Alcohol and drug (AoD) related issues were highlighted (relatively early within the design of the review) as requiring particular attention. While a number of concerns were raised as to the challenges of delivering care, the limitations, as well as the complications and overlaps with mental health services, a range of opportunities were also identified.

These included opportunities to integrate the roles of community-based mental health staff and community-based addiction staff, to integrate addictions clinicians into Intervention and Support Practice Teams (ISPTs), to provide mental health support for people undertaking existing prison based intensive AoD treatment programmes, and to develop a more coordinated approach to assessment, treatment and training across mental health and addictions services.

Investment Nine: Forensic Mental Health Services

The particular challenges faced by Forensic Mental Health Services (Forensics) were also explored within the review. It was noted that while the delivery of mental health services within prisons was difficult - many of the issues were amplified with respect to the delivery of forensic-level care. The issues encountered will almost certainly be more complex, chronic, acute, more difficult to treat, and accordingly lead to outcomes which are far more modest.

Insofar as these issues could be addressed, a number of options and recommendations were put forward. Including the need for greater national consistency in the delivery of care, the desire to develop and implement innovative models of care which mitigate resourcing constraints and challenges, improving data availability and reporting, streamlining and better coordinating referral processes. As with other areas, the impact of workforce, resourcing, and facility issues were again both significant and interrelated.

Investment Ten: Young People (Emerging Adults)

A number of meetings and hui (both online and in person) were organised to explore the particular issues faced by young people within prison. These discussions were largely centred on the more specific issues and challenges they were likely to encounter, how these might differ from the adult population, and what remedial or focused solutions might be possible. Justice issues, background and environmental catalysts often featured as part of these conversations. In terms of mental health, it was noted that many of the concerns (highlighted throughout this review) were not necessarily unique to young people. However, that these were likely to have an impact which was disproportionately more significant when compared to the adult population. Discussed, as well, were more unique issues and challenges. Including – concerns over safety, the removal of educational opportunities, heightened feelings of isolation and loneliness, ill- suited rehabilitation programmes, greater risk of exploitation, and family strain.

Emphasis should therefore be placed on prioritizing the needs of young people in relation to accessing and receiving mental health support. Further, that security classification processes as they relate to young people are reviewed, including consideration of the role of mental health services in these processes. Further, that settings are provided and so as to allow young people time to settle before discerning placement/security classification. Consideration of options for ensuring early engagement for young people with mental health services during the settling in and adjustment phase is also proposed. Additionally, more research to better

understand the mental health needs of young people within New Zealand prisons.

POU KOKIRI: MENTAL HEALTH CATALYSTS

Beyond the service and delivery related *Investments* described above were other factors which were seen as essential to improving mental health outcomes. While some of these were detailed within the *Mental Health Platforms* (and as part of various population health initiatives) - other opportunities were also identified - but which did not always sit well within this context. To a great extent, these were seen as mental health supports, or scaffolds, and key to establishing a foundation upon which various service delivery initiatives could be deployed and sustained. In this regard, *Four Catalysts* for mental health have been identified.

Catalyst One: Measuring Success

Determining the efficacy of mental health treatment and care has always been problematic. Not only due to the variability of outcomes possibly, or the complexities of simply measuring change. But more so the often significant impact that external factors – unrelated to any formal treatment or care plan – will have on what outcomes are possible. For Prison settings, these environmental factors or contingencies will have a far more profound impact on health outcomes than what can be expected within non-carceral or community settings. The pressures will be different, the options for care more restrictive, and the availability of emotional or psychological support less obvious. Given the issues, and the imperative to routinely evaluate or assess the impacts of care, it will be important that new tools are developed to measure outcomes and effectiveness. These tools will need to be bespoke to a prison settings and likewise cognisant of what outcomes are possible and valued. This will not mean that existing tools, such as Kessler-10 have no value or should be removed – rather, that complimentary instruments should be introduced and in order to provide a more comprehensive (and relevant) assessment of progress and outcomes.

Catalyst Two: Research Activity

Without timely and accurate information, it will be difficult for *Ara Poutama Aotearoa* to understand need and to likewise explore potential solutions. At present, a considerable amount of information (relevant to mental health) is collected. However, the data is not currently being used to its full potential, nor is it sufficiently broad enough to answer some of the more fundamental or pressing questions – such as the level of need, access challenges, and outcomes. Periodic investments into mental health research, organised and initiated through *Ara Poutama Aotearoa*, has been well considered and aligned with the needs of the organisation. The recently supported Neurodiversity Study[2] is a good example of this. However, there is a lack of strategic research planning or intent. And accordingly, little guidance in terms of how mental health research is planned, prioritised, integrated, and ultimately translated into mental health gains.

What will be required is a more organised and deliberate approach to mental health research within *Ara Poutama Aotearoa*.

Catalyst Three: Organisational Culture

One of the more challenging issues to emerge as part of this review has also been the most difficult to quantify and assess. Nonetheless, these issues have had a discernible impact on how care is delivered, and by extension, the outcomes achieved. In sites, settings, or environments where there was high levels of collegiality, professionalism, and adherence to policies and procedures existed, the care provided appeared to be more organised, seamless, and efficacious. Conversely, some services were less well positioned and often expressed concerns that internal tensions or external relationships would compromise care and outcomes. Solutions to these issues will be difficult to discern and implement, and are considered more fully with the relevant section of this review.

However, providing more purposeful operational guidelines and clearer expectations as to the relationships expected between health, mental health, custodial, and management teams, would be a positive step towards alleviating many of these tensions.

2 A research team, led by Auckland University of Technology, is undertaking an exploratory study to better understand the cognitive strengths and weaknesses of the prison population, using a culturally informed bespoke battery of neuropsychological tests.

Moreover, creating an environment where the opportunities for service delivery and enhanced mental health outcomes are maximised.

Catalyst Four:
Transition into the Community

This review has centred on the delivery of mental health services within our prison system, however, a range of concerns were also raised about those who transitioned into the community. Specifically, the lack of support available to them and the particular needs that were often missed during this transition process. To this end, and if health outcomes are to be sustained for those in our care, better arrangements are needed to ensure that post-release care and support is both effectively managed and cognisant of the complex range of barriers faced by those recently released from prison.

Catalyst Five:
Te Ara Whakamau: Strategic Alignment

Ara Poutama Aotearoa recently released a major proposal for change - *Te Ara Whakamua*. The proposal has been broadly designed to create the systems and structures upon which the future goals and aspirations of *Ara Poutama Aotearoa* could be advanced. While at the time of preparing this review the outcomes of this process are still unclear. This section raises a number of issues for consideration and as they relate to the future delivery of mental health services.

POU HUA: OUTCOMES AND RECOMMENDATIONS

This Executive Summary section offers a brief overview of the key findings from this review. With far greater detail provided within the body of this report. Moreover, and while some information has been provided as to various seminal recommendations, a suite of additional recommendations are also offered. These are summarised in the *Pou Hua: Outcomes and Recommendations* section of this report.

Notwithstanding the utility of these recommendations, and the extent to which they can be implemented, a major consideration will be to ensure that the resources required to drive change are in fact assessed and made available.

Summary Comments

This review has been incredibly complex. Not simply due to the quantity of information collected, or the vast number of groups and individuals spoken to. Nor due to the range of strategies, policies, initiatives, or investments (both historical and contemporary) which have required assessment and review. To a large extent, it has been the diversity of opinion, and variety of views collected, which has been the most difficult methodological or analytical challenge to overcome.

In spite of these difficulties, the most universally consistent finding from the review is that staff within *Ara Poutama Aotearoa* are incredibly passionate and committed to their work. They are eager to explore enhanced pathways for the delivery of mental health care and likewise new opportunities to improve mental health outcomes.

"...this is not the easiest job in the world...but we do it because we care about people, and we want to make a difference..."

Prioritising the need for security (over health service delivery) will mean that many of these challenges cannot easily be managed or resolved. Notwithstanding, the purpose of this review is not to simply itemise or elucidate these concerns – rather, to identify what enhancements are possible, where new opportunities for development and exist, and how mental health outcomes for those in our care can be improved.

Table 1: Pou Hinengaro - Recommendations

Pou Hinengaro: Mental Health Platforms	**Recommendations**
Platform One: Environmental Catalysts	1. Review prison sites to assess where opportunities to create more therapeutic environments exist. **(Medium-Term Investment)** 2. Continue to ensure that mental health is integrated into all parts of the Corrections system (e.g., policies, procedures, training). **(Medium-Term Investment)**

Platform Two: Mental Health Training and Awareness	3. Review and update of the current training programme for custodial staff to ensure there is sufficient training in mental health and trauma-informed care. This will include consideration of incentives that can be offered to staff to complete mental health training, consideration of the option of credentialling staff, and work to ensure that staff are given sufficient time to attend mental health training. **(Medium-Term Investment)**
Platform Three: Mental Health Promotion and Education	4. Develop and implement a mental health promotion and education framework which includes innovative approaches that address the unique needs of people in prison. **(Medium-Term Investment)**
Platform Four: Coordination and Integration	5. Implement a single-point-of-entry model for mental health referrals to ensure better integration and coordination between mental health services. **(Medium-Term Investment)** 6. Enhance the integration of services delivered by Psychological Services and Mental Health Services within Ara Poutama Aotearoa. **(Medium-Term Investment)**

Table 2: Pou Rautaki - Recommendations

Pou Rautaki: Mental Health Investments	**Recommendations**
Investment One: Therapy within a Prison setting	7. Review the evidence base to understand how mental health services can be delivered more effectively within the prison context, and update the current service delivery to reflect this. **(Medium-Term Investment)**
Investment Two: Women in Prison	8. Examine what enhanced (and more bespoke) models of mental health care for women might be possible, and implement any subsequent development opportunities. **(Medium-Term Investment)** 9. Improve training and information on the specific challenges faced by women in prison and the implications for mental health. **(Medium-Term Investment)** 10. Ensure that any health promotion and education initiatives that are introduced consider the needs of women (also refer recommendation 4.) **(Short-Term Investment)**
Investment Three: Cultural Catalysts	11. Investigate, develop, and support the implementation of culturally inspired mental health approaches within a bicultural delivery model. **(Priority Investment)** 12. Increase access to cultural supports (e.g., tohunga) and develop a clear framework for how these supports can assist with the delivery of mental health care. **(Priority Investment)** 13. Improve access to cultural activities and services which promote hauora (such as rongoā Māori), including a framework for delivering these types of support alongside existing mental health services. **(Priority Investment)** 14. Investigate factors which may contribute to inequitable access to mental health services for Māori, and implement any opportunities that arise from this investigation that address any identified inequities. **(Short-Term Investment)** 15. Develop a framework to support improved whānau engagement as part of mental health service delivery. **(Short-Term Investment)**

Investment Four: Workforce Development	16. Undertake a comprehensive review of mental health workforce development strategies that focuses on the specific needs of Ara Poutama Aotearoa (aligned to existing internal initiatives, as well as initiatives led by other agencies). **(Short-Term Investment)**
Investment Five: Workforce Retention	17. Develop a formal and comprehensive workforce retention strategy which considers factors such as mitigation of environmental and clinical challenges, professional development pathways, job security and renumeration. **(Long-Term Investment)**
Investment Six: Logistical and Resource Challenges	18. Increase access to therapeutic spaces within prisons, and enhance the quality of currently available spaces (i.e., fit-for-purpose therapy rooms) **(Short-Term Investment)** 19. Improve use of existing systems to ensure greater access and continuity of care for people who require mental health support (e.g., mental health alerts, transferability constraints etc.) **(Medium-Term Investment)** 20. Develop mental health-focused therapeutic communities within prison units (including in high and maximum security). **(Long-Term Investment)** 21. Review processes by which medication is administered to identify areas for improvement, efficiency and flexibility (particularly with regard to the timing of medication administration). **(Medium-Term Investment)** 22. Consider how mental health services can be more effectively delivered for people with high security classifications, acknowledging safety challenges and custodial supervision requirements. **(Medium-Term Investment)** 23. Explore how technology (e.g., video-technology, online courses, prison televisions, phones or tablets) might be used more effectively to support prisoners in accessing mental health care and resources. **(Medium-Term Investment)**
Investment Seven: Roles and Responsibilities	24. Develop and implement a mental health staff allocation model which ensures appropriate baseline staffing levels at each site, to enable the effective delivery of mental health services. **(Priority Investment)** 25. Establish Intervention and Support Practice Teams at prison sites that do not currently have these teams. **(Short-Term Investment)** 26. Review the roles and responsibilities of existing mental health staff to ensure effective delivery of mental health service delivery models, and that staff are delivering support which is appropriate to their scopes of practice. **(Short-Term Investment)** 27. Phase out trauma counsellor and trauma focused roles (with a focus on strengthening all clinicians' skills in responding to trauma related issues). **(Short-Term Investment)** 28. Explore ways in which a lived experience perspective can be built into the design, delivery and governance of mental health services. **(Short-Term Investment)**

Investment Eight: AoD and Mental Health	29. Integrate the roles of mental health staff and addiction staff working in the community. **(Medium-Term Investment)** 30. Integrate addictions clinicians into Intervention and Support Practice Teams. **(Medium-Term Investment)** 31. Develop a more coordinated approach to assessment, treatment and training across mental health and addictions services. **(Medium-Term Investment)** 32. Provide mental health support for people undertaking existing prison based intensive AoD treatment programmes (i.e., Drug Treatment Programmes). **(Medium-Term Investment)**
Investment Nine: Forensic Mental Health Services	33. Develop a service level agreement with Forensic Mental Health Services which clarifies key roles and responsibilities with respect to mental health service delivery within Ara Poutama Aotearoa. **(Priority Investment)** 34. Collaborate with Forensic Mental Health Services on initiatives to address workforce issues (also refer recommendation 16). **(Short-Term Investment)** 35. Improve the process of referral to Forensic Mental Health Services within prisons (also refer recommendation 5). **(Medium-Term Investment)** 36. Collaborate with Forensic Mental Health Services to ensure that effective data and information sharing practices are occurring, with respect to people in prison who are receiving forensic-level support, and those who are receiving, or are requiring, mental health inpatient admission. **(Short-Term Investment)** 37. Collaborate with Forensic Mental Health Services to consider additional options for improving mental health service delivery within prisons and addressing, or identifying innovative solutions to mitigate, issues such as challenges with accessing mental health inpatient beds. **(Medium-Term Investment)**
Investment Ten: Young People (Emerging Adults)	38. Develop a process for ensuring that young people in our care are prioritised in relation to accessing and receiving mental health support. **(Short-Term Investment)** 39. Review and update security placement processes for young people, including consideration of the role of mental health services in these processes. **(Medium-Term Investment)** 40. Develop settings which allow young people time to settle before discerning placement/ security class decisions. **(Long-Term Investment)** 41. Provide opportunities for early engagement for young people with mental health services during the settling in and adjustment phase. **(Short-Term Investment)** 42. Undertake targeted, translational research into the mental health needs of young people in prison (also refer recommendation 44). **(Medium-Term Investment)**

Table 3: Pou Kokiri - Opportunities for Development

Pou Kokiri: Mental Health Catalysts	**Recommendations**
Catalyst One: Measuring success	43. Improve the ways in which outcomes data is collected, analysed and reported within Ara Poutama Aotearoa, including: • the development of a new bespoke mental health outcome measure, and • investigation into additional ways to collect service user's perspectives and levels of satisfaction with mental health service delivery. **(Medium-Term Investment)**
Catalyst Two: Research Activity	44. Prepare a strategic mental health research agenda which details research needs and opportunities, research priorities, research translation, funding requirements and options, workforce issues and potential collaborations, and recommendations (including a roadmap) for implementation. **(Medium-Term Investment)**
Catalyst Three: Organisational Culture	No specific recommendations are proposed. This area is to be addressed within and alongside other investment areas and which consider workforce development and retention, mental health training and awareness, and the better integration of mental health into Corrections' broader policies, procedures and strategies.
Catalyst Four: Transition into the Community	45. Implement improvements to relevant policies and procedures to ensure greater continuity of mental health care for people who transition between prison sites or are released. **(Short-Term Investment)**
Catalyst Five: Te Ara Whakamua	46. Conduct a review following the implementation of Te Ara Whakamua to understand the impacts that this has had on mental health service delivery within Ara Poutama Aotearoa, and what improvements can be made. **(Short-Term Investment)**

INTRODUCTION AND BACKGROUND

There is no shortage of irony in the knowledge that New Zealand's first mental health facility was attached to the Wellington Jail in 1847. The reasons for this were both pragmatic and philosophical. But with little evidence to suggest that creating enhanced opportunities for therapy was a primary motivator. For the most part, notions of treatment and rehabilitation were largely offset by colonial perceptions of mental illness. A collective fear of those whose behaviours did not conform to the conventions of the day and where these types of restrictive environments would serve to not only ensure public safety, but to also reduce the perceived risk of contamination.

While the practice of accommodating the mentally ill within jails was not widespread and relatively short-lived, the approach was to find favour in various parts of the country and throughout the 1800s. In some instances, the lines between mental health and incarceration were to be blurred even further when, in 1872, a decision was made to construct a network of regional lunatic asylums. Although these new facilities did mean that patients were no longer housed within jails – the architectural design of the asylums bore a remarkable similarity to the facilities they were designed to replace. Oftentimes placing the need for security and public safety above the desire to provide treatment and care, typically resulting in these asylums being constructed in remote, isolated, or rural locations.

"The asylums, which had been humane and effective alternatives for the care of the mentally ill, became large, physically isolated institutions which were little more than great crowded warehouses of despair."[3]

Although these connections and similarities have received a degree of academic debate and inquiry, these examinations have (to a large extent) been framed as simply historical curiosities. A colonial relic of an age when mental illness was poorly understood and as a broader illustration of how far contemporary approaches to treatment and care have evolved and advanced.

This is certainly true - for the most part at least - and in that the deleterious impacts of restrictive and remote environments is now well-understood. Likewise, the idea that community connection, engagement, purpose, and whānau are essential to mental health and wellbeing. The drivers of illness, although far from being completely understood, are now known to emerge from a mix of organic and non-organic catalysts. A complex and dynamic interplay of factors which are difficult to predict and even more challenging to ameliorate.

Yet, and in spite of all that we have learned, an uneasy connection between the mental health and corrections sectors has remained. And while the health sector has long-since recognized the futility of providing care within restrictive, isolated, and remote settings – correctional facilities have not been so fortunate. There are of course various reasons for this, and in that the seminal function of prisons is to incarcerate, to provide security and remove liberty, and (by extension) to execute punishment for crimes committed. These are in fact "ensuring-truths" or principles which cannot easily be removed or transposed. However, an equally important question emerges from this discussion. That is, and in spite of these challenges – how can mental health treatment and care best be provided within a prison environment? An environment where the needs of patients are typically far more complex than those in the community, where conventional approaches to care are ill-suited, and where the setting itself may in fact be a driver of illness.

This report is therefore designed to explore and investigate these issues. To consider the broad range of clinical, structural, philosophical, logistical, and at times judicial challenges of providing care within a corrections environment. Further, and perhaps more importantly, to offer key guidance on how mental health services within New Zealand prisons might best be delivered and to achieve the best possible outcomes.

While this report has been endorsed by the Chief Mental Health & Addictions Officer and Chief Māori Health Officer, further consultation will be undertaken within the Department of Corrections to decide whether, and how, each of the recommendations outlined in the report will be implemented, with an initial focus on progressing the priority investments.

AIMS AND OBJECTIVES

To ensure that the outcomes and recommendations described within this review were informed by a robust

3 K. Mason, (1988), Psychiatric Report: Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients, Department of Health, Wellington, p. 135

and structured process, a single aim or research question has been established:

What types of services should be provided across Prison sites to deliver the best possible mental health outcomes?

Attached to this question were a set of six secondary objectives:

1. *To broadly describe past and current approaches*
2. *To understand strengths, existing challenges, and potential opportunities for development*
3. *To explore where gaps in service delivery exist. And to identify potential remedial pathways.*
4. *To provide clear and detailed recommendations on how enhancements to the delivery of mental health services, could be introduced,*
5. *To investigate the potential impact of environmental and structural barriers, and;*
6. *To ensure that the recommendations provided are pragmatic, solution focused, and ultimately contribute to improving mental health outcomes.*

METHODS

The aim and objectives of this review are both broad and ambitious. This is deliberate, and designed to ensure that all possible opportunities are identified, examined, and assessed for relevance. Likewise, that these are informed by robust evidence, and derived from a well organised and structured methodological process. A detailed methodology has been developed for this purpose and is included as an addendum to this report. As the process of data collection took place, changes to the formally described methods were required. In part, to account for unforeseen challenges, but to also take advantage of data collection opportunities which were not previously considered. To this end, the methodology is bespoke to this review and describes the various processes used to collect, store, examine, and synthesise information. How data was collected, why, from who, and to what extent. How this material is then prepared and organised and how various triangulation protocols were included to assess (and re-assess) the findings and recommendations.

Included as part of the methodology are a set of principles. These are designed to both elevate and guide the investigation. To ensure that an appropriate focus is maintained and that the outcomes (especially) have utility and are fit for purpose. The interpretation and application of the methodology has been nuanced – as the review progressed, in order to best align with the expected timelines and the availability of staff/ informants. Likewise, by assessing and prioritising data requirements. This organic and iterative approach allowed for information to be collected in the most efficient and least disruptive manner. Moreover, to ensure that timelines did not compromise the overall integrity of the report findings and recommendations.

To this end, this report has been informed by numerous interviews and discussions, surveys and schedules. Both formal and informal engagements, both virtually and in person, with staff and clinicians, whānau and iwi representatives, policy makers and strategists, academics and researchers, custodial staff, managers, independent experts, special interest groups, paeora, tohunga, and cultural advisors. Comprehensive and targeted reviews of relevant literature were also undertaken and which included both internal and external documents and papers, policies, evaluations, data reports, both grey and published material. As well, and perhaps most significantly, numerous site- visits were organised and provided an opportunity to examine and detail the various issues experienced by those charged with the delivery of care. Likewise, what potential solutions to alleviate these could be considered.

Presentations, meetings, and hui were also organised – partly as a means of collecting data, but to also feedback on developments, initial learnings, and potential pathways or outcomes. This process, as well, helped facilitate the data analysis and triangulation protocols important to validating the conclusions and recommendations.

PARAMETERS AND LIMITATIONS

With most reviews, the convention is to highlight limitations towards the end of the document and so that any conclusions are appropriately contextualised or framed. However, elevating these discussions to the beginning (rather than end) of the review will help better discern how and why a particular approach or path was preferred – and especially when presenting the recommendations.

To this end, the review has been mindful to ensure that the recommendations could be applied as seamlessly and effectively as possible. Meaning that care has been taken to frame these in ways which supported their integration or application within existing structures, policies, or standards. This did not mean that new and innovative approaches were set-aside. Indeed, a

primary driver has been to consider where possibilities for transformational change might exist. However, emphasis was placed on the identification of pragmatic and meaningful solutions, rather than those which may be too philosophical or theoretical and therefore struggle to find traction.

As well, it was not possible to engage with all sites, or to interview every potential informant. For various logistical and temporal reasons a different methodological approach was adopted. An approach which allowed themes and narratives to be clustered, assessed, and reviewed, through the process of data-saturation. Rather than a more quantitative approach which was heavily reliant on sample size and representation.

MENTAL HEALTH WITHIN A CORRECTIONAL SETTING

Few issues can be understood without firstly understanding its context - the environment within which it sits, the factors which serve to support and confound, and which shape both the challenges and perceived opportunities. Reviews of literature are typically used for this purpose and by drawing upon the research and expertise of others, by sifting through relevant (and oftentimes irrelevant) information and until a picture emerges through which a foundation or context can be set.

For this review, there has been no shortage of data, literature and information which has set to explore the various relationships, connections and tensions that exist between the mental health and corrections sectors. The challenge, however, will be to discern the utility of this material, and to express these insights in ways which are relevant and informative. International studies, for example, can hold considerable insight, but will need to be reviewed cautiously - and so that these data can be interpreted through a local lens. Some fields of research may likewise hold considerable interest and be the subject of high-levels and public and academic debate. But – may just as easily be out of scope or only of cursory interest.

Criminological research highlights this issue. In that although these studies provide valuable sources of information – there is no guarantee that this will be relevant or within scope – at least for what is required here and for this particular review. To a large extent, criminological interest in psychological discourse has centred on exploring how mental health (or illness) may be used as a predictor or rationalizer of crime and criminal activity. The idea being that crimes (especially those which are particularly heinous) are not simply inspired by criminal intent or opportunity, but are motivated by pathologies which can drive these actions and behaviours. Attempting to draw these types of associations is not without controversy. While forensic clinicians will rightly attest to the fact that some crimes may, have, and will be precipitated by mental illness – they will just as quickly cast doubt on any attempts to formulate an absolute or binary position. Noting that these connections must be approached with caution and in the knowledge that rationalising criminal behaviour, through a diagnostic lens (and for judicial intent) can be fraught.

The point here is that although reviews of literature and research will be critical to establishing a base and foundation for this study, the challenge will be to discern what information is most relevant and what should be left aside. Likewise, how this data is synthesised in ways which contribute to context as well as the establishment of valid conclusions and recommendations.

Having considered these parameters, the issue then turns to what information should be sourced and expressed. How this can provide the context required, and the imperative to undertake this type of investigation. Epidemiological data is ideal in this regard and can offer useful information on prevalence, severity, demographic and ethnic characteristics and any number of other variables. Likewise, and depending on design and scope, insights into potential drivers and mitigators. Methodological challenges, especially within a correctional setting, have however confounded efforts to provide accurate profiles and to draw comprehensive conclusions – particularly in terms of the prevalence of mental illness within a prison environment.

For the most part, these methodological challenges are well-known, and which have typically centred on the technicalities of securing a suitable sample size, the utility and validity of assessment tools, the collection and interpretation of information, and the ability to control for a wide array of variables and confounders. Similarly (and often uniquely) the logistics of simply obtaining access to participants within prisons, allaying safety concerns, and the process of securing informed consent in an ethically robust manner.

Putting these issues aside, epidemiological insights can effectively respond to the most fundamental of

questions – that is, why is this type of study needed. In this regard, and notwithstanding various technical and methodological variances - there is remarkable consistency with respect to three primary conclusions which emerge throughout the epidemiological literature.

The first is that the prevalence of mental illness amongst the prison population will not mirror that of the general or community population. Rates of illness will typically be higher, across almost all diagnostic categories, for both men and women, and even when controlling for any number of socio-economic or demographic factors. Second, these issues are likely to be more complex and co-morbid – most commonly anxiety and depression with significantly higher rates of alcohol and substance misuse. Third, higher levels of deprivation (prior to incarceration) and when compared to the general population will also feature – homelessness, unemployment, as well as a greater likelihood of being victims of sexual and domestic abuse (particularly for women).

These three tenants are consistent across almost all epidemiological studies - both in New Zealand and overseas. Often irrespective of what methodology is employed, the diagnostic tools used, when the study was undertaken, and the relative sample size and location. The point being, that although no methodology or approach will be ideal, when viewed collectively, a number of compelling conclusions can be drawn.

"Where studies of mental illness have been conducted with prison populations, the prevalence has been consistently shown to be high. There is no reason to believe that countries which have not conducted such surveys will have significantly different prevalence rates."[4]

This type of preface is important when attempting to draw meaning and conclusions from any studies conducted within New Zealand and on the local prison population. The fact being, that while our local studies may not be as sophisticated, timely, or comprehensive as some of the larger international cohorts, their utility in terms of what they reveal or imply will remain valid.

4 https://www.euro.who.int/ data/assets/pdf_file/0017/249200/Prisons-and-Health,-11-Mental-health-in-prison.pdf (15/01/23)

Especially when viewed alongside corroborative findings garnered from larger and more recent investigations.

Two of the most comprehensive and locally relevant prevalence studies took place some 15 years apart – in 1999 and 2015. But have nevertheless been critical to framing discussions on why initiatives to support mental health within our prisons should be prioritised. The most recent of these studies[5] offered insights into the 12 months leading up to the clinical interview. Results were clustered into 12 diagnostic categories with the results summarised below;

MENTAL DISORDERS

- Nearly all (91%) prisoners had a lifetime diagnosis of a mental health or substance use disorder and 62% had this diagnosis in the past 12-months.
- Female prisoners were significantly more likely to have a 12-month diagnosis of any mental disorder than male prisoners (75% compared to 61%).
- General population comparison: Prisoners were three times more likely than the general population to have a 12-month diagnosis of any mental disorder (62% compared to 21%).

ANXIETY DISORDERS

- Just over one in five (23%) prisoners had an anxiety disorder diagnosis in the past 12-months, while 30% had a lifetime anxiety diagnosis.
- Female prisoners had a significantly higher prevalence of post-traumatic stress disorder compared to males for both 12-month and lifetime diagnoses, with over half (52%) of women having a lifetime post-traumatic stress disorder diagnosis.
- General population comparison: A lifetime post-traumatic stress disorder diagnosis was four times higher among prisoners (24%) than in the general population (6%).
- Prison population comparison: The lifetime prevalence of generalised anxiety disorder was just over 1% in the 1999 prisoner mental health study which had increased to nearly 9% in 2015, while the lifetime prevalence of panic disorder had also increased from nearly 2% in 1999 to nearly 6% in 2015.

MOOD DISORDERS

- Nearly a third (32%) of prisoners had a lifetime diagnosis of any mood disorder, while 24% had a 12- month mood disorder diagnosis.

5 https://www.corrections.govt.nz/data/assets/pdf_file/0013/13603/Comorbid_substance_use_disorders_and_mental_health_disorders_among_NZ_prisoners_June_2016_final.pdf

- When compared to other ethnic groups, Māori prisoners had the lowest prevalence of lifetime diagnosis of major depressive disorder (17%).
- General population comparison: The 12-month prevalence of any mood disorder was three times higher for prisoners (24%) than in the general population (8%).
- Prison population comparison: When compared to the 1999 prisoner mental health study, the lifetime prevalence of major depressive disorder decreased slightly (from 23% to 21%), the lifetime prevalence of bipolar increased from 2% to 11%, and dysthymia increased from 1% to 5%.

SUBSTANCE USE DISORDERS

- A substantial majority of prisoners (87%) had a lifetime diagnosis of a substance use disorder, and just under half (47%) had a 12-month diagnosis of a substance use disorder.
- Marijuana was the most prevalent drug of abuse with 24% of prisoners having a lifetime diagnosis, while stimulants were the most common drug of dependence with 23% having a lifetime diagnosis.
- General population comparison: Prisoners were seven times more likely to have a lifetime prevalence of any substance use disorder compared to the general population.
- Prison population comparison: The prevalence of stimulant abuse and dependence (combined) had increased nearly 10-fold since the 1999 prisoner mental health study, from 4% reported in the 1999 study to 38% (15% for abuse and 23% for dependence) in 2015.

EATING DISORDERS

- The lifetime prevalence of eating disorders among prisoners was 5%, while 3% were found to have a 12-month diagnosis.
- The prevalence of eating disorders was twice as high among female prisoners as among male prisoners, for both 12-month (7% compared to 3%) and lifetime (10% compared to 5%) diagnoses.
- General population comparison: Prisoners were seven times more likely to have a 12-month eating disorder diagnosis than the general population (3% compared to 0.5%).
- Prison population comparison: The lifetime prevalence of eating disorders increased five-fold (from 1% to 5%) from the 1999 prisoner mental health study to the 2015 study.

COMORBIDITY

- One in five (20%) of prisoners were found to have a 12-month diagnosis of a comorbid mental health and substance use disorder, while 42% were found to have a lifetime comorbidity diagnosis.
- Comorbidity was higher among women than men, for both 12-month and lifetime diagnoses.
- There was little variation by ethnicity for the lifetime and 12-month prevalence of comorbidity, with the highest rates found among prisoners of European descent.
- Prisoners with a lifetime diagnosis of a substance use disorder had almost half (48% compared to 93%) the prevalence of comorbidity compared to people with a lifetime anxiety disorder.

MULTIPLE DISORDERS

- Two-thirds (66%) of prisoners were found to have two or more lifetime diagnoses of a mental or substance use disorder, while 31% were found to have two or more 12-month diagnoses.
- A higher proportion of female prisoners (72%) compared to male prisoners (65%) had a lifetime diagnosis of two or more mental health and substance use disorders.
- A high proportion of prisoners diagnosed with a lifetime anxiety (84%) or mood (81%) disorder were found to have a lifetime diagnosis of three or more disorders, compared to 40% of prisoners with a substance use disorder.
- General population comparison: Prisoners were nearly four times more likely to have two or more 12- month diagnoses of mental health and substance use disorders than the general population (30% compared to 8%).

PERSONALITY DISORDERS

- One in three (33%) prisoners was found to have a clinically significant personality disorder, with a slightly higher prevalence among men than women.
- The most common personality disorders detected were paranoid (15%), antisocial (11%), obsessive-compulsive (10%) and borderline (9%).
- The highest prevalence (46%) of personality disorders were found among prisoners with a lifetime comorbid mood disorder diagnosis.
- Prison population comparison: The lifetime prevalence of personality disorders was nearly twice as high (60% compared to 33%) among New Zealand prisoners in 1999 compared to the current 2015 study.

PSYCHOSIS SYMPTOMS

- The lifetime presence of psychosis symptoms (such as seeing visions and hearing voices) was present in 13% of prisoners, and in 7% of prisoners in the past year.
- Prisoners with a lifetime diagnosis of an anxiety (23%) or mood (20%) disorder had the highest prevalence of ever experiencing symptoms of psychosis compared to 13% overall.
- Prison population comparison: The lifetime prevalence of schizophrenia and related disorders was estimated to be 6% in the 1999 prisoner mental health study, while 12% of prisoners were found to report symptoms of psychosis in 2015.

PSYCHOLOGICAL DISTRESS

- Over one in four (28%) of prisoners experienced psychological distress in the past 30 days.
- There were significantly higher rates of psychological distress among female (47%) compared to male (27%) prisoners.
- The prevalence of psychological distress was more than twice as high (60% compared to 28%) for prisoners with a 12-month diagnosis of an anxiety disorder compared to the total.
- General population comparison: Prisoners were nearly five times more likely (28% compared to 6%) to have experienced psychological distress in the past 30 days compared to the general population from the 2013/14 New Zealand Health Survey.

SUICIDAL BEHAVIOURS

- Over one-third (35%) of prisoners had ever thought about suicide, 17% had ever made a suicide plan and 19% of prisoners had ever attempted suicide.
- Female prisoners had higher rates of suicidal behaviours than men, including ever thinking about suicide (44% compared to 34%) and ever attempting suicide (29% compared to 18%).
- General population comparison: Prisoners had higher rates of suicidal behaviours than people in the general population, including being twice as likely to have ever thought about suicide (35% compared to 16%) and four times as likely to have ever attempted suicide (19% compared to 5%).

MENTAL HEALTH TREATMENT

- Nearly half (46%) of prisoners diagnosed with a 12-month mental health or substance use disorder had received some form of mental health treatment in the past year.
- Female prisoners had significantly higher rates of mental health treatment than males for nearly all disorders, including 60% of women with a 12-month diagnosis of any mental disorder obtaining mental health treatment compared to 45% of men.
- Pacific peoples were substantially less likely to access health services for their mental health than prisoners of European descent (33% compared to 54%).
- General population comparison: Fewer than half (46%) of prisoners with a 12-month diagnosis of any mental disorder received some form of mental health treatment in the past year, which was slightly higher (39%) than found in the general population.

The issues revealed by these data are in many ways unsurprising and broadly consistent with what has been revealed internationally. Most significantly, the high-level assertion that the mental health profile of prisoners is considerably different to that of the general population – especially in terms of prevalence, acuity, and complexity. Leading on from this is the idea that conventional or community-based approaches to addressing these concerns are unlikely to achieve outcomes which are either meaningful or sustainable. What will be required is a comprehensive re-think of how mental health is approached within a prison setting and what options to better challenge these concerns are possible.

MĀORI, MENTAL HEALTH, AND CRIMINAL JUSTICE SYSTEM

"…when the large mental health facilities closed in the late 1980s many celebrated the fact that our people [Māori] would no longer be institutionalised. Sadly, when you look at the number of Māori within prisons, I can't help but think that we simply replaced one mental health institution for another..."

Quite apart from the knowledge that the mental health profile of our prison population is in contrast to that of the general population, is the understanding that the ethnic composition of our prisons is similarly incongruent. Indeed, there is often a sense of

trepidation (within the Māori community at least) when statistical information on the New Zealand prison population is either reviewed or released. The unfortunate reality is that when these data are prepared, the focus inevitably centres on the disproportionately high numbers of Māori within our correctional facilities – 52% of the prison population are Māori - yet Māori constitute less than 18% of the general population.[6]

These numbers have often been used to highlight the needs of Māori, and likewise to employ strategies aimed at reducing Māori levels of incarceration and recidivism. However, so too have these been used with more pernicious intent, and when cultural, ethnic, genetic, or physiological factors – unique to Māori, are used to explain or rationalise high rates of Māori incarceration. The idea being that Māori are somehow predisposed to engaging in criminal activity and that these factors can be used to rationalise maladaptive or anti-social behaviours. By doing so, it then becomes possible to frame Māori as the problem, to pathologize ethnicity, and (by extension) to explore solutions by moderating ethnic or cultural characteristics.

These interpretations, however, lack the sophistication and insight through which more reasoned and evidence-based conclusions can be formulated. When in fact, the drivers of crime have little to do with ethnicity – or for that matter culture. And are more so connected to a broad range of environmental conditions which not only drive criminal endeavour but likewise serve to better elucidate and explain these data. Low levels of employment, poor experiences of education, poverty, and homelessness (for example) are all well-known drivers of crime. So too are an array of factors which cannot be so easily located or quantified.

This may include feelings of isolation or disengagement from communities or societal institutions. Thoughts of hopelessness and a lack of self-worth. Coupled with the inevitable frustrations that emerge from being unable to control one's life or destiny. A place where choices are limited and optimism for the future significantly compromised. Issues which can often be sourced to negative historical or colonial experiences and which are further amplified due to the loss of culture and identity. All said - these challenges are consistent with the realities and experiences of many Māori. And, provide a far more sophisticated reasoning for these data and for the high rates of Māori incarceration.

6 54% Male, 64% Female. NB. 90% of the Māori prison population are Male.

The mental health sector has likewise faced similar challenges. Especially when attempting to unpack the elevated and disproportionately high rates of mental illness amongst Māori. The parallels with the prison population (while concerning) are not unsurprising. We know for example, that the lifetime prevalence of mental illness amongst the Māori population is also greater than 50%. Further, and when compared to non-Māori, Māori are likewise more likely to have comorbid and complex conditions, have higher levels of acuity, poorer access to care, and inconsistent treatment opportunities. By cross-referencing these data against various socio-cultural, economic, and demographic variables a similar picture emerges. Significantly, that the elevated rates of mental illness amongst the Māori population has no causal relationship with either ethnicity or culture and is far more likely to be governed by social, environmental, historical and economic pressures. All of which disproportionately impact Māori.

The differences between the health and corrections sectors are often stark. At least in terms of structure and philosophy. However, and for Māori, there are a number of remarkable similarities and which align to form three key conclusions.

The first is that the elevated rates of illness and incarceration experienced by Māori cannot be attributed to ethnicity, nor framed as uniquely criminogenic or pathological. The evidence is clear and overwhelming and which points to the profound impact that historical and environmental stressors can have. Further, that a broad array of catalysts (past and present) have collectively led to these impacts being disproportionately felt by Māori.

The second, is that sustainable solutions to these problems must be comprehensive enough to account for these complex and diverse challenges. Moreover, and while reintegration or recidivism programmes (within Prisons) or treatment and care services (for mental health) may provide immediate impact or relief – rates of incarceration and levels of mental illness are unlikely to improve and unless these initiatives are aligned to broader strategies which promote and sustain Māori development.

The third and final point is that although ethnic culture is not seen as either a driver of crime or mental illness, it may play a significant role in shaping potential solutions. Both the mental health and corrections sectors have variously explored ways in which this may be achieved and there is mounting evidence to support the efficacy of these culturally inspired interventions. However, these initiatives have often taken place

independently and in ways which have not allowed these ideas to coalesce in ways which promote mutual benefit. By exploring resonant ideas, it may be possible to develop new and innovative approaches to mental health care within prisons. Care which is underpinned my Māori worldviews, and which is capable of producing outcomes not previously possible. These ideas are explored in considerably more detail, later in this report.

MĀORI CENTRED SOLUTIONS

In light of the previous discussion, *Ara Poutama Aotearoa* has for some time recognized the potential of culture, Māori values and processes, to promote more positive outcomes for Māori. While not always specific to mental health, these investments have nevertheless occurred at multiple levels and throughout the organisation. Strategies to engage and recruit more Māori staff throughout *Ara Poutama Aotearoa* and within a range of roles. Including custodial, policy, administration, management (and senior management) clinical, and cultural positions, as well as new teams and structures designed to better advance the strategic aspirations that *Ara Poutama Aotearoa* have for Māori. Likewise, a broad range of motivational, therapeutic, cultural enhancement and tikanga inspired programmes, units, pilots, and assessment tools have been developed and implemented. Most of which have been shown to deliver positive outcomes and which have further highlighted the value of culturally inspired solutions.[7]

Notwithstanding the utility of these investments, and the desire to proactively address the disproportionately high numbers of Māori within prisons, these programmes have not always been supported in a coordinated or sustainable manner. Meaning that the outcomes anticipated were not always realised, and that opportunities to develop mutually beneficial and supportive relationships did not always manifest. The *Hōkai Rangi* strategy was developed, in part at least, to better organise and consolidate these investments. And to support a more coordinated and outcomes focused approach to the implementation of Māori focused initiatives.

Covering the period from 2019 to 2024, *Hōkai Rangi* is a six-year strategy designed to deliver better outcomes for Māori, and to provide solutions aimed at reducing the high number of Māori within prisons.

Hōkai Rangi expresses our commitment to delivering great outcomes with and for Māori in our care and their whānau, so that we can begin to address the significant over-representation of Māori in the corrections system[8].

The strategy is based around six key areas or investments;

- Partnership and leadership
- Humanising and healing
- Whānau
- Incorporating a Te Ao Māori worldview
- Whakapapa, and
- Foundations for participation

Partnership and leadership centres on best-practice leadership and shared decision making, *Humanising and healing* promotes the idea of a values led organisation – one which is designed to uphold mana and dignity, Whānau emphasises the important of family to achieving and supporting collective outcomes, Incorporating a *Te Ao Māori worldview* highlights the value of culturally inspired initiatives, *Whakapapa* links to identity and belonging, while *Foundations for participation* emphasises the rights of all to fully participate in society and within their communities.

The strength of *Hōkai Rangi* is in part derived from the fact that clear investments and initiatives are attached to these principles and that short-term, medium-term, and long-term outcomes are identified. Viewed collectively, these key focus areas illustrate a comprehensive and well-considered suite of activities. All intended to work in concert with each other and which have likewise been informed through consultation with key Māori stakeholders. Quite apart from its integrated design, *Hōkai Rangi* also draws heavily from various cultural themes and priorities. Collectively motivated by the idea that strategies to support Māori must be underpinned by a strong cultural foundation.

To this end, it will be essential that the outcomes and recommendations generated from this review are aligned to the *Hōkai Rangi* strategy. In part due to ensure strategic alignment - but more significantly will be the potential to garner mutually beneficial outcomes.

7 For example: Specialist Māori Cultural Assessment Tool, Tikanga Māori Programmes, Te Ara Māori Units, Te Tirohanga, Mauri Tu Pae, Te Kupenga, Whare Oranga Ake, Tiaki Tangata, Māori Pathways

8 Department of Corrections. (2019). Hōkai Rangi: Ara Poutama Aotearoa Strategy 2019-2024. Wellington. NZ Government

TE MATATIKI O TE ORANGA

Action 2.4 of the *Hōkai Rangi* strategy called for the development of a Kaupapa Māori health service, inclusive of rongoā Māori, and which was centred on the wellbeing of whānau, hapu, iwi, and hāpori Māori. Given the conceptual and philosophical challenges of constructing a Kaupapa Māori service within a crown agency, Action 2.4 was reframed as *Te Matatiki o te Oranga*. A service that would be underpinned by Te Tiriti o Waitangi and Kaupapa Māori principles and as a key mechanism for achieving Pae Ora.[9] While work on the development and design of *Te Matatiki o te Oranga* is ongoing and not currently complete, the summary objectives of the service are described below.

Te Matatiki o te Oranga is responsible for determining how health services will be developed and delivered to people in our care, focusing on improving Māori health outcomes, reaching Pae Ora and achieving health equity for Māori. This will be done through strengthening and building upon existing services and creating new services that meet the needs of people in our care; while restoring the imbalanced view of disease and disorder and elevating *mātauranga Māori* approaches.[10]

The objectives of this review are primarily centred on the design and delivery of mental health services. However, given the focus on Māori, and the desire to explore new and innovative modes of mental health care, there will be significant areas of alignment with *Te Matatiki o te Oranga.* Likewise, numerous opportunities to explore collaboration and to promote mutually beneficial outcomes. These opportunities are most evident within *Investment Three: Cultural Catalysts* – described later in this review, and where detail is provided on how mental health services for Māori might best be delivered within a carceral setting. Likewise, how concepts such as matakite can be explored as well as the opportunities to support mental wellbeing through the considered use of rongoā.

Investment Four: Workforce Development and *Investment Five: Workforce Retention* describe various workforce challenges. While these issues are again framed within a mental health context, a number of concerns (specific to Māori) are included and which will likewise help support the objectives of *Te Matatiki o te Oranga.*

Catalyst One: Measuring Success, highlights the need to develop and implement measures of mental health outcome which are better suited to the realities and expectations of those in our care. Part of this process will be the requirement to consider the cultural framing of these instruments and the extent to which these tools incorporate domains which match the expectations of Māori. It will be important, again, that these new tools are framed alongside *Te Matatiki o te Oranga* and so that gains for Māori can be maximised through a deliberate, collaborative, and well organised approach.

RESPONDING TO CHALLENGES

The complex profile and elevated rates of mental illness within our prisons has made it difficult to create solutions which are both sustainable and fit-for-purpose. Issues which are further compounded by logistical and structural challenges - challenges which are oftentimes unique to this setting and which cannot be ameliorated through conventional or established modes of endeavour. Simply put - the dual foundations of security and incarceration will typically moderate the impact of any potential solution or intervention.

In spite of this, numerous initiatives (over a number of years) have been introduced in order to better respond to the mental health needs of prisoners. Notwithstanding the desire to proactively respond to these challenges - the impacts and outcomes of these initiatives have not always been as efficacious or enduring as anticipated. Oftentimes lacking the resource, infrastructure, coordination or integration required to support success. Or simply not being afforded with the time and space to truly determine effectiveness.

Over the past five or so years greater emphasis has therefore been placed on consolidating the approach that *Ara Poutama Aotearoa* has taken to the delivery of mental health services. Moreover, to explore solutions that were more focused, cohesive, and consistent. These efforts were to receive a considerable boost in 2017 when services for people with mild to moderate mental health needs were introduced into Prisons. As a consequence, Packages of Care providers are now contracted to deliver up to six sessions of support, with *Improving Mental Health* (IMHS) service providers were also introduced to provide mental health support to provide support to people with mild to moderate mental

9 Pae Ora in this context refers to three key principles. Mauri Ora – Healthy Individuals, Whānau Ora – Healthy Families, and Wai Ora – Healthy Environments

10 Department of Corrections, 2023, Te Matatiki o te Oranga: Workshop Pre-Readings, Brentwood Hotel, Wellington. P3

health issues. In response to a recognised need for specialist support for women, trauma counsellors and social workers were also introduced at all women's prisons in 2017.

Also in 2017, the *Ara Poutama Aotearoa* received additional funding to improve intervention and support for people with moderate to high mental health needs. Specifically, for those who did not meet the criteria for support from Forensic Mental Health Services. This funding enabled *Ara Poutama Aotearoa* to pilot *Intervention and Support Practice Teams* (ISPTs) at Christchurch Men's Prison, Auckland Prison and Auckland Region Women's Corrections Facility. Initially intervention and support practice teams worked primarily in intervention and support units.[11] But, which has since been expanded to include support for people with moderate to high mental health needs across all units within each of these prison sites.

More recently, in 2021, three new ISPTs were established at Rimutaka Prison, Mt Eden Corrections Facility and Spring Hill Corrections Facility. One further ISPT was established at Otago Corrections Facility in 2022, and steps were being taken at the time of this review to recruit to one further ISPT at Waikeria Prison. Clinical nurse specialist (mental health) positions have likewise been created and situated at seven prison sites where *Ara Poutama Aotearoa* does not currently have ISPTs. These clinical nurse specialist roles provide expertise and help coordinate care by triaging referrals to ensure that support is provided by the appropriate service. Additionally, they can offer clinical services to those with moderate to high mental health needs.

All these initiatives were introduced with good intent – but it has again been difficult to assess their overall effectiveness, what further enhancements are needed, and whether or not a more bespoke delivery model is required. The reasons being that a conventional, community, or established mode of delivery is unlikely to find favour within a correctional setting. And, unless these are nuanced in ways which appreciate the complexity of this environment. A less well considered issue is the fact that the desire to innovate, has not always kept pace with the need to consolidate. The result being that a range of programmes have been trialled, piloted, or introduced - but have not always been coordinated in ways to support their success. What often eventuated was a suite of well-meaning, but loosely connected investments. Each with varying levels of impact, and which were frequently hamstrung by a lack of central coordination, or strategic alignment. Issues that were further compounded by short- term contracting arrangements – often driven by an uncertain funding environment.

All considered, these multiple issues help support a single consolidated conclusion. That, in order to improve the quality-of-service delivery, and the outcomes achieved, a new approach will be required. An approach which is capable of building on past successes, but which also identifies more innovative and sustainable solutions for future development.

TE ARA HINEGARO: PATHWAYS TO MENTAL HEALTH AND WELLBEING

Having provided some context to this review, this section describes the primary outcomes of the research and information collection process. These have been informed through a variety of methods, data collection, review, analysis, and validation protocols. Likewise, through active consultation and engagement with a broad range of primary stakeholders, key advisors, and experts, and which were complimented through presentations, hui, and wānanga.

Given the breath of information collected, and the range of views expressed, the organisation and synthesis of this data created a number of logistical and analytical challenges. Discerning how data and themes could be clustered and sectioned, and ultimately arranged in ways which supported both the findings and recommendations. In the end, four primary analytical sections were created.

The first, *Pou Arataki: Mental Health Principles*, has been organised into six sub-sections (principles), and describes the broad parameters upon which the outcomes and recommendations for this review have been framed.

The second section, *Pou Hinengaro: Mental Health Platforms*, is made-up of another four subsections (platforms), and considers the various environmental, social, cultural and public health drivers of health and wellbeing. Those which are unique to a prison setting, and which can be leveraged to improve population based opportunities.

The third section, *Pou Rautaki: Mental Health Investments*, contains 10 sub-sections (investments)

11 Intervention and Support units (ISUs) are specialised prison units which house prisoners who are vulnerable or who may pose a risk to themselves.

and draws greater attention to various service delivery, treatment and care opportunities identified as part of the review.

Pou Kokiri: Mental Health Catalysts, is made-up of five sub-sections (catalysts) and describes issues which are not always connected to service delivery but will be essential to maintaining quality and future growth.

POU ARATAKI: MENTAL HEA LTH PRINCIPLES

While the aims of this review are deliberately ambitious, and designed to bring about transformational change, a key aspect of this process will be to understand how improvement is defined, what changes are possible, and the limitations attached to this. Quantifying improvement is one of the more enduring challenges within the mental health sector. Oftentimes due to the fact that many conditions will be chronic. Without any expectation of cure, and where the best than can be hoped for is the ongoing management of a lifelong affliction.

How improvements are assessed, measured, and linked to an intervention or activity adds further complexity. Above all else, highlighting the value of setting expectations that are both cautious and measured - but also optimistic. Moreover, offering a suite of recommendations which can be implemented, that align with existing structures and policies, and which are both pragmatic and sustainable.

With these parameters in mind, there are five key principles which have been used to guide this review - and especially the recommendations. These principles were identified as part of discussions with a broad range of groups and individuals, across a variety of professions, and in light of the desire to ensure that the review was framed in a manner which would ultimately drive change and improve the mental health and wellbeing of Prisoners.

"…this review can't be just another review, or just another report or bit of paper which is written and then filed away. It needs to result in change, good change, and so that things improve. Some improvement, any improvement would be good. But you need to make sure as well that we can pick these recommendations up and run with them. It will be a waste of time if you write this up and nothing happens or if we can't actually use what's been written…"

PRINCIPLE ONE: TRANSFORMATIONAL CHANGE THROUGH MEASURED INVESTMENT

For the success of this review, navigating a course between optimism and realism will be key. To ensure that a focus on sustained growth and improvement is maintained, and that the inevitable tensions between what is desired, and what is possible, is well considered and appropriately managed.

Although the idea of prompting transformational change remains central to the success of this review, a key consideration is the notion that transformation with a correctional setting is likely to present differently to how this might appear within a community environment. Almost certainly, the options available to bring about change will be far more limited and oftentimes mitigated by environmental or structural factors not seen within community settings. However, it is also possible that initiatives which may seem to be relatively modest - at least from a community perspective - lead to outcomes which are disproportionately better than what might be expected in non-prison environments.

"…I can tell you what would improve the hauora of these men and especially their hinengaro and behaviour. Getting them better access to phone calls and their whānau. On the outside we take it for granted that we can just call someone, txt, or FaceTime them. Anytime we want. For the guys in here it's not the case at all. Small things like having a korero with whānau on the outside is something they really look forward to and can have a massive impact on how they behave. Taking that away can also cause a whole lot of other problems - and that's for everyone…"

The point here is that modest levels of change or investment (be they structural, organisational, or clinical) can have significant impact – especially within prison settings and in terms of mental health outcomes. Exploring what these are, and how they might be activated, will be key to the success of this review.

PRINCIPLE TWO: PRAGMATIC SOLUTIONS

Principle Two extends upon *Principle One* and highlights the value of framing the recommendations (as much as possible) to sit within existing operational models or frameworks. That is, working within current systems rather than looking to create entirely new approaches that may be unworkable, far too challenging to implement, or inconsistent with Departmental philosophies, strategies or workstreams.

There are both risks and opportunities here. The primary risk being that innovation is somehow stymied through the creation of parameters which are too restrictive or constrained. While working with or within existing organisational frames increases the likelihood of recommendations being both supported and implemented.

A balanced approach, therefore, will likely bring about the type of transformational change desired, while ensuring that any recommendations can be introduced seamlessly and in ways which support their success. What this means in practice is to discern recommendations that serve to improve mental health care and outcomes – and, which likewise avoid compromising other primary or operational functions of *Ara Poutama Aotearoa.*

This may result in new initiatives, structures or approaches, as well as added investment. Or, to simply use existing resources in more efficient or efficacious ways. A further point of leverage, for example, will be to consider how the recommendations identified here might support existing strategies or priorities - such *as Hokai Rangi, Hikitia, or Wahine: E Rere Ana ki te Pae Hou.*

"...we don't need more theory; we just need to know what will work..."

PRINCIPLE THREE: NUANCED APPROACHES

One of the more frequently raised issues to emerge as part of this review was the idea that community based, conventional, or established models of mental health treatment and care, policies, strategies, and interventions were ill-suited to a correctional setting. Indeed, a major challenge has been the inability to provide care or support due to the various restrictions required within a custodial environment.

"...While a shortage of clinical staff has certainly impacted the delivery of mental health care, the availability of custodial staff has caused similar challenges. To a large extent, custodial staff will drive and determine which health and mental health services can and cannot be delivered. With health staff routinely advised they cannot enter a unit because there is not enough custodial staff. As a consequence, tensions between custodial and health staff can develop. Issues which are not helped by both professions being understaffed. Delayed or cancelled escorts are common. Further still are the issues which inevitably arise when medication is not provided when required. Creating an environment which is even more unsafe than it already is..."

Many of these restrictions, be they structural, logistical, or legal, will be unable to be modified (for a range of reasons) and which therefore highlights the need for a more bespoke or nuanced suite of recommendations. This will not simply require the reinterpretation of models of practice but to further cast a more sophisticated lens on the extent to which any of the recommendations identified here are indeed fit-for-purpose and appreciative of the realities that exist within these settings.

"...security classification and placement directly affects the ability for Māori to receive mental health, rehabilitative, occupational, and educational services and to access wellbeing and leisure activities (rugby, outdoor exercise, gym). Placement in high and maximum security makes it more difficult to interact with staff due to restrictive regimes, movements, limited non-contact spaces, group rooms, psych staff numbers in maxi/ high security environments. Our best evidence-based rehabilitative interventions are provided in supportive therapeutic communities that are only available in lower security environments..."

Some of these unique characteristics have already been touched-on and include the fact that the prison population does not mirror the community population. The needs are likely to be more acute, more complex, and difficult to treat. Likewise, the setting itself may well be a driver of illness and create a range of additional challenges not typically found within the community. Conventional health education or health promotion programmes or initiatives (for example) are also likely to be unworkable within a Correctional Facility. Meaning

that opportunities for self-care, supportive conversations, and environmental engagements (all key to mental health and wellbeing) are quite simply not possible.

The point being, that unless the recommendations are nuanced in ways that appreciate or reflect upon these types of unique challenges, they are unlikely to produce the outcomes anticipated. Or at the very least – be significantly compromised.

"…how we do things here, and how they do it on the outside are different. We don't have the same access to resources, we don't have the same tools we can use and some of the models and strategies just can't be used. We have to work differently…And it's not just about moaning about what we can't do but to think creatively about what we can do…"

PRINCIPLE FOUR: COMPLEXITY AND DIVERSITY

This review is singularly focused on examining the mental health issues and opportunities within a correctional setting. However, it is clear that many of the concerns raised (and solutions provided) are unlikely to be universally felt. Given the range of issues observed and diversity of opinions expressed –sites, services, and staff will in fact experience challenges differently, and depending on any number of factors and variables. Access to resources, to staff, the type and range of services available, logistical and relational issues will all likely be different. And even in situations where these differences are subtle – the outcomes and implications can be more significant.

The key, at least for this review, will be to discern and account for these variances, while at the same time presenting issues of common interest, and at a level which resonates well enough to inform solutions which are accurate, meaningful, and relevant.

PRINCIPLE FIVE: PEOPLE CENTRED

The fifth principle emphasises the need to ensure that the outcomes of this review must ultimately lead to gains in health and wellbeing. This does not imply that structural, policy, procedural, or philosophical changes will not be important. But that these must be measured on the extent to which they support mental health and improve the wellbeing of those in our care. It was frequently expressed that the Departmental approach to the delivery of services was oftentimes centred on throughput or process, rather than health outcomes or health gains. Measures of impact were therefore based on output activity, and which were not necessarily aligned to improvements in health and wellbeing.

"…we collect a lot of information, we monitor a lot of things, and we do a lot of things. What we don't always know is if these things (especially in health) are actually providing benefit. I know this is a difficult thing - especially in mental health, but we need to have confidence that what we are doing is leading to gains in health…"

PRINCIPLE SIX: CULTURALLY FRAMED SOLUTIONS

Ara Poutama Aotearoa has long-since recognized the value of culturally inspired solutions. Recent efforts to accelerate these initiatives, and to explore future opportunities (such as *Te Matatiki o te Oranga* and *Hokai Rangi*) have provided additional direction and impetus - likewise a platform upon which more innovative and sustainable solutions can be explored. In terms of mental health, it will be important to further leverage these developments. To ensure alignment, and to support the growth and development of approaches to care that meet the specific needs of Māori.

SUMMARY TABLE: POU ARATAKI: MENTAL HEALTH PRINCIPLES

Table 4: Key Principles and Definitions

Principle	Definition
Transformational Change through Measured Investment	The ability to explore mental health solutions or supports that are relevant to a prison setting and meaningful to a prison population
Pragmatic Solutions	The desire to create solutions which are manageable, pragmatic, and which work alongside existing structures, policies, and parameters.

Nuanced Approaches	The need to develop and implement approaches which draw upon the existing discourse, but which are framed or nuanced to operate within a prison environment.
Complexity and Diversity	The idea that sites, services, people and resources vary across the estate, and that solutions will need to consider this diversity
People Centred	The expectation that gains in health outcomes will be a primary driver and objective.
Culturally Framed Solutions	The requirement to provide solutions which directly impact Māori, and which draw upon cultural frames and philosophies.

POU HINENGARO: MENTAL HEALTH PLATFORMS

The principles above describe high-level parameters or criteria – guidance on how the outcomes and recommendations of this review should be presented, situated, and framed. Beyond these considerations will be the need to offer more precise insights into the issues raised and what remedial solutions are possible.

Notwithstanding the fact that a significant number of issues, challenges, and potential solutions were expressed – many of these were not strictly connected to the delivery of services, or the provision of care. Rather - structural, behavioural, relational, and environmental considerations. These did not always directly impact how care was provided. But were considered fundamental to achieving gains in mental health, to supporting wellbeing, and creating a more sustainable platform for the delivery of mental health care.

From this process, four themes were to emerge and are referred to here as *Pou Hinengaro: Mental Health Platforms.* The significance of these platforms are that they draw attention to conditions or considerations needed to bring about more transformational and enduring gains in mental health and wellbeing. Conditions which extend beyond service delivery initiatives and which highlight the unique environmental, social, cultural, and situational characteristics of prisons. Not only how these can precipitate mental ill-health but might likewise be utilised as a mechanism to promote mental well-being.

Each *platform* is presented in four parts. The first provides a rationale and description of the *platform* - examples of issues and challenges, as well as supporting commentary from key conversations and findings. The second part is a more analytical discussion on the implications of the *platform*, while the third centres on recommendations. This particular section is perhaps the most significant in terms of how these *platforms* might be translated into more pragmatic strategies or investments and so that they are more than simply a set of aspirations or goals.

The fourth and final section describes how soon or at what level of urgency these recommendations should be actioned. Given the keen interest in identifying solutions to current mental health challenges, some recommendations will be slated for urgent action. While others, due to their complexity, may be seen as longer-term priorities. Regardless, an agreed set of timelines, and strategies for implementation, will be important to initiating a transformational approach to the delivery of mental health care within *Ara Poutama Aotearoa.*

For this review, three broad timeframes have been identified.

1. Short-term investments (12-months to three year time-frame)
2. Medium-term investments (three to five year time-frame)
3. Long-term investments (five year plus time-frame)

A fourth category Priority investments has also been added and refers to tasks or activities positioned for immediate actioning or attention.

PLATFORM ONE:

ENVIRONMENTAL CATALYSTS

"…so it's become the new norm to place somebody into prison rather than to take them to hospital…and the environment and prison will almost guarantee a worse outcome for them…"[12]

There is significant and long-standing evidence to highlight the various and often complex drivers of

12 Dr Erik Monasterio, as quoted on Q&A: TVNZ, Sunday December 3, 2023

mental illness. These can be framed within various biological or physiological triggers – a genetic predisposition, organic trauma, as well as a broad spectrum of environmental catalysts. These can include being victims of violence or abuse, as well as less obvious factors such as poor housing, poverty, unemployment, disengagement from education, and an inability to access both formal and informal support. The manner in which these interact with each other and contribute to mental illness is hugely complex and often incredibly dynamic. That said, we know enough to at least contemplate both the drivers of illness and the features which can likewise support wellbeing.

Insofar as environmental conditions might precipitate or promote mental ill-health, there is significant evidence to support the idea that settings that restrict access to the natural world or are devoid of human contact are likely to have a negative impact on wellbeing. Likewise, are situations where opportunities for growth are limited, where aspirations for the future are compromised, and where there is a lack of control over one's life and destiny. Compounding these issues further are negative interpersonal or relational confounders. Engagements with individuals or communities which promote or cultivate fear, which are stress inducing, unsafe, or designed to promote mistrust, tension, or aggression.

The unfortunate reality is that these examples and settings are common within a prison environment. And in the case of limiting choice or restricting movement, are in fact the foundations upon which these institutions have been built. While these issues are well-known, our ability to manage their impact or to bring about positive change will be limited. This is not simply due to structural or legal barriers. But also, behavioural or interpersonal challenges which will collectively conspire to ensure that prisons are unlikely to be places where mental health and wellbeing is able to truly flourish. In many ways prisons are (by design) structured to be as oppressive and uncomfortable as reasonably (and legislatively) possible – and are tenants which cannot easily be alerted.

"We are talking about prison here. So this whole discussion about mental health and wellbeing can seem a bit pointless. Everything you see around you is supposed to be as confining and oppressive as possible. If the prisoners don't come in with a mental health problem. They almost certainly will leave with one…"

"You look around this place and think this is not a good place to be. It's a prison right - its not supposed to be a good place. Walls and doors, people telling you what to do, when to do it. What you can and cant do. As well as having to live with people you don't like or who may not like you. You know, people talk about how hard it was during the COVID lockdown. Imagine that 24/7 but worse…"

These caveats aside, the idea of exploring ways in which more reasonable and achievable options for better managing these environmental conditions is still worth considering. The impacts of which are likely to be felt in three key areas.

Firstly, the immediate and long-term impacts of our current mental health interventions will be enhanced when applied in settings that are more conducive to health and wellbeing. Given that prisons are unlikely to ever be places which are able to truly support wellbeing - the point here is that any change to the existing environments (however modest) will be beneficial. And likewise support peripheral gains in terms of treatment efficacy, and gains in mental health outcomes.

"…its really hard to provide any kind a therapy here. I mean - just look around this place…"

Second, and as noted, prison settings not only serve to moderate what treatment outcomes are possible, but also create fertile environments upon which mental health concerns can manifest. The implications are that while a mental disorder may not be present at the time of sentencing - incarceration may very likely cause an issue to develop – or, to accelerate the presentation of a pre-existing problem. Issues which may not have developed and until having been exposed to the right environmental conditions.

"…I have no doubt that this place is the cause of many of the mental health problems we see. Some of the guys freak-out as soon as they get here, or after a while and once reality sets-it. What do you expect really…"

Third, there will be other non-health related outcomes which are likely to support other strategic objectives of *Ara Poutama Aotearoa.* This will include being able to assist with and support existing rehabilitation and reintegration programmes and by extension other behavioural (non- mental health) concerns.

"These guys can often play-up and make working here a challenge. However, you need to understand why they play-up. For most of them there will always be a reason. A problem with their kids or partner, money, or something else going on outside. Things that play on their mind which they can't do anything about. A simple phone-call might be the only thing they have to help with all these issues. You remove that one thing - and all hell breaks loose."

That's not a mental health or behavioural issue. It's a simple reality of the environment, the restrictions, and the process.

Platform One: Discussion

It would be both naive and unhelpful to suggest that prisons can be transformed into settings which promote and sustain mental health and wellbeing. Simply put – they are not designed for this purpose and are unlikely to be ever framed in this way. However, there are some more reasonable goals that might be achievable and which centre on reducing harms (in terms of mental health) and mitigating some of the more obvious environmental risks and drivers of illness.

These opportunities will need to be both practical and achievable, and from a non-custodial perspective, relatively modest. Anything beyond this may simply be unworkable and inconsistent with the primary purpose and functions of a prison. This may include providing greater access to environmental spaces, subtle policy changes (to permit this), or new programmes and supports. Given the diverse environmental conditions, and access to resources which exist across various prison sites, a blanket "one-size-fits-all" approach is unlikely to be helpful or indeed workable. Rather, more bespoke approaches which assess how more therapeutic environments can be created and at what cost.

Platform One: Recommendations

Given the previous discussion, focus should be placed on a review of each prison site to assess where opportunities to create more therapeutic environments exist. These opportunities might be logistical or physical, or similarly initiated through improved processes or policies. Those which can be implemented without too much in the way of resource or investment should be prioritised. Moreover, and while these can appear to be relatively minor, they may (as described) have a more dramatic and enduring impact on mental health. At least a population level, and in spite of the fact that overall efficacy will be difficult to quantify. The implications for the design of new facilities/units should also be explored.

Leading on from this, it is worth ensuring that *Ara Poutama Aotearoa* continues to ensure that mental health (and in particular a trauma-informed perspective) is integrated within all parts of the corrections system (including broader policies, procedures, and operating manuals). Moreover, how they are able take into account the needs of people who have mental health issues in a more sustainable and comprehensive way. Importantly, in a manner which is cognisant of the realities, parameters, and constraints which exist within a prison environment.

Platform One: Timelines

Both of the key opportunities described above should be considered <u>medium-term</u> investments. Moreover, it is expected that the integration of mental health within all parts of the corrections system will be an ongoing endeavour without a clear end date. Nevertheless, it will be important to set a milestone for reviewing progress.

PLATFORM TWO: MENTAL HEALTH TRAINING AND AWARENESS

Platform Two, Mental Health Training Awareness, leads on from *Platform One*. But draws greater attention to the role that custodial staff can play in supporting wellbeing - recognising and mitigating risks, providing support, or facilitating access to appropriate treatment and care. At least to some extent, a degree of training in mental health is already offered, albeit in a fairly modest way – but which provides a sound level of foundational knowledge and insight. The delivery of the Mental Health Literacy Programme (MH101) as part of CODP has allowed significant numbers of new custodial staff to undertake mental health training. Work underway to review and update the overall CODP programme, and the development of a learning and development pathway and support framework for custodial staff in women's prisons, also deserve important mention.

Many other types of training opportunities are however not as well organised. Often opportunistic, with varying levels of support or endorsement, and which are

sometimes ill-suited to a correctional setting. Additionally, other forms of training will likely receive greater attention and as the more primary expectations of these roles are prioritised.

Nevertheless, there is a degree of overlap between having some knowledge of mental health and the broader roles and functions of a Corrections Officer. In discussions with staff, behavioural challenges were often raised as being one of the more pervasive and challenging aspects of the role. Frequently, causing friction between custodial staff and prisoners and more broadly across the prison population. The reasons for this are varied and will not always be connected to some underlying mental health issue or concern. Notwithstanding, there will also be some benefit in understanding how and why certain behavioural concerns might manifest. And, what remedial actions are possible or appropriate. Once available, data from the Neurodiversity Study will further support training in this space and at the very least rationalise why some behavioural issues might take place.

There are at least two opportunities here. The first is that more enhanced training in mental health will increase opportunities for those in need of care to receive this. While providing this type of conduit may not be viewed as being core to the functions of a corrections officer – the fact remains that they will often have the most direct and consistent levels of engagement with prisoners. And are arguably better positioned to detect changes in behaviour.

"...We need to look at how we might provide additional training for our front-line staff, specifically in terms of mental health and so that they can at least understand which might be going on for some people. Even if they are able to discern what is a behavioural issue and a mental health issue. And how these things can be connected..."

"...Offering this training obviously has to be pitched at the right level and be clinically safe. However, they can be used to help support clinical staff, and to help identify when problems occur or could develop and even how they might be part of the solution..."

The second opportunity centres on the fact that any knowledge of how mental health can be supported (or conversely impeded) within a prison setting creates a range of unique possibilities. Allowing corrections officers to address or mitigate potential risks or catalysts, to help support the creation of more therapeutic environments. Or to simply understand how certain environmental conditions or restrictions might drive a mental health episode.

"...For some of these guys, the only thing they have to look forward to is a phone call to their family. If for some reason they are unable to do that, many will just go crazy. Cause all sorts of problems. As well - it can send them to some dark places. The worst thing is that if there is no explanation. I've also seen some staff take pleasure in saying no to things - just cause they can. What does that do for mental health!!!"

Platform Two: Discussion

There is a reasonable argument to be made that mental health is not the responsibility of Correctional officers, staff, or those within non-clinical roles. This view has a degree of merit and especially when considered within the broader context of the various other challenges and responsibilities that impact these roles. There is however an equally as valid retort - and which suggests that correctional officers are the most well positioned to understand and appreciate the stresses and strains which impact the daily lives of prisoners. To observe the factors or situations that positively or negatively impact their health and wellbeing. To consider what immediate forms of relief are possible and to provide a level of engagement which oftentimes is more stable and constant than what might be expected from a mental health clinician.

Amongst the various engagements that took place as part of this review were opportunities to shadow and observe Corrections staff and Correctional officers. One of the more profound observations was the significant variation in how staff engaged with prisoners. Likewise, the extent to which the quality of these relationships impacted on the behaviours of prisoners and the ease at which staff were then able to perform their roles. Maladaptive, confronting, or challenging behaviours are not always an indication of a mental health problem. Nor will these types of issues always be resolved through positive engagement strategies or approaches. Nonetheless, there is some broader value in exploring how these types of relational skills and greater knowledge of mental health might be more formally promoted to support both mental health and more general compliance and engagement.

"...We got to see one women, a corrections officer, interacting with one of the prisoners. She was just awesome. The way she spoke to him, explained why he couldn't get what he wanted, and what she could do, rather than what she couldn't. He was upset - but you could tell he would have gone crazy if she hadn't engaged him in the right way. How do you teach or replicate those qualities? At the end of the day - I think it's just knowing how to be a good person..."

"...There really is a massive opportunity to target and train custodial staff. Simple things about how to engage with people with specific presentations, what are the risks and triggers. Why they might be acting a certain way and what they can do to de-escalate the situation. Even in terms of understanding what is a behavioural issue and what is a mental health issue..."

"...Some custodial staff think people are just crazy and treat them like this. when actually there is something else going on - you know. And at the same time, some with think certain people are just playing up when in fact there could be a more significant issue..."

Platform Two: Recommendations

There are five primary recommendations relevant to *Platform Two.*

There is one overarching recommendation relevant to *Platform Two*, which is that a review and update of the current training programme for custodial staff is completed to ensure there is sufficient training in mental health and trauma-informed care. Specifically, to provide greater insight into mental health education, mental health promotion, signs and symptoms of distress, environmental pressures and drivers, behavioural and clinical issues as well as cultural considerations. It will likewise be important that these programmes or modules are evaluated for efficacy, application, and knowledge acquisition. That is, not simply completion. As well, other health training programmes could also be evaluated to explore how they might be delivered with a mental health lens.

Credentialing could be offered as a form of incentive. This could be achieved by working alongside relevant tertiary providers and by ensuring that any additional training was framed in a manner consistent with a correctional setting.

Consideration should also be given to the formal allocation of time to permit attendance and completion. Further, that custody rotations take into consideration an individual's desire/ motivation and their competence/expertise in a particular area.

Further, beyond credentialing, other incentives (for example financial) could be offered to encourage participation and successful completion. Likewise, that scholarships be awarded to future encourage participation.

Platform Two: Timelines

While the overarching recommendation described above is considered to be a medium-term investment, it is likely that various elements, as described, will be implemented in a staged manner (with some aspects implemented on a shorter-term basis).

PLATFORM THREE: MENTAL HEALTH PROMOTION AND EDUCATION

"...What we do [can] creates harm: Inadvertent re-traumatisation during an intervention without structure to manage this. Lack of access to wellbeing promoting things. Non-follow up. Brief intervention then massive gap before additional work commences. No community follow up upon release. Transferability constraints not in place for people working with IMH - Start work and then abruptly stopped. Referral processes between providers if a person does transfer - OCF have different providers and so has to create new referral - delay in support..."

A recurring theme throughout this review is that prison settings create numerous challenges, especially for mental health, and which are not found within community settings. Indeed, one of the many challenges attached to this review has been to account for these concerns and to provide recommendations which are fit-for-purpose and reflective of these realities.

Putting aside these confounders, there are also a range of opportunities which are not currently being explored (or at least to the extent that they could be) and which

might take advantage of key prison characteristics or features. That is, limited access to entertainment and news, controlled and highly regimented settings, long periods of inactivity, and ample opportunities for reflection and contemplation.

"...we are all aware of the problems that confinement and prisons create, however, there are also some unique opportunities (due to confinement) which we should look to utilise..."

The idea of exploring the ways in which the time spent within prison cells, or prison settings can be better utilised is not new. There have in fact been a number of initiatives trialled in the past and which currently serve this purpose. However, reframing these concepts with a mental health promotion or education lens creates a range of additional opportunities.

Insofar as these opportunities might be contemplated, it is worth noting that conventional theories on mental health promotion are reasonably well-developed and understood. The general premise being that mental wellbeing is governed by a complex interplay of individual, social, economic, and environmental factors. By adopting a holistic and proactive approach, mental health promotion seeks to improve the overall mental health of communities and promote more inclusive and supportive environments.

The manner in which health promotion activities are implemented can vary, and in ways which are not always suited to a prison or corrections setting. However, and based on a review of relevant literature, there are at least six key approaches which may be relevant to this discussion and likewise inform this review.

1. Raising Awareness: Increasing general awareness and understanding of mental health issues, reducing stigma, and encouraging discussions about mental health.
2. Building Resilience: Strengthening the ability of individuals to cope with life challenges, stress, and adversity, thereby reducing the risk of developing mental health problems.
3. Supportive Environments: Creating environments that promote mental wellbeing.
4. Prevention Programs: Implementing targeted interventions and programs to prevent the onset of mental health issues.
5. Promotion of Positive Mental Health: Focusing on positive aspects of mental health, including promoting emotional wellbeing, self-esteem, and personal growth; and,
6. Early Intervention: Identifying and addressing mental health concerns early to prevent their escalation of reduce the severity of potential issues.

Theories on mental health education offer similar, though somewhat more nuanced perspectives on wellbeing. And tend to centre on the provision of information and knowledge about mental health, mental illness, risk factors, and certain protective factors that empower individuals to make more informed decisions. There are at least eight aspects of mental health education which are relevant to this review.

1. Understanding Mental health: Initially by providing basic education about mental health, including common mental illnesses, their symptoms, and potential causes. The goal being to help individuals recognize and understand their own mental health challenges and those around them.
2. Stigma Reduction: Addressing the stigma surrounding mental health problems and ensuring a non-judgmental and supportive environment. Encouraging individuals to seek help without fear of being ostracised or labelled negatively.
3. Coping Strategies: Teaching practical coping strategies and stress management techniques that individuals can use – especially during times of inactivity. These skills can be particularly invaluable for reducing anxiety and improving overall wellbeing.
4. Communication Skills: Enhancing communication skills, active listening, and empathy. The broader goal here will be to encourage healthier relationships and to respond to conflicts in a more constructive manner.
5. Anger Management: Offering programs which focused on anger management and emotional regulation to reduce the potential for violence and improve successful reintegration possibilities.
6. Substance Abuse Education: Addressing the relationship between mental health and substance abuse. Highlighting the fact that substance abuse can exacerbate mental health problems, and that treating these coexisting disorders is essential for rehabilitation.
7. Self-Awareness and Mindfulness: Encourage self-reflection and mindfulness practices, which can help individuals develop self-awareness and gain better control over their emotions and reactions, and
8. Peer Support: Establishing peer support groups, to actively and openly discuss mental health

challenges and to provide mutual support to each other.

Platform Three: Discussion

While the theories which inform mental health promotion and education programmes are well-evidenced and tested, their utility within a prison setting or correctional environment will be very much contingent on how these ideas are interpreted and applied. Likewise, the extent to which they are deemed relevant or simply disregarded.

To this end, and in discussions with a range of public health experts and researchers, coupled with more focused engagements with staff and clinicians from *Ara Poutama Aotearoa*, the framework below was developed. The key function of which was to compile and relay what health promotion and health education opportunities might be worth exploring and implementing.

With the options and examples given, some will already be in place at various locations or sites across the *Ara Poutama Aotearoa* estate. Likewise, there will also be a variable mix of these available and which may not have always been formally endorsed or supported. The point however is that a more consistent and organised examination of what investments are possible (and likely to be beneficial) should be explored.

Table 5: Health Promotion and Education Initiatives

Initiative	Description and Application	Considerations
Awareness and Education	Increasing the level of information available to prisoners on mental health issues and exploring what types of platforms for information dissemination is available. Foundational and nuanced education on mental health, including common mental illnesses, their symptoms, and potential causes. This would necessarily include information on substance use/abuse.	This material will need to build on established discourse but emendated to function within a corrections setting.
Building Resilience, Coping Strategies, and Self-Awareness	Developing initiatives to help build and strengthen prisoner mental health resilience. With a particular focus on stress, anxiety, and depression. Teaching practical coping strategies and stress management techniques that individuals can use – especially during times of inactivity. This may likewise involve self- reflection and mindfulness.	Initiatives will need to build on conventional clinical guidelines and insights but be framed in ways which are suited to a prison setting. This will be of critical importance to ensure that these investments are not out-of-sync with the realities, routines, and constraints of prison life.
Supportive Environments	Creating physical and structural environments which support and promote higher levels of mental wellbeing.	The manner in which this is achieved will again need to be carefully considered. Given the fact that opportunities to create these types of environments may be limited and often variable across sites. These may also be relatively modest in terms of what is possible and proposed. Nonetheless, the impact on wellbeing could be more pronounced.
Prevention Programmes	Prevention programmes will be similar to raising awareness and resilience initiatives but will be designed to be more structured, proactive, and formal in terms of delivery and training.	A number of mental health prevention programmes are currently available. Including school-based, community, and workplace initiatives. Reviewing these with a corrections lens would be an appropriate start-point.
Promotion of Positive Mental Health and Communication Strategies	Proactive initiatives which centre on emotional wellbeing, self-esteem, and personal growth. Enhanced communication skills can form part of this process – focusing on active listening, and empathy. The objective being to encourage healthier relationships and to	Implementing these types of initiatives within a prison environment can be contentious. Suffice to say that wellbeing, personal growth, and self-esteem programmes will need to be both measured and cognisant of various

	respond to conflicts in a more constructive manner.	environmental parameters, realities, and constraints.
Stigma Reduction	Initiatives aimed at reducing stigma surrounding mental health problems. Encouraging prisoners to seek help without risk of feeling ostracised or perceived negatively.	Over the past several years, considerable local investment has been made into a range of de-stigmatisation initiatives. *Noku te Ao* is perhaps the most well supported and resourced. As a start point, potential collaborations and insights from this programme should be explored. Again – with an eye on how these might operate within a prison setting.
Peer Support	Peer support groups can provide an opportunity to proactively promote and support mental health and wellbeing. As well as a mechanism through which those experiencing mental ill- health can receive less formal, peer-led, support.	It may not always be possible to establish or routinely organise these types of groups and there will likely be high levels of variability across sites and sections and in accordance with a range of personal circumstances (both legal and clinical).
Cultural Framing	Culturally framed health promotion and health education initiatives have been shown to be particularly helpful in engaging Māori. It would be useful to explore how these concepts might be applied and further nuanced within a prison setting or corrections environment.	It will be important that any activity in this space is aligned to other areas of departmental investment. Especially Hokai Rangi, Te Matatiki o te Oranga, and Hikitia.

Platform Three: Recommendations

The overarching recommendation attached to this *platform* is that a mental health education and promotion framework be developed and implemented.

Within this, consideration should be given to the potential utility of innovative approaches to mental health promotion/education that consider the nuances of the prison population and environment, including the use of technology (such as televisions).

Attempts should also be made to include mental health promotion and education across all aspects of the corrections system, with consideration given to how internal policies and practices can be adapted to this end.

Platform Three: Timelines

The recommendation attached to this *platform* should be viewed as medium-term investment.

PLATFORM FOUR: COORDINATION AND INTEGRATION

During the initial series of site visits (and associated discussions) it emerged that past and more recent efforts to improve access to mental health care had not always been coordinated in ways which had optimised their potential. A theme which was further emphasised during various "off-site" meetings with a range of IMHS providers, managers, and staff.

"...It's all a bit unclear sometimes, we are not sure what others are doing in this space, our role, how care is coordinated, and various lines of communication. It can all be a bit vague to tell you the truth. Everyone is keen to get on with the work. But sometimes it's difficult to know who is doing what and when. It can lead to big inefficiencies, and I do feel sorry for those in our care..."

This lack of coordination had led to a somewhat inconsistent approach to how care was delivered or administered – resulting in outcomes that were similarly inconsistent and variable across prisons. For some sites and providers, high levels of innovation and enthusiasm was observed, while for others, there appeared to be a lack of overall direction and engagement. Policies and practices appeared unclear, engagement with patients inconsistent, and relationships (clinical, custodial and managerial) accordingly strained. Further, that there was a perceived duplication of mental health workers/services across some sites.

"...it was very easy to talk and to open up to the counsellor. But it had been over a year since I last

spoke to someone. But it was good to learn new tools and coping skills..."

The reasons for these inconsistencies can be attributed to a number of complex and often interrelated factors. Factors that existed at both macro and micro levels – and which likewise tended to be either operational or relational. For example, many felt that past contracting arrangements lacked the detail and level of specificity through which care and support could be delivered in a more coordinated and organised manner. While a degree of flexibility was welcomed, this had frequently led to an uneven and inconsistent approach to care with significant variations in terms of process and outcomes.

Issues which were further complicated by a contracting environment that offered little in terms of long- term sustainability and retention. Quite apart from these challenges, access to staff was inconsistent, turnover high, with roles and responsibilities unclear. Relationships with custodial, management, and other health staff was also (for some) highly variable and which likewise impacted on how care was administered and what options were possible. The reasons for these relational challenges were often highly turbid, and not consistent across all prisons. Nonetheless, it was clear that these types of issues were impacting on the delivery of care, staff morale, and health outcomes.

"…The turnover of nurses in health and mental health is 34.3% and 31.6% respectively. This is more than double the turnover in the custodial space (14.4%)…"

Conversely, and for those services where engagement was both active and positive, processes and procedures were likely to be more certain and well administered. Likewise, there was more of an intent to adhere to regulations or protocols and to operate in an organised and deliberate manner. Relationships with health services and other teams similarly tended to be more functional and collaborative. As were relationships with custodial staff. Team members were often drawn from a diverse range of professional backgrounds. With the ability to explore clinical, cultural, social and environmental needs.

Platform Four: Discussion

The desire to improve the delivery of mental health care within *Ara Poutama Aotearoa* was founded on a well-intentioned eagerness to address a raft of longstanding challenges within the organisation. Likewise, to offer a proactive response to a range of associated concerns. While the intentions were certainly well-meaning and evidenced- based, their implementation (in terms of increasing access and the provision of care) has not been without challenges. And in this regard, has led to a series of inconsistencies and broader variability in terms of how services are delivered and what outcomes have been produced.

Some of these inconsistencies will be more difficult to control for than others. Especially where interpersonal or relational factors are concerned. However, bringing about greater levels of consistency in terms of focus and scope would help bring about some of the changes required. As would more consistent policies, practices, procedures. Adherence to regulations, that are also mailable enough to support innovation, would allow for more consistency and greater confidence in the potential of systems to deliver the outcomes anticipated.

Platform Four: Recommendations

A number of solutions could be explored to alleviate or manage many of the issues described. Implementing a more centralised location or system where individuals can access mental health care would be a start and benefit both prisoners and staff. This "single-point- of-entry" approach could be developed around six principles.

1. Centralised intake – a designated point or process where prisoners could request support,
2. Triage – initial assessment and review,
3. Health Records and History – the management of relevant medical/health records
4. Appointments and Referrals – scheduling, organisation, and possible referrals
5. Coordination – to facilitate coordination between various health and social service staff, and;
6. Security and Control – to assist with maintaining security and controlled access.

A further recommendation is better integration of the services delivered by mental health teams and those delivered by Psychological Services.

Platform Four: Timelines

Both recommendations attached to this platform should be viewed as <u>medium-term</u> investments.

SUMMARY TABLE: POU HINENGARO: MENTAL HEALTH PRINCIPLES

Table 6: Platforms and Descriptions

Platform	Description
Environmental Catalysts	To explore opportunities for creating environments or settings which are more conducive to mental health and wellbeing. These will need to be bespoke to prison context and site-specific.
Mental Health Training and Awareness	To increase levels of understanding about mental health and wellbeing amongst non-clinical and custodial staff. Focusing on key mental health issues and behaviours, symptoms, remedial pathways, actions, and supports. Likewise, exploring opportunities for formalise and incentivise this type of training.
Mental Health Promotion and Education	To raise awareness of mental health. Focusing on – awareness and education, building resilience, coping strategies, and self-awareness, creating supportive environments, prevention programmes, promotion of positive mental health, communication, stigma reduction, peer support, and culturally framed initiatives.
Coordination and Integration	To provide a more coordinated, consistent, integrated, and more comprehensive approach to the delivery and resourcing of mental health services.

POU RAUTAKI: MENTAL HEALTH INVESTMENTS

The issues described in the previous two sections have helped to inform the various opportunities available to promote, sustain, and support mental health. Likewise, how these might be framed within a prison setting in order to maximise mental health outcomes.

Beyond these ideas, will be the need to consider what enhanced (and more specific) options for service delivery might also be explored. How these options can be developed and implemented, and again used to support a more comprehensive approach to the delivery of mental health care.

The following section of the review is designed for this purpose and is organised into ten topics or investment areas. As with previous sections, these Investments are presented in four parts – an introduction, a discussion, recommendations, and proposed timelines.

INVESTMENT ONE: THERAPY WITHIN A PRISON SETTING

There is no shortage of psychological models, approaches, theories, or practices which are used to guide mental health treatment and care. Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Mindfulness, and Solution-Focused Brief Therapy (SFBT) are just some examples amongst the plethora of options available and which continue to evolve and expand. The adaptation and reinterpretation of these models is likewise common. Often designed to better meet the needs of certain populations, nationalities, ethnicities, genders, age-groups, disease types, or any number of other sub-classifications.

To a great extent, these models anticipate and encourage a degree of adaptation and reinterpretation - and are often designed in ways which invite this. Due to this diversity, it can be difficult to unpack the central tenants or philosophies upon which these psychological models of care are founded. Save for the fact that they are all designed to create shifts towards more positive

thoughts, feelings, emotions, or behaviours. For psychological or talk-based therapies, these shifts will typically centre on better managing individual thought patterns or emotions and often through the design and implementation of various internal coping strategies or interventions. Likewise, through the active management of particular strains or stressors, as well as utilising external environments, settings, communities or engagements to help promote and sustain mental health and wellbeing.

A challenge emerges however, when conventional or community-based models are exposed to environments where these core values of treatment and care are not only unsustainable - but are in many ways impossible to implement. For prison settings, these types of therapeutic challenges are especially relevant and were concerns frequently expressed during discussion with Corrections staff – especially clinicians and clinical managers. Case-in-point was the idea that existing or community-based models of care were not fit-for-purpose and often founded on therapeutic principles that were unlikely to find a secure footing within a prison environment.

"...There are numerous challenges with working inside a prison - and not just for us - but for everyone. But, for a clinician (or anyone involved in providing care), there are some things which are especially problematic. In mental health, we are taught to use different types of models or approaches and to explore how the physical environment can be used as a tool. Here, some of the models simply won't work, and there are also major limitations on how useful the environment can be. I mean - look around, it's a prison. It's designed to keep people contained, compressed, and oppressed. How is that for mental health...?"

To better illustrate these challenges, the concept of Mindfulness was offered as a simple example of how an established therapeutic model might struggle for application within a prison setting. The approach is broadly founded on the idea that a greater sense of wellbeing can be achieved through practising a few key principles or integrating certain concepts into your life and the environments you engage with.

"...Mindfulness is the practice of deliberately bringing your attention to something in the present moment. This could be your thoughts, feelings, bodily sensations, or something in the surrounding environment…. Mindfulness involves becoming aware of your thoughts, feelings and body sensations as you experience them. As you become more aware of what's going on for you, you get better at being able to meet your own needs. For example, you might become better at noticing when you need a break, when you are hungry or full, and when you are tired or need to get out for some exercise..."[13]

For many struggling with mental ill-health, Mindfulness has provided a welcome source of relief and support. Likewise, the flexibility through which various mindfulness principles can be emendated to accommodate different settings or personal circumstances. An issue emerges when these principles are unable to be implemented or sustained, and by the simple fact that they are applied in settings that they were not designed to operate. Settings that may in fact be in direct conflict with the core values they are intended to promote, and which are key to its broader efficacy.

For example, the idea of becoming "better at noticing when you need a break, when you are hungry or full, and when you are tired or need to get out for some exercise" assumes a degree of control and personal liberty. Liberties which are often not possible within a prison setting, and which may require levels of emendation or interpretation which are simply not possible.

While this example was presented hypothetically (and to simply illustrate a point) there was a high degree of consistency amongst those spoken to, and with respect to the challenges of applying conventional modes of therapy within a prison setting. Most (if not all) therapeutic interventions or models will suffer from similar challenges. Oftentimes due to the fact that the environmental substrates upon which these models are designed to leverage are not available within a prison and which will ultimately compromise or confound their efficacy.

These are all issues which clinicians within *Ara Poutama Aotearoa* are well aware of and which have led to some innovative and bespoke solutions. Oftentimes by amending interventions to better account for these restrictive environments or to take advantage of the fact

13 https://www.healthnavigator.org.nz/healthy-living /m/mindfulness/ Jan 25, 2023

that the settings are more controlled and highly regimented. In this way, staff have generally (and sensibly) sought to re-interpret how these models are applied or to explore therapeutic solutions which are reflective of the environment.

Notwithstanding these innovations, overcoming the tensions between established therapeutic practice and the realities of prison life has been a fundamental challenge to improving mental health outcomes. Further still, that the outcomes of care (and what is possible to achieve) will also require careful consideration. Simply put, many of the outcomes or gains promoted within a community setting may in fact be impossible to cultivate within a prison environment. Adding further to this complexity is the fact that those in our care are not homogenous. And will (as with the general population) have needs that are incredibly diverse and which will ultimately impact on the type of care needed and their ability to resonate with the interventions provided. Moreover, these needs are likely to be more complex, more difficult to treat, and less likely to respond to treatment and care – at least when compared to the general population.

Solutions to these issues will therefore be complex. But have already been somewhat foreshadowed through the design of new models of care which have been tailored to this environment. Not all of these have been officially endorsed or implemented and might only look to account for some of the more obvious logistical challenges of treatment within a prison. Likewise, and again based on discussions with clinical staff, some of the therapeutic options currently being offered do not appear to have been developed in any organised or evidenced-based fashion. Often based on what the clinician or staff member might be familiar with, what they had recently read, or what training or presentations they had most recently been exposed to.

While it is unclear as to the overall efficacy of these types of treatments (for example pressure-point therapy, origami, and aroma therapy) the simple fact is that some of these interventions are being provided in an organic, unregulated, and disconnected manner. This does raise some concerns, not only in terms of the outcomes generated, but also the training required, the relationship to other therapies, the possibility that issues are only exacerbated, and that they may simply be unhelpful and an inefficient use of time and resource.

Ultimately however, the main point here is that the design of models of mental health care which are reflective of the New Zealand prison environment, and flexible enough to accommodate a range of situations, sites or settings, will be an important step toward improving mental health service delivery.

Investment One: Discussion

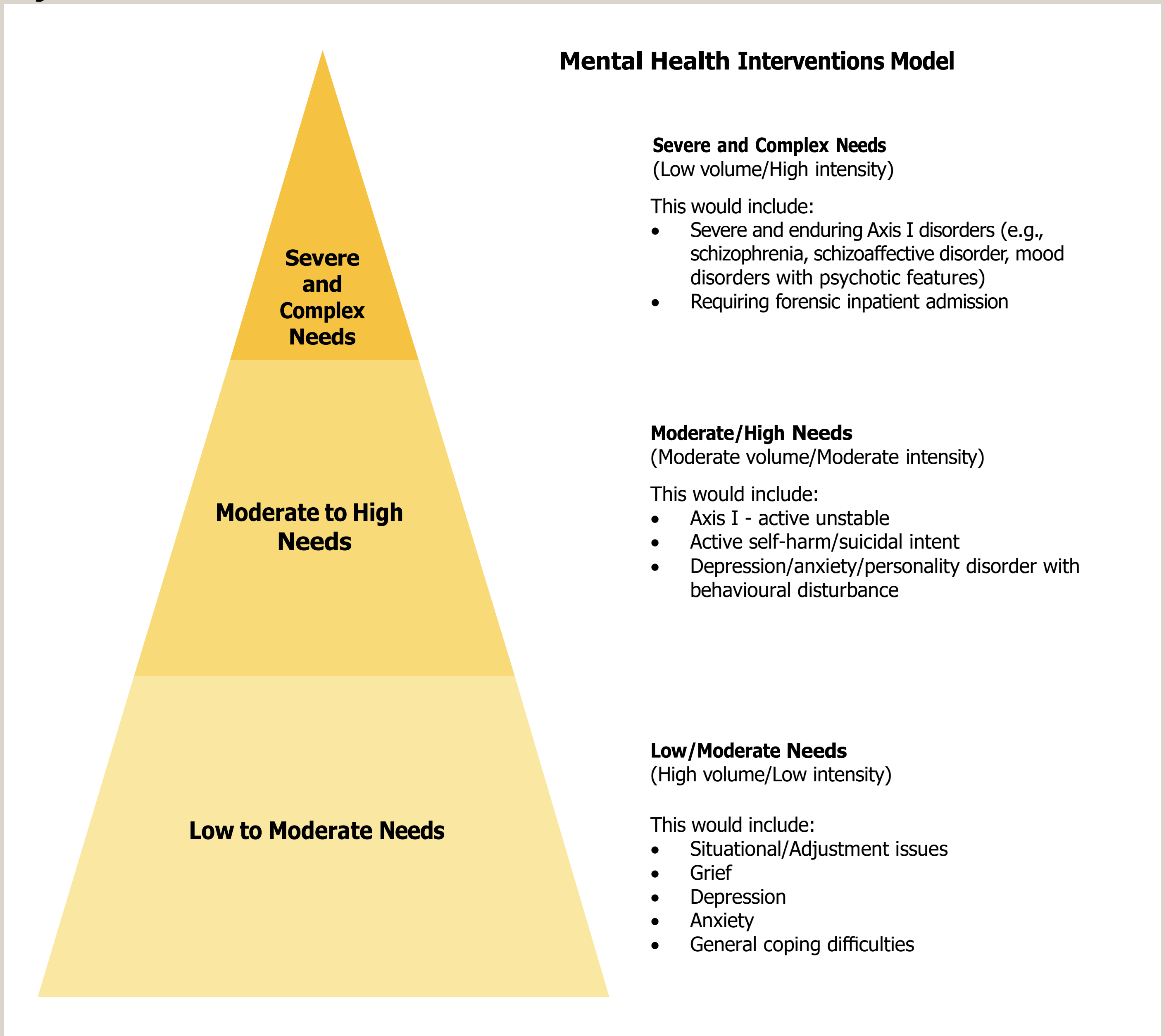
The challenges of adapting community-based models of care to operate within a custodial setting are both well-known and relatively well-understood. However, solutions to these issues have been more difficult to locate. As noted, many clinicians (even if informally) have sought to adapt their practice and models of care. Largely to take into account the various challenges and restrictions described previously.

However, there remains a lack of consistency in terms of how these adapted models are applied. Moreover, their clinical efficacy, the outcomes generated, potential issues, possibly enhancements, and the extent to which they are founded on discourse or more iterative processes. Although the impacts of these challenges are highly variable (across sites, units, and amongst individual clinicians) the issue of consistency remains, as does the idea that there is dearth of local research to help support more bespoke, research and evidence based, models.

Adding to these challenges is the fact that some interventions don't appear to be based on any evidence or therapeutic intent – rather applied in a haphazard and opportunistic manner.

Further still, is the idea that the requirement for mental health care is not universally distributed. Nor will the resources needed follow a linear path. For example, the number of individuals with severe, high or complex needs may be comparatively low – but the resources and investment required are relatively high. Likewise, the outcomes possible (or expected) will typically vary according to diagnosis, as will the type and range of treatment options available. The following schema has been constructed to illustrate these points:

Diagram 1: Mental Health Interventions Model



Investment One: Recommendations

The overarching recommendation emerges from the previous discussion, that is, that efforts should be made to update the current mental health service delivery model to reflect, and more effectively function within, the prison environment.

This requires investment into the development of new models of care. which are malleable enough to be applied in a range of settings or as a compliment to more conventional approaches or models.

This will be no easy task, nor one which can be completed quickly. It will be important that any new model(s) is/are able to draw upon established theory or discourse, that ideas are tested and refined, that outcomes are assessed and validated, challenges and limitations identified, and that logistical, resource, policy, and strategy considerations are examined and managed. The opportunity, however, will be to construct a model of care which is better suited to a prison environment (and its complexities) and which is able to garner outcomes which are more positive and sustainable.

This could include the use of groups for psychoeducation/ awareness and mental health promotion, the use of therapy groups where appropriate, increased support from custodial systems for mental health therapy. For example, the

prioritisation of mental health interventions in relation to movements and other custodial operations. Likewise, the considered adaptation of convention models (such as CBT) to function within a prison treatment setting.

This recommendation also reflects the need for greater consistency and management of how, where, and what therapies or approaches are being used. The objective here is not to constrain innovation, or monitor activity, but more so centres on the need to understand variations in practice and how a more consistent approach to treatment and care can be facilitated.

Finally, there will be a need to consider the logistical, structural, resource, and training required to implement, apply consistently, review, and monitor the application of these models. Further still will be the requirement to consider what services are provided, how these are organised, prioritised and resourced, what range of interventions are needed, and the types of outcomes which can be expected.

Investment One: Timelines

The implementation of the recommendations described previously is likely to present a number of challenges and cannot be simply legislated, contracted, or imposed. What will be required is a consolidated and deliberate process of research and investment. Designed to not only undertake the studies required, or to implement the recommendations suggested, but to also ensure that these activities are progressed in a manner which reflects the existing expertise of corrections staff and is bespoke to an Aotearoa setting. These recommendations should therefore be viewed as a medium-term investment.

INVESTMENT TWO: WOMEN IN PRISON

The idea of developing more focused approaches to the delivery of mental health services has been a recurring theme throughout this review. There are a number of reasons for this and which are often linked to the idea that prison environments will be highly dissimilar to community settings. The mental health issues will be more complex, more difficult to treat, and to have far more restrictive treatment and care options. The demographic and cultural profile of the prison population is likewise unique, and again calls for approaches to care which are dynamic and responsive enough to reflect these challenges. Part of this dynamism will be to introduce programmes of care which leverage cultural frames, especially for Māori, and given that Māori make-up a disproportionately high number of inmates. The idea being that culturally inspired approaches will help in creating treatment options that are more resonant and engaging – and ultimately, more effective. These concepts are not entirely new and have underpinned the design of Māori mental health services for more than 30 years. The key however will be to consider how these models might function within a prison setting and in ways which promote health outcomes which are both positive and culturally resonant. Extending these ideas beyond the need for culturally inspired programmes, is the notion that a number of gender-specific issues also exist and which likewise call for approaches to care which are similarly nuanced. Data reveals that the 12-month prevalence of mental illness amongst women in prison is approximately 75%, and that rates of comorbidity. (substance and mental health) are about 62%.[14][15] Rates which are significantly higher than the general population and even when compared to the male prison population. Further compounding these issues is that women in prison are also significant more likely to have been victims of family violence,[16] to have suffered some form of traumatic stress,[17] and to have experienced a drug dependence disorder.[18]

Departmental research indicates three quarters of women in New Zealand's prisons have been victims of family violence, rape and/or sexual assault as a child or adult. In addition to these traumatic experiences, women are more commonly affected by mental health issues including high rates of post-traumatic stress disorder, comorbidity, and substance addictions that mask and manage their trauma financial pressures stemming from low educational achievement, being from economically disadvantaged backgrounds, un- or under-employed, and recipients of state benefits parenting difficulty and stress associated with difficult relationships, poor physical and mental health, and child custody issues.[19]

14 Indig, D., Gear, C., and Wilhelm, K., Comorbid substance use disorders and mental health disorders among New Zealand prisoners, New Zealand Department of Corrections, 2016.

15 https://www.corrections.govt.nz/ data/assets/pdf_file/0004/44644/Corrections_Wahine_-_E_rere_ana_ki_te_pae_hou_2021_-_2025.pdf (June 2023)

16 68%

17 52%

18 44% (Lifetime prevalence)

19 https://www.corrections.govt.nz/ data/assets/pdf_file/0004/44644/Corrections_Wahine_-_E_rere_ana_ki_te_pae_hou_2021_-_2025.pdf (June 2023)

In discussions with Corrections staff, and especially those charged with the care of women, these types of data were frequently expressed. As was the view that the realities experienced by women while in prison were often significantly different to those of men. To the extent that not only were the prisons settings (culture and environment) dissimilar, but likewise the types of internal and external pressures which impacted their mental health and wellbeing.

As an illustration, it was noted that for many women, the sense of helplessness and worry was often externalised. Meaning that although the more typical pressures and challenges of incarceration were ever-present, many would be faced with the additional burden of contemplating how family members – children, parents, and siblings, would be supported and cared-for. Notwithstanding that men would likewise experience similar challenges, the impact on women was oftentimes more profound and less likely to be ameliorated over time. In the majority of cases, women would be the primary caregiver, the source of emotional and social support, as well as providing protection from various forms of threats. Having these types of responsibilities compromised while in prison would often be the cause of considerable angst and worry and which was best exemplified by the comment below.

"…the men's and women's prisons are quite different. Not just in terms of how they operate - but also the culture of the place and the way women engage with each other. Its still an unpleasant place to be, but women can be less adversarial to a point. The other big difference is that women are often more concerned about family outside. Worried about them and how they might cope with them being in here. It can get them really down and out…"

Given these differences, it is unlikely that a uniform or standard approach to the delivery of mental health services within prisons (however nuanced) would garner equitable outcomes - at least for women, and unless measures are taken to ensure that gender-related concerns or characteristics are considered. Although to some extent these ideas have already been expressed previously within this review (particularly as they relate to structural or service delivery reforms) and which are likely to peripherally impact women - creating initiatives that are designed specifically for women will be key to ensuring the overall efficacy of the recommendations. At the very least, initiatives which better reflect the unique mental health needs of women in prison and which offer treatment and care options that are relevant to their realities, experiences, and pressures – both internal and external.

Investment Two: Discussion

There are currently a number of initiatives in place to further advance the interests and wellbeing of women in prison. Many have been inspired by *Wahine – E rere ana ki te Pae Hou – the Department of Corrections Women's Strategy.* The outcomes and recommendations proposed in this review have the potential to both inform and support this strategy. Indeed it must, and in order to facilitate a more cohesive, integrated, and mutually beneficial suite of investments and activities. Ultimately, to ensure that outcomes are maximised and that resources are used in the most efficient and beneficial manner. While many of the key investment areas and initiatives attached *to Wahine – E rere ana ki te Pae Hou* have either been completed or are well-advanced, there are nevertheless some key areas of investment of where alignment is possible. These include:

- WS2.4 Prototype Nā Wai Au to connect wāhine Māori to their cultural identity and whakapapa.
- WS2.5 Provide culturally responsive trauma training to staff to provide staff with extra skills to do their jobs.
- WS2.7 Increase cultural and gender-informed interventions to support women while on remand.
- WS4.3 Provide better connections to cultural networks to enable greater access to, and practice, of tikanga.
- WS4.5 Increase access to mental health and addictions support for women to better address their health needs.
- WS4.6 Ensure continuity of health care between the custodial environment and the community to support better health outcomes.
- WS4.7 Improve access to medical screening for women to enable improved health outcomes.
- WS4.8 Increase women's access to interventions through the consideration of physical health needs and different learning styles, and;
- WS5.5 Strengthen our existing partnership approach with Māori service providers to support better outcomes for wāhine Māori.

The outcomes of this review have the potential to have both a direct and more peripheral impact on the initiatives above. Regardless, the more important consideration is that some thought is given to how the

recommendations of this review might align with the more strategic objectives of *Ara Poutama Aotearoa* and to especially support the mental health and wellbeing of women.

Investment Two: Recommendations

The need for more specialised and fit-for-purpose models of care will be critical to improving mental health outcomes. These new models must account for both the realities of operating within a correctional setting as well as providing scope for the incorporation of cultural methods or therapies. To further enhance the utility of these measures (described in *Investment One* of this review) it is further recommended that additional approaches be developed to specifically focus on the needs of women in prison. These approaches may build upon new developments or treatment innovations elsewhere within *Ara Poutama Aotearoa* and as the options for mental health care are expanded. However, these will need to be examined and reframed to reflect the unique perspective of women and so as to ensure that the outcomes expected are maximised for both women and men. That is, any new approaches or models of care will need to be assessed for relevance to women and for possible emendation.

Beyond the design of new models of care, training and information for staff on the specific challenges faced by women in prison and the implications for mental health will also be important.

Further, any public health, health promotion, health education, and training opportunities (as described in Platform Three) will need to be considered for their relevance and suitability for women. And where relevant - amendments made to enhance their overall relevance, resonance, and broader utility.

Investment Two: Timelines

The timelines for *Investment Three* should be aligned with the timelines described in *Platform Three* and *Investment One*. However, additional time may be required to assess the utility of these recommendations for women. In any regard, short/medium-term timelines would be appropriate for investigation and implementation.

INVESTMENT THREE: CULTURAL CATALYSTS

"…Lots of our people fall between the cracks. And sometimes it feels as if the Department of Corrections is the vacuum cleaner..."

The relationship between culture and mental health is now well-established. Since at least the mid- 1980s, these developments have led to the design of a number of culturally inspired solutions. From new models of treatment and care, to more innovative public health, health promotion, health education, and service delivery initiatives. The application of these concepts has tended to vary, often deliberately so, and in order to accommodate a variety of different setting and environments. Moreover, and while Māori models of health might provide conceptual or philosophical guidance, the manner in which these are applied in practice or within clinical settings will inevitably vary.

There will be multiple reasons for this. But can be due to the availability of cultural and clinical support, regional variations in how cultural traditions are introduced, differences in focus or service scope, as well as deeper philosophical interpretations on the application of culture to mental health.

Notwithstanding - the core principles of utilising cultural frames as a means of better engaging Māori (and by extension improving mental health outcomes) has remained constant. And, which has contributed greatly to the design of strategies aimed at arresting current trends and the disproportionately higher number of Māori who suffer from mental ill-health.

Ara Poutama Aotearoa has likewise been eager to explore how culture might be utilised as a means of improving outcomes for Māori. Many of these initiatives have been deployed in non-health settings and have been designed to assist with rehabilitation or reintegration programmes. Further, to align with broader departmental goals of reducing recidivism. The theories which have informed these programmes have however been based on similar philosophical underpinnings. That is, the idea that culture can be used to better engage Māori, to support programme resonance, and to create more positive and enduring outcomes.[20]

Investment Three: Discussion

Given the scope of this review, divergent views on a broad range of issues were often expressed. At least to some extent, these differences were linked to professional or situational tensions. For example, where the needs of health professionals came into conflict with prison or custodial processes or procedures. Or where logistical or security requirements were prioritized over the delivery of health services. For the most part, these types of issues where not unsurprising (or unexpected) and again highlighted the ongoing difficulty of providing health care within a prison setting.

Putting aside these concerns, there was at least more general agreement as to the potential of culture to better support the broader goals and aspirations of Ara Poutama. As described previously, this has resulted in the design of various culturally inspired programmes - aimed at reducing recidivism, improving behaviour, or enhancing the resonances of certain training courses and programmes (te reo, carving, weaving, and tikanga). However, most enthusiasm was directed towards the delivery of mental health care and other rehabilitative or therapeutic programmes. A point which was well summarised by the comment below.

"...the relationship between culture and health is now well-established. However, these relationships are most obvious within the mental health sector. Where a person's thoughts, feelings and behaviours are fundamentally governed by their culture..."

"...for Māori, cultural factors can play a large part in terms of how they engage with clinicians, how they resonate with the therapy, and what they ultimately get from this process. It can be the difference between a good outcome and an outcome which is not..."

At least to some extent, a number of approaches have already been employed to introduce cultural frames or models within various treatment settings. From the involvement of cultural advisors or kaumatua, to the employment of Māori clinicians capable of administering culturally inspired therapies and models. Likewise, training for non-Māori on Māori philosophies and concepts, elucidating theories on culture and identity, and advising on Māori perspectives of health and wellbeing. The utility of these initiatives (and the potential to garner enhanced health outcomes) was highlighted as a significant opportunity by the vast majority of those spoken to as part of this review – both Māori and non-Māori. Ideas and concepts which were further enhanced through various site-visits and observations.

One of the more profound examples of this took place during a visit to a special treatment unit and where culture and tikanga Māori was used to underpin both the operation of the unit and various other therapeutic programmes. While it was not possible (due to the brevity of the visit) to consider the outcomes or efficacy of these investments, it was nevertheless clear that the integration of cultural platforms had led to a number of well-considered therapeutic benefits. This included heightening the resonance of interventions, the design of new (culturally framed) models and programmes, improvements in behaviours amongst prisoners, the development of unique peer support mechanisms, and the formation of clearer, more positive, and mutually beneficial relationships between staff and prisoners.

"...you might be surprised to know that most of these men are considered to be some of the most difficult and problematic throughout the prison...but we have been sitting here, talking in a respectful and honest way, without any sense of feeling anxious or threatened.

"...it's because they all want to be here, they understand the kaupapa of the unit, the expectations we have, how we treat each other and how we behave..."

Notwithstanding the general utility and support for culture within various programmes and therapeutic settings - and the range of environments within which these have been introduced – the organisation and implementation of these initiatives has not always been seamless or well-planned. With some initiatives having been developed in an opportunistic or organic manner. And with varying levels of support or organisational endorsement. While this approach has allowed for high levels of innovation, this has come at the cost of consistency, function, and purpose. Likewise, a lack of clear perspective on how these initiatives can be

20 Current examples include; Te Piriti, Mauri Tū Pae, Tamaua Te Koronga, Specialist Māori Cultural Assessment (SMCA), The Whare programme, Te Whare Tapa Whā Alcohol and Other Drug Intensive Treatment Programme, Tikanga Māori, Whare Oranga Ake (2 units), Te Tirohanga (5 units), Tiaki Tangata (reintegration support)

supported to grow in a more organised and integrated manner. To this end, there are at least eight key issues relevant to this discussion.

The first is that culturally inspired interventions have the potential to promote mental health outcomes (especially for Māori) over-and-above those which might be possible through conventional modes of care. This is likely to be achieved when both western and non-western approaches are applied in unison. And in ways which meet the cultural and clinical needs of service users. This point is especially important in that cultural expectations are likely to vary according to an individual's level of cultural knowledge and insight. Some service users may be very familiar with Māori customs, language, history, or genealogy. While others will simply identify as Māori but have little in the way of language proficiency or familiarity with customs and traditions.

Before introducing culture into any therapeutic environment, it will therefore be important to firstly understand the cultural expectations and needs of service users. This will ensure that cultural practices are appropriately framed and are maximised in ways which contribute to mental health and wellbeing. For some, this may mean frequent and ongoing use of the Māori language and greater utilisation of Māori protocols, customs, history, and metaphor. For others, the expectations may be more modest. Nonetheless, the primary consideration will be to ensure that cultural needs are assessed and shaped around the expectations of the individual. Noting as well, that although the level and complexity of cultural input might vary, this will not necessarily determine the utility of the outcomes expected. In this manner, a modest level of cultural input may have a more profound impact on the wellbeing of an individual with only limited cultural knowledge. Especially those who are eager to learn more about their traditions and who are able to draw previously unexplored value and strength from these practices. Assessments of cultural knowledge, an understanding of cultural needs, and a programme shaped around the expectations of the individual will have a greater chance of leveraging culture in ways which optimise mental health outcomes.

Leading on from this issue, point two highlights the need to better consider how clinical assessments are undertaken, especially for Māori, and where cultural paradigms have the potential to shape how symptoms of illness are interpreted and diagnosis assigned. One of the key issues here is the concept of *matakite*. Which, while difficult to define according to western or non-Māori frames, is perhaps best explained through an examination of the word itself – "mata" which refers to a face or surface, and "kite" which means to see or perceive. Together, *matakite* implies someone who has the ability to see beyond the surface or to perceive things which are not immediately apparent to others.[21] In both traditional and contemporary times, *matakite* are said to possess spiritual or psychic abilities. Abilities that enable them to gain insights into the future, to communicate with ancestors or spirits, and to provide guidance or predictions of the future. Oftentimes through visions, dreams, meditation, or trance-like states.

Insofar as these abilities are perceived, the general view within Māori society is that *matakite* are valued for their wisdom and capacity to tap into a deeper metaphysical understanding of the world. For non-Māori however, this will not always be the case, and may in fact engender feelings of fear or anxiety, apprehension and even mistrust. These types of tensions can be significantly amplified within a mental health setting. And which have ultimately led to expressions of *matakite* being misread as symptoms of illness and disease.

"…you know one of the major issues with the Department is the way in which matakite is treated. Some of the clinicians have no idea of what they are dealing with and make really silly assumptions. I'm not saying that all our people with mental health issues are matakite, but so do and we need process so that these types of things can be identified and not treated as an illness…"

These types of challenges are not easily resolved and highlight the issue of attempting to relay the philosophies or conventions of one culture through the interpretive lens of another. For Māori, there will be at least two primary considerations here. The first is that not all visions or spiritual expressions can be attributed to *matakite*. Even when the individual is Māori, and when these expressions are culturally contextualised or framed. For example, an experience or episode which draws heavily upon Māori culture, history, or language, cannot be assumed as *matakite*. Rather, a more typical audible, sensory, or visual hallucination that is couched within a cultural frame.

21 Wananga presentation: Wiremu Niania, Department of Corrections Staff Presentation 2023

However, there will likewise be situations where a clinical diagnosis is assigned to a cultural experience. The implications here are potentially more problematic in that an individual can be unnecessarily diagnosed with a problem or disorder. And are accordingly provided treatment for a condition where none is required.

The complexities of effectively navigating these two schools of knowledge (one which is derived from western science and the other mātauranga Māori) creates a number of unique challenges. While some may view these as an inevitable tension between two diametrically opposed systems, in reality they share many areas of common interest and philosophical alignment. Western trained clinicians, for example, will derive their knowledge through an organised (and often restrictive) formal training process. Followed by structured and ongoing assessments of proficiency, and which will be complemented through experience and other less formal engagements and interactions with patients and families. Tohunga, and those experienced in recognising *matakite*, will often be exposed to a similarly formalised and equally as thorough teaching and training regime. Likewise complemented through experience and enhanced with knowledge derived from interactions with people, their whānau and the natural environment.

The point here, is that there are multiple shared foundations upon which cultural and clinical experts can engage. And - that quite apart from simply recognising the value and knowledge of each - will be the opportunity to share insights and expertise. To discuss situations where *matakite* might be present and how an approach, derived from a collective interest in health and hauora, can be prepared. How these opportunities are expressed in practice will to a great extent rely on the willingness of clinicians to engage cultural experts. Largely due to the fact that health professionals will typically be the initial point of contact and assessment – at least within *Ara Poutama Aotearoa*.

That said, it will not be enough for these engagements to be left to chance, discretion, or the good-will of clinicians and health staff. Rather, more formal processes will be required and so that active cultural support is provided when required. While the ability to access suitably experienced cultural experts or tohunga may create some initial challenges, this should not prevent the formalisation of a process whereby clinical staff are able to access specialist cultural expertise.

22 https://www.mahiaatua.com/therapeutic-offerings/

"…[we don't want]..kairuruku coming in to just do the karakia and not being part of the overall clinical governance structure…[or]…to just 'blessing the muffins…"

A third point, is that although some useful models and approaches have been developed to support the integration of culture within mental health treatment settings[22] – these have not been consistently applied. At least within *Ara Poutama Aotearoa.* Moreover, some approaches have evolved more organically, in a less structured or formal way, and according to what cultural expertise might be available at any particular site or service. While a degree of variability and innovation can be expected (and encouraged) this approach does not support a consistent level of delivery and comprehensive access to cultural supports and therapies.

Given the dynamic range of environments where culture might be used to support mental health care, it would make no sense to recommend an overly prescriptive or rigid set of cultural investments or activities. Especially when there is likely to be regional variations in cultural practice and unequal access to cultural expertise. However, a broader suite of guidelines (which are able to detail options, convey functions, and explore the application of cultural interventions) should be considered.

These guidelines will be able to draw-upon much of the existing discourse. Especially given that a number of reviews, reports, papers, presentations and programmes have already attempted to relay the delivery characteristics of Māori mental health services. Such as, cultural assessments, the use of karakia, tikanga, Māori arts and crafts, marae, whakapapa, taiao, mirimiri, and Rongoā.[23] Like *matakite* and tohunga, the use of rongoā within western therapeutic environments has been contentious. However, there is

23 Mental Health Commission, (1997), Blueprint for Mental Health Services in New Zealand: Working Document, Mental Health Commission, Wellington

24 Traditional form of Māori massage

25 See for example Ministry of Health, (1996), Towards Better Mental Health Services: The Report of the National Working Party on Mental Health Workforce Development, Ministry of Health, Wellington. See also Te Pümanawa Hauora, (1995), Guidelines for Purchasing Personal Mental Health Services for Mäori: A Report Prepared for the Ministry of Health, Department of Mäori Studies, Massey University, Palmerston North; P. Kingi, (1994), 'Körero Mai: Mäori Mental Health and the Treaty of Waitangi', in Mental Health News, Summer 1995, p. 11.

now broad agreement as to the therapeutic benefits of various types of traditional remedies, infusions, poultices, and plant extracts.

Especially when combined with karakia, incantations, and mirimiri.[24] The concurrent use of rongoā alongside more conventional pharmacological approaches can therefore aid the design of more comprehensive treatment and care plans. Supporting outcomes which are more holistic and better aligned with the cultural and spiritual expectations of service users.[25] The precise manner in which rongoā can be used to support mental health outcomes for Māori will require further consideration and investment. To ensure that both cultural and clinical expectations are met and likewise that the integrity of rongoā processes are maintained and supported. To this end, securing the advice and support of the National Rongoā Māori manager will be critical.

The fourth point leads on from the previous. But is centred on the idea that although existing models of care can be used to inform the delivery of mental health services within Ara Poutama - they are not ideally suited to this environment. This issue has been noted elsewhere within this document and when highlighting the need for models of treatment which have been specifically designed to function within a prison setting. However, there is an aligned need to explore how cultural approaches might be similarly nuanced.

Again, Māori staff have done well to discern how cultural models of care can be emendated to function within a carceral setting. However, these reinterpretations have often been driven by intuition and constrained by resource and capacity. A more deliberate, kaupapa Māori inspired approach, aimed at better discerning the application of culturally inspired mental health interventions within custodial environments will be required to maximise these therapeutic opportunities.

The fifth point is that the integration of culture within a mental health setting must be reframed and legitimised as a therapeutic opportunity. In that while cultural activities or protocols might be the primary observation, the intention is less about building cultural capability, confidence, or knowledge. Instead, creating a foundation upon which enhanced mental health outcomes can be supported. The two ideas may not be mutually exclusive – to the extent that both cultural gains and clinical outcomes might be observed concurrently. However, it should be reinforced that the primary purpose of introducing cultural concepts or paradigms (within a mental health setting) will be to support clinical outcomes and broader gains in Māori mental health.

"…I sometimes get the sense that people can devalue the role of culture, therapy, and mental health. The purpose of a whakatau, mihimihi, the use of our reo and tikanga. Yes - its about sharing our traditions and culture. But, the purpose (at least within mental health) is about wellbeing. You know - we need to reframe the korero, so that people understand why we do things and its value in terms of hauora…"

Point six, is an issue of particular importance to Māori but which sits outside of contemplating how services for Māori can be delivered, rather, how care is accessed and what structural and organisational barriers currently prevent this.

It was noted in discussions staff that factors were at play which are likely to contribute to inequitable access for Māori to mental health services. Senior psychologists noted that security classification has a direct impact on how people in prison receive mental health, rehabilitative, occupational, and educational services. As well as access to wellbeing and leisure activities (rugby, outdoor exercise, gym). Being placed in high or maximum security inevitably makes it more difficult interact with staff - largely due to more restrictive regimes and movements. As well, there will be more limited access to non-contact spaces, group rooms, and psychological staff. Given that rehabilitative programmes are likely to be most effective when organised within supportive therapeutic communities, and that these are typically only available in lower security environments, this does create a number of challenges in terms of both accessing care and the types of therapeutic outcomes which are possible.

Many of the automatically populated items that determine security classification are static. Such as type of offence, number of offences, and length of sentence. However, and while ethnicity is not used as a determining factor, our own data reveals that Māori are significantly and disproportionately disadvantaged in these areas.[26] Disproportionate charging and sentencing, in combination with the weighting of offence history items in the security classification system are likely to negatively affect Māori in terms of

26 https://www.corrections.govt.nz/resources/research/over-representation-of-Māori-in-the-criminal-justice-system/4.0-overall-summary-and-conclusions: August 30, 2023

driving overrepresentation in high and maximum security. Moreover, and by extension, impacting on how mental health care is accessed, what treatments are available, and what outcomes can be expected. An added challenge is that amending an individual's security classification (once assigned) can be difficult.

"…Once the initial security classification has been set, it can be really difficult for someone to work towards reducing their classification. Subsequent security classification "reviews" include an additional section (A5) which requires subjective opinions relating to the Compliance with staff requests, positive interaction with staff and other prisoners, compliance with prison rules, [and] motivation to achieve offender plan activities..."

"…This can lead to this section being heavily reflective of opinions of custodial staff and/or broadly based on file notes which, when people are busy, can tend to reflect only major incidents or negative interactions. The section description for A5 in the guidance document indicates that the case officer completing the review is to "Canvas opinions from unit officers, Unit PCO, CIE Instructor or other employment supervisor, and programme providers to complete this section" but this does not seem to be happening regularly. Of the 25 psychologists… contacted in an informal poll, only two had ever been contacted regarding a security classification review, despite working with people when a security class review had been done, and that had only happened on a couple of occasions. There is very limited opportunity for feedback from case management, psychology, health or programme facilitators to feature in the scoring of these items and it is up to the case officer to seek input. Furthermore there is no guidance to support consideration of input from others such as chaplaincy, kaumatua, physical fitness officers, education tutors, volunteers or whānau (eg: perhaps around motivation)…"

The penultimate point is that while new models of care (capable of leveraging cultural frames) will be critical to improving mental health outcomes for service users - more is needed to consider how whānau input might be integrated within these models or processes. For most Māori mental health services – whānau engagement will be the fundamental platform upon which options for treatment and care are derived. However, and for those delivering care within a prison setting, a significant rethink is required. Both in terms of how whānau might be engaged, but also the extent to which they are able to support therapeutic options for care.

A primary issue of concern is that access to whānau will be significantly compromised. Not simply due incarceration – but also as a consequence of various departmental policies, internal time-tabling, security status, unforeseen restrictions, travel and cost challenges. Challenges that will be in addition to those which are more commonly experienced by community mental health services. Such as effectively engaging with whānau, assessing their willingness or ability to provide support, and the extent to which interactions are therapeutic or counterproductive.

Further still, is the need to consider how whānau engagement or interaction might work best within the confines and restrictions created by a prison environment. Moreover, how these engagements (once developed) can be used for therapeutic purposes. Again in a manner which is reflective of the various logistical and operational constraints.

"…connection with whānau can be critical. But this can be a real challenge in the prisons. Issues around consent, holding whānau hui, and just getting them here (or via AVL) is often a problem. As well as finding them, deciding whether or not they are a positive influence, and if they have the time or resources to engage and support. The tragic thing is that whānau can be massive in terms of providing context and assessment and ya'know just having that contact can have a major impact on the mental wellbeing of the men…."

"…Everyone talks about Te Whare Tapa Wha, but how does that work here when people are deliberately moved away from their whānau. I know there are things that cant happen. But my point is what can we do instead…"

The eighth and final point is that although a range of initiatives have been introduced (over a number of years) to encourage the use of cultural frames within therapeutic settings, and, that these have been shown

to have high value and high therapeutic impact[27] - there is significant potential to build on these developments and create more organised and enduring opportunities. Not simply to increase the number and range of activities – but to deliver outcomes which have not hitherto been possible. *Hikitia*[28] is an example of how opportunities for development and growth within this space can be progressed. Further, an illustration of the type and range of resource required to support success.

"Hikitia represents our commitment to invest more in mental health and addictions treatment. The service will enable a journey towards wellness for men requiring specialised care in prison, uplifting their mana and oranga (wellbeing). The service will provide for people of all ethnicities and cultures.

The service will be built on a kaupapa Māori foundation, reflecting the needs of the disproportionate number of Māori within the prison system. The service recognises access to culture as a right and will draw on traditional Māori knowledge and best practice clinical care."[29]

However, and if gains in mental health and wellbeing are to be explored, investment into the cultural/clinical interface, and the design of new and innovative models of care, including those which accommodate whānau input, will be critical and must be viewed as a priority for future growth and development.

Investment Three: Recommendations

There is a need for a more organised and deliberate approach to the integration and application of culture within therapeutic settings. Initiatives such as Hikitia will go some way to ameliorating these issues – especially in mental health, and as this initiative matures and evolves. However, inconsistent and variable access to culturally inspired or supported mental health supports is likely to remain. And unless active measures are put in place to consolidate how cultural therapies or programmes are delivered and supported.

The challenges created here are not insignificant, and are further complicated by structural and logistical issues, inconsistent access to cultural expertise, broader workforce issues, uneven demand (across sites), and variations in how these cultural investments are utilised and applied. Notwithstanding, prioritization should be given to stocktaking where, how, and to what extent culturally supported or inspired mental health interventions are being delivered. Likewise, understanding uptake, access, delivery challenges, and potential pathways towards developing a more consistent and comprehensive bicultural service delivery model. Within this, consideration should be given to how kairuruku practitioners might be better positioned to assist with delivering enhanced and culturally inspired mental health outcomes. This issue is particularly relevant given the recent review of these roles, the desire by kairuruku practitioners to extend their responsibilities, and the limitations created by resource constraints. To this end, it is worth exploring how the recommendations generated from the *Nga Kete Matauranga*[30] review might be implemented. Moreover, how guidelines might be created to support the more organised and consistent involvement of kairuruku practitioners in mental health service delivery.

Relatedly, it is recommended to explore the mechanisms, policies and support required to increase access for service users and mental health staff to tohunga and cultural experts. Specifically in situations which might involve *matakite* and where advice on appropriate plans of support are required. As noted, variability exists in terms of how cultural processes and practices are applied. Likewise, how Māori models of health are interpreted and utilised. Nonetheless, it will be useful to better understand and elucidate this scope, to explore where gaps and tensions exist, and so that necessary supports can be created. Likewise, with the use of rongoā and so that these traditional remedies (and broader culturally-inspired engagements that can contribute to improvements in wellbeing) can be applied more consistently and in ways which support improved mental health and wellbeing for service users.

In terms of assessing how issues such as security classifications can impact on access for Māori to mental health support, longer-term research and evaluation will

27 Nathan, L et al, (2000), Te Whakakotahitanga: An Evaluation of the Te Piriti Special Treatment Programme for Child Sex Offenders in New Zealand. Psychological Services, Department of Corrections, Wellington.

28 https://www.corrections.govt.nz/news/waikeria_prison_development/hikitia_mental_health_and_addiction_service

29 https://www.corrections.govt.nz/news/waikeria_prison_development/hikitia_mental_health_and_addiction_service

30 Christina Kake (2023), Nga Kete Matauranga: Baskets of Knowledge, Internal Report Prepared for the Director of Mental Health and Addictions. Ara Poutama

be required. Some psychometric instruments use a numerical system to 'level the playing field' to address situations where one group is unfairly disadvantaged by a certain factor. For example, in tools that report on risk for sexual offending, advancing age is modified by a negative score because it is known that scores for older men do not accurately represent their risk – they were 'over-scored'.

It could be that future research will support a re-development of the security classification system or a modifying of the score to adjust for the disparity in sentencing experienced by Māori. This research could, as well, be constructed through a mental health/equity lens rather than simply focusing on the disproportionately higher number of Māori assigned with higher security classifications.

Re-training and upskilling of custody teams to emphasise the importance of depth and breadth of information to form a more balanced and comprehensive opinion (as this relates to possible reclassification) would also help ameliorate current challenges and ambiguities. Revising the wording in the current documentation to ensure input from a broader range of perspectives (including kaumatua and cultural advisors) would further help this process.

Finally, it is recommended that consideration be given to how whānau engagement or interaction might work best within *Ara Poutama Aotearoa*, and in particular within the confines and restrictions created by a prison environment. Moreover, how these engagements (once developed) can be used for therapeutic purposes. While, as previously indicated, whānau engagement would typically be the fundamental platform upon which options for treatment and care are derived within a Māori mental health service, careful consideration is likely required so as to successfully enact this type of approach within *Ara Poutama Aotearoa.*

Investment Three: Timelines

There will be priority, short-term and medium-term activities associated with *Investment Five*. Likewise, some which should be prioritised for urgent action.

In the short-term it should be possible to formalise and introduce approaches to mental health service delivery which strengthen the relationship between culture and mental health and support bicultural practice.

Processes and arrangements to engage tohunga and other cultural supports should be prioritised for urgent attention. Likewise, consideration for the introduction of rongoā Māori and other culturally inspired activities which contribute to orange for service users should be prioritised.

The research and opportunities needed to address the issues which impact on access for Māori to mental health care, such as issue with security classification), will take time to undertake and will be a medium-term objective. Likewise, action to further embed the role of whānau in mental health service delivery will likely be a medium-term undertaking.

INVESTMENT FOUR: WORKFORCE DEVELOPMENT

"…we need more counsellors as it seems to be only one superwoman getting things done here. But one is better than none I guess. Thanks heaps for all your help... !!"

Workforce-related issues were expressed throughout most (if not all) of the interviews, discussions, hui, and presentations. Many of the concerns raised were not always confined to mental health care, or the delivery of mental health services. Rather, more general conversations as to the lack of staff throughout Ara Poutama and the corresponding impact on the ability to provide treatment in a timely, ongoing, and sustainable manner.

As an example, it was highlighted that unlike care provided within a community setting - negotiating access to patients, rooms, resources, and facilities could frequently be difficult. Issues that were often compounded by the availability of custodial staff to facilitate access and where pressures elsewhere would often be prioritised. Simply put, increasing the clinical workforce would not necessarily improve access to care. And unless custodial staff were likewise available to help support this process. Below are some extracts taken from a group interview:

"...Clinic Rooms located in the yard in the units, can be very noisy, distracting. Tāngata whaiora are usually guarded resulting in poor engagement…"

"…Clinic Room doors cannot be closed due to security reasons. Tane hanging around the room can hear the conversations. …On occasions have been locked inside the room with Tāngata whaiora with no Custody Staff in sight, which has created an unsafe environment as

Custody Staff do not have Codes to get into the Clinic Rooms in case of an emergency...”

“...No window coverings, resulting is Tāngata whaiora mostly being distracted and looking outside....”

“...Often due to custody staff shortages, will be asked to see Tāngata whaiora out in the Yard or through the Hatch while they are locked in their Cell...”

“...Tāngata whaiora are called in by custody Staff when they are socialising and engaging with their peers. They often express their dis-content, and embarrassment due to lack of their Privacy...”

“...Other Tane in the Unit become aware of their involvement with Forensics. This may result in other Tane targeting and exploiting Tāngata whaiora to obtain their medications...”

“...Numerous occasions where Custody Staff have interrupted the interview to ask when we will be finishing. This results in reduced quality of care, and coerced into disengagement...”

The recent efforts by *Ara Poutama Aotearoa* to increase the custodial workforce may help ease these types of challenges and the ability of staff to support treatment activities. Notwithstanding it is unlikely that these workplace tensions will ever be resolved completely and may have little impact on other logistical and operational challenges. Such as the availability rooms and negotiating access to service users.

Aside from these issues, are concerns which are specific to the mental health workforce (within *Ara Poutama Aotearoa*) and which extend across a broad and often complex range of challenges. Challenges which cannot easily be resolved, but which will be critical to improving mental health care and outcomes.

"...we actually do not have the number of clinical staff available to provide the care which is needed. Training, recruitment, and retention of staff is a big issue. For the whole sector – but far worse for us. Its not a career option that many would consider to be honest...”

31 K. Mason (1988), Psychiatric Report (The Mason Report), Ministry of Health, Wellington.

32 For example, Te Pou, Te Rau Ora, Le Va, Te Wharaurau, and Te Rau Puawai

Investment Four: Discussion

Mental health workforce issues have been raised as a significant area of concern for at least three decades.[31]

In spite of this, and notwithstanding the various efforts, investments, and strategies to address these deficits[32] – workforce challenges persist as a significant impediment to the effective delivery of mental health services. Issues which were again highlighted as part of the most recent mental health and addiction review.

“Members of the workforce told us of their love of their jobs, but reported stress, burnout and exhaustion from overwork and an increasing risk of assaults. One manager warned, “All the dreams of the Inquiry will come to naught if we don’t have a workforce”. There were loud and clear calls for more peer- support workers; more staff trained in Māori culture and Pacific cultures; and more training in mental health and addiction within primary health care and other sectors (education, corrections, police and social work).”[33]

“We are under-staffed, burning out, told to just get on with it and suck it up. No breaks are allowed on an afternoon shift as they pay us for this time. Abuse towards staff is on the rise ... We are always over 100% capacity. We are asked to do double shifts every day, we feel under-valued and paid.” (Staff voice)[34]

...There have been many times when my stress levels are so high I have been unable to think clearly and make decisions. I feel my clients have not had the optimum care from me as I fumble through the paperwork and the liaising between other health professionals who are often themselves pushed for time. I run out of time to see my young people which is the whole reason I do this job. (Staff voice)”[35t]

Part of the challenge stems from the fact that mental health and addiction workforce is broad. And which includes peer support workers, general support

33 Government Inquiry into Mental Health and Addiction (2018), He Ara Oranga: Executive Summary, Government Inquiry into Mental Health and Addiction, Wellington

34 Ibid

35 Ibid. p59

workers, consumer advisors and advocates, family and whānau advisors, psychiatrists, nurses, counsellors, social workers, psychologists, occupational therapists, psychotherapists, pharmacists, other allied health workers, general practitioners, cultural workers (including kaumātua, mātua, and Māori, Pacific and Asian workers), housing facilitators, primary care coordinators and training providers. Supporting growth and retention across these multiple sectors can therefore be logistically challenging and resource intensive.

As a partial response to these issues, the *Mental Health and Addiction Workforce Action Plan 2017 – 2021 (The Action Plan)* was developed. While the plan highlighted a number of seminal challenges within the sector, such as those described previously, it was largely aimed to:

…identify the priority areas and actions required to develop an integrated, competent, capable, high-quality and motivated workforce focused on improving health and wellbeing…[36]

The plan subsequently identified four priority areas, and fourteen actions. These are described in the following table.

Table 7: Mental Health and Addiction Workforce Action Plan

Mental Health and Addiction Workforce Action Plan 2017-2021			
Four Priority Areas			
1. A workforce that is focused on people and outcomes	2. A workforce that is integrated and connected across the continuum	3. A workforce that is competent and capable	4. A workforce that is the right size and skill mix
Fourteen Actions			
1.1. Implement an outcome approach commissioning workforce development in line with the New Zealand Health Strategy and national frameworks. 1.2. Develop strong leadership programmes and pathways at all levels to support the changing environment. 1.3. Use data gathered to revise and adapt the workforce development infrastructure (national, regional and local) to	2.1. Enable a more mobile, responsive workforce that can adapt to new models of care. 2.2. Strengthen collaborative ways of working to deliver co-ordinated and integrated responses. 2.3. Facilitate health and other agencies to share information, knowledge and resources they can use to address the social determinants of health.	3.1. Build capability across the health workforce to respond to mental health, addiction, and physical health issues. 3.2. Support the development of the primary and community workforce to respond effectively and facilitate access to appropriate responses. 3.3. Strengthen and sustain the capability and competence of the mental health and addition workforce.	4.1. Use workforce data to understand the current and future size and skill mix of the workforce. 4.2. Grow and develop the Māori workforce. 4.3. Develop recruitment and retention strategies to address and grow the Pacific, peer and consumer workforces. 4.4. Develop mental health and addiction career pathways both for those already in health and social services and for new recruits.

36 Ministry of Health, (2018), Mental Health and Addiction Workforce Action Plan 2017–2021 (2nd edn). Wellington: Ministry of Health.

ensure expected outcomes are being met.		3.4. Strengthen the workforce's capability to work in multidisciplinary ways.	

The objectives of the *Action Plan* were ambitious, and highlighted the need for significant and coordinated investment into the mental health workforce. Peripherally, however, the Plan has also signalled the challenges of effectively implementing, monitoring, and sustaining these initiatives. Where it can be argued that many of the 14 actions have been insufficiently met, or at the very least not achieved the outcomes expected. For example, and while the idea to "Grow and Develop the Māori Workforce" is critical, the reality is that this issue still sits as a significant and enduring issue for Māori. Moreover, many of actions (due to being highly interpretive) would be difficult to measure and track.

Notwithstanding these challenges, and our collective ability to measure efficacy, there are three broad conclusions which can be drawn. The first is that any investment into the development of the New Zealand mental health workforce will be complex, involving a variety of different professional bodies, educational institutions, researchers, providers, policy makers, strategists, funders, and representatives of the workforce. The second is that significant resource will be required in order to activate these investments. Resource to not only manage, coordinate, and advance these investments, but to also incentivise careers in mental health, and to support the type and range of activities suggested. Lastly, and perhaps most significantly, is that strategies (of any kind) will be of little value unless these are accompanied by a deliberate suite of well-supported and targeted initiatives. A failure to do so will ensure that the goals promoted, are unlikely to be achieved – or at least to the level anticipated. To this end, and in spite of the investment into workforce development – significant issues remain.

For this review, the implications are that any strategy to address the mental health workforce issues faced by *Ara Poutama Aotearoa* must work in concert with broader developments currently in place within the wider health sector. There is insufficient resource to engage in an alternate or bespoke approach. Especially given the size and scope of the challenge, the resources required, and the fact that leveraging off (or aligning with) existing strategies will be the most effective and efficient path to follow.

What this means in practice is that *Ara Poutama Aotearoa* should avoid replicating any of the current workforce development initiatives. And instead focus its energies on working with and alongside these programmes and strategies. To ensure that the needs of the Corrections sector are integrated within planning and that careers within *Ara Poutama Aotearoa* are viewed as a positive and legitimate opportunity.

Investment Four: Recommendations

Based on the discussion above, it is proposed that a comprehensive review of mental health workforce development strategies is undertaken. That this review focuses on the specific needs of *Ara Poutama Aotearoa* and that bespoke collaborative opportunities are explored. This may include targeted marketing and promotional initiatives, scholarships, internships, and a range of other proactive incentives.

It will be important that the Department seeks (in the first instance) to work alongside existing initiatives (for example Te Rau Puawai[37] or Te Pou[38]) to avoid replication and so that the resources invested are used as efficiently and effectively as possible.

Investment Four: Timelines

It is expected that the recommendation outlined in *Investment Five* is likely to be a <u>medium-term</u> investment.

INVESTMENT FIVE: WORKFORCE RETENTION

Investment Five leads on from *Investment Four* but is sufficiently different (and significant) enough to warrant a standalone discussion. The issues here were again emphasised during various discussions with mental health staff (across various sites and professions) – and in regards to the difficulty of attracting people into the

37 https://www.massey.ac.nz/student-life/m%C4%81ori-at-massey/he-ringa-%C4%81whina-tauira-m%C4%81ori/te-rau-puawai-m%C4%81ori-mental-health-workforce-development-programme/about-te-rau-puawai/

38 https://www.tepou.co.nz/

Department but especially keeping them engaged. The following comment was typical of the issues raised:

"…There are massive workforce issues in the mental health sector. You don't have to read much to know this. Services everywhere are struggling to find staff across all our mental health professions. Those few that are looking to specialize or think about a mental health career are in high demand - and have options. Do you think working in a prison or working with prisoners is appealing. Cause I tell you, for most it isn't…"

"... Ya'know we are competing for a very small workforce and we can't provide the lifestyle, the environment, and the money people want. Let me put it this way - they can get better money elsewhere, better conditions, and better opportunities..."

"...The people working here at the moment have a real passion for the job. But they are not the type of people you find every day…"

Investment Five: Discussion

Recruitment issues may (at least in part) be alleviated by the opportunities created through *Investment Four.* However, the challenge of retention is far more complex and will require solutions which are more active and reflective of the types of challenges which inspire staff to remain or to explore alternate employment opportunities elsewhere. External to *Ara Poutama Aotearoa.*

Many of the mental health staff spoken to expressed concerns about the ability of *Ara Poutama Aotearoa* to retain new staff. Five major challenges were identified.

The first was that the realities of working within a prison setting was difficult for many. The issue of having to frequently submit to screening and monitoring, of having to negotiate access to patients, of requiring custodial support, and simply having to enter and exit a prison facility as a core part of the role. Issues of particular concern to younger staff were also noted:

"…for young people especially, having a good work-life balance is important. The hours we work, and how these are organised, doesn't really appeal to them - especially when they have other options. As well - most of them need their phones. That's how they live their lives, even while at work. Having to hand these over can be a big thing for them you know…"

A second issue concerned the opportunities for growth and development and the perception that these were limited within the current environment. It was felt (by some) that career pathways were both limited and unclear, that support for relevant training limited, and that these issues made it difficult for many staff to see a long-term future for them within *Ara Poutama Aotearoa.*

"…most people want to grow and develop within their area. But sometimes we don't know what our options are and next steps might be. For some people that lack of clarity or opportunity means they will just go a look for options elsewhere…"

The third issue was in part linked to the first but centred on the fact that the clinical environment (particularly with the prison population) was especially challenging. While some would relish this opportunity, for others – these challenges were not especially welcomed. Working with a population with highly complex needs, and with few resources and limited treatment options did not appeal to many. The notion that less challenging clinical settings and opportunities could be explored elsewhere meant that some staff found it difficult to stay.

"…this is not the easiest place to work…there are a whole lot of challenges and things you encounter here that you wouldn't find elsewhere in mental health. Most of the people you see here are ready and willing to stand-up to these challenges. But for others, it's easier to just go and look for another job somewhere else. With less stress and fewer issues to manage…"

A fourth issue was of particular concern to contracted staff. That is, the uncertain and relative short-term nature of contracts and the associated volatility around how future mental health services would be delivered. Issues which made it difficult to attract staff and to likewise provide the level of employment security needed to retain them.

"…what is the bigger purpose of this review, what will happen and what'll be outcomes be for us and our workmates. Everything is really unclear and we can't keep going with all this uncertainty…I don't know if

the Department have a plan or what…it's just all over the place to be fair…"

The final issue was linked to broader issues within the mental health sector. The limited numbers of staff available and the competition from other sectors and professions. To this end, it was felt that it was becoming increasingly difficult to retain staff when more lucrative and secure employment options were available elsewhere. Within an increasingly competitive market - *Ara Poutama Aotearoa* (as well as contracted providers) were not in a position to offer salaries or conditions that would support staff retention.

"…to be honest, the pay that they offer here, and for the work we are required to do, most people will look to move out. Why wouldn't you when you can get more money somewhere else and for doing less work…it's not something people like to talk about, but you know with the way things are going in the economy and the cost of living - money matters…"

"…There have been 80 nurse terminations in the last 12 months and 64 new employees. Better pay is ranked third in reasons for leaving alongside career development (1). Arguably they are one in the same as the latter typically results in the former…"

Investment Five: Recommendations

A deliberate and well-supported workforce recruitment and retention strategy will be fundamental to improving mental health outcomes. While recruiting suitably credentialled, experienced, and enthusiastic staff will help address a number of workload and capacity issues an aligned challenge will be to ensure that these staff are supported and retained.

Like much of what has been described previously – there is no easy solution here. However, an ad- hoc, reactive, disjointed, and insufficiently supported retention strategy is unlikely to achieve the outcomes desired.

It is recommended, therefore, that a formal and comprehensive workforce retention strategy be developed. This strategy will need to consider each of the five concerns raised in the previous section. That is;

1. Options to mitigate and account for workplace challenges
2. Growth and development pathways and opportunities
3. Supporting clinical and environmental challenges
4. Creating certainty and security in terms of contracting and service delivery; and
5. More competitive staff remuneration packages

Investment Five: Timelines

The recommendation described in Investment Five are unlikely to be resolved quickly or simply. Nonetheless, it should be viewed as a long-term *investment*, and which will be critical to addressing many of the workforce retention issues currently experienced. A failure to explore any of the options described previously will only perpetuate and potentially exacerbate existing workforce challenges.

INVESTMENT SIX: LOGISTICAL AND RESOURCING CHALLENGES

Logistical or care delivery challenges were frequently raised by those spoken to. Most often, were concerns raised by clinicians and with respect to the frustrations many experienced when attempting to provide timely and effective care. While it was accepted that to some extent these challenges were unavoidable (and more broadly reflective of the difficulty providing health care within a prison setting) many of the issues experienced were more simply related to structural, environmental, or resourcing factors.

"…in here, health and mental health can be the last thing on a very long list of priorities. I know we have spoke about staffing and all of that, but there are other major resourcing issues as well. You know it's hard to even find a space around here to see people. Then there is the whole issue of getting people to those rooms and how this is organised and prioritised…"

"… [there is] limited utility in increasing person resource when there is not the infrastructure for them to do their work…"

Investment Six: Discussion

The logistical, organisational, and resourcing challenges experienced tended to vary from site to site. But were

nevertheless consistently (and almost universally) raised as an area of particular concern.

"…Clinics can no longer be booked in order of acuity or priority, in order to accommodate Correction Services… tāngata whaiora are now booked to accommodate the booking timetable, and regimes… this is because custody has declined access to tāngata whaiora on numerous occasions as they are currently 'not locked out or cannot be locked out..."

"FMHS (Forensic Mental Health Services) continue to experience hurdles with access, and these includes other logistical barriers including but not limited to, other services utilising the clinic rooms, lack of custody support (meal breaks), and incidents."

"Health Services unable to facilitate tāngata wahiora with decline recommendations from FMHS. i.e., counselling from emerge[39] has a 1 month wait, ACC counselling for sensitive claims has a 12 month wait, and there is no AOD assessment currently available at Spring Hill Corrections Facility. Even with their best efforts, Health Services continuing to experience ongoing issues with prescriptions and medications. GPs are not able to re- prescribe a medication in some instances..."

"…Tāngata whaiora have to be prematurely discharged from FMHS to be able to access Emerge counselling. Due to Emerge service's extended waiting times, tāngata whaiora on occasions have experienced further deteriorated with their mental health..."

A primary issue centred on the lack of available spaces for interviews, and which were often over-subscribed. Compounding matters further were criticisms that therapeutic spaces were more often than not poorly lit, dirty, inappropriately furnished, noisy and lacking in privacy.

"…the spaces allocated to us, even when these are available are not fit for purpose. They are certainly not therapeutic and makes it really difficult for us…We will almost always be discussing highly sensitive, emotive, and personal issues…Even when you can't hear what is being said, people can still see into the rooms. I get that there are reasons for this, but it doesn't help with the discussions we need to have and the outcomes we are want to achieve…"

Time limitations on spaces, which were often due to operational constraints, had a similar impact on the ability to deliver appropriate and sustained care. Sessions did not always conclude when needed nor was sufficient time available to explore or resolve any sensitive issues that may have been discussed. Those receiving care would typically be required to immediately return to a stressful environment, setting, or unit. Cellmates were not always empathetic and thoughts of isolation and helplessness common.

"…it can take a lot of time to explore some of these very personal and challenging issues with the men. It takes a lot of time to get there. But when progress is interrupted due to time-constraints or whatever, you can just pick things up from where you left off the next time around. It doesn't work like that. Also - you cant just start to dig into things, get people to open up and be vulnerable, and then cut them off - send them back and expect it all to be okay. They are left vulnerable, confused, frustrated, angry, and more often than not unstable and worse off!..."

The suitability of existing or conventional models of care was again raised as a significant issue – albeit from a logistical and organisation perspective. Self-soothing strategies were used as an example of how many of the options available here were "off the table" and simply couldn't be suggested or organised. Physical or creative activities, time-out, time in nature, or even social supports were often not available or possible. Even when some activities could be organised, the timing and duration of these were not always useful from a therapeutic perspective.

"…Lack of meaningful activities/work (even if people are able to engage in therapy and form a trusting therapeutic alliance, much of the work can be undone in the idle time between appointments with the therapist…"

Noted too was the fact that access to support people or whānau between sessions was inconsistent if at all

39 Refers to Emerge Aotearoa who are contracted to provide mental health support to people with mild to moderate mental health needs via the Improving Mental Health Service (IMHS)

possible. Obtaining consent posed additional challenges in that there was often the perception that there were few alternatives or that punitive measures would be taken if this was declined. Continuity of care was also identified as a significant logistical and organisational concern. With many of those spoken to noting that care could be interrupted by a number of factors - operational issues, transfer to another prison, or intra-prison transfers. The end result being that those with the most significant need were often being moved on to other locations. Care would therefore be interrupted, progress and outcomes stalled, and with no guarantee of a seamless transition.

"…sometimes we feel like we are just starting to make progress. A good relationship is built, they get better accustomed to their environment and setting and how to manage any issues they might have - given the obvious constraints. Then they are moved out or moved on. I get it, sometimes this is for good reason, though sometimes it's still all a bit unclear. Regardless, the main point is that it's never good for continuity of care and for achieving a positive outcome in the long term..."

While it was noted that corrections staff were generally open to learning more about mental health, high staff turnover did impact on how environments, conducive to mental health and wellbeing, could be nurtured. It was noted that time invested into teaching or upskilling staff on mental health could be quickly undone as staff moved on or were re-deployed.

"…we can spend a good amount of time just teaching staff about mental health. This is often quite information but they at least get a sense of what we are trying to achieve and why we are looking to do the things were are doing. When they understand this, the are more open and helpful. However, when they more on for whatever reason, we have to start all over again. It gets frustrating…"

For those prisoners interviewed as part of this review, similar perspectives and frustrations were expressed. That while most were generally happy with the care provided – resourcing and access issues were frequently raised. *The following comments were typical.*

"…my experiences with mental health services within Corrections has been below satisfactory. While the help I have received has been great for my mental health, it's the path to getting help that has proven to be near on impossible…"

"...It was good [the care received] I have learnt a lot and no matter what I get stressed and feel horrible being bolied-around (sic) and found a new way to clear my head. I thank you so much for everything - it was so very helpful..."

An aligned frustration concerned the administration of psychotropic medications and that these were frequently governed by custodial rather than clinical timelines. Meaning that compliance was problematic for some medications with soporific properties. Especially when the latest that these could be administered was early evening. When ideally, these would be given just prior to "lights-out".

"…the latest they can get medication is 6:00pm or thereabouts. People secrete medication to take later so that they are not sedated…"

Investment Six: Recommendations

The recommendations relevant to this investment area are largely centred on alleviating the various structural, organisational, resource and logistical challenges of providing care within a prison setting. Initially, there will be a need to Be a focus on increasing access to therapeutic spaces within prisons, as well as improving the quality of the therapeutic spaces that already exist. This should not simply focus on increasing the number of spaces available, but to also ensure that they are of the right quality and standard. That they are in fact therapeutic, confidential, and appropriately resourced.

A second recommendation relates to ensuring that the systems and processes that are used to ensure greater access and continuity of care for people who require mental health support (e.g., mental health alerts, transferability constraints) are used consistently and more actively. This process will not only require technical or programming support, but also procedural and policy changes.

The creation of mental-health focused therapeutic communities – including in high and maximum security (step down units) has likewise been touched-on previously. However, and for this investment area, they will be no less relevant and beneficial and especially with regards to managing logistical or structural barriers

to care. Potentially, as well, increasing therapeutic engagement.

Likewise, a more flexible approach to when medications are administered should also be explored. Especially for medications which are known sedatives and as a means of supporting higher levels of compliance.

It is further recommended to consider how mental health services can be more effectively delivered for people with high security classifications. It has been noted elsewhere and throughout this review that the availability of custodial staff would frequently (and ultimately) determine whether or not therapy could be delivered. This largely due to safety concerns and the need for custodial staff to be present or in close proximity. From a therapeutic perspective, having another (non-clinical) person present is unlikely to facilitate open and deep conversations. However, these requirements also complicate when and how rooms can be used. Given the security concerns and the need for custodial support. Notwithstanding the need to manage potential harms to clinicians, the majority of prisoners (receiving care) would pose little threat – but still require this type of supervision. A more sophisticated approach, where the requirement for supervision was based on security status and other behavioural or operational indices, could be employed. Thereby addressing the concern, at least in part, that therapy is not delivered due to a lack (or reallocation) of custodial staff. This recommendation will require additional thought and investigation, especially given the potential range of policy and safety, issues which may need to be explored and resolved. Nevertheless, these are possibilities and options which should be subject to further investigation.

A final recommendation would be to explore how technology (e.g., video-technology, online courses, phones or tablets) might be used more effectively to support prisoners in accessing care. As noted, many of the frustrations expressed by clinical staff have centred on their inability to engage with prisoners in a timely and structured manner. Oftentimes due to the availability of rooms, structural or custodial processes or parameters, or any number of unexpected changes or challenges. Having the ability to make better use of this type of technology, or to explore more innovative modes of engagement, should be explored. There are a number of impediments here, many of which are already known and which include various security related issues, concerns, and controls. Likewise, other logistical issues concerning how these tools or resources and potentially accessed, used, and in what environments or settings. Nevertheless, a more detailed investigation into how video technology might be used to support the delivery of mental health care must be explored.

For Māori, and as *Ara Poutama Aotearoa* looks to deliver health services which are more culturally inspired, the possibility of using technology to engage with whānau is especially relevant. The manner in which this could be used within a mental health setting, and for therapeutic benefit, will need to be carefully and more fully examined. Especially given that whānau input may not always be welcome, or beneficial – and that these issues may be difficult to discern. Likewise, the risk that it is seen as an additional mode of communication, rather than a therapeutic opportunity. Notwithstanding, there will be some considerable merit exploring what possibilities exist and how appropriately framed engagement can be supported through the use of technology.

Investment Six: Timelines

None of the recommendations detailed within this investment area can expect to be completed in the short-term. However, increasing and improving therapeutic spaces should be achievable in the medium-term, as should be any changes which support greater continuity of mental health care. Therapeutic communities, if possible, will require more investment, research, and consideration (both in terms of cost and logistics) and will be a long-term objective, as will the opportunity focused on greater utilisation of technology to support mental health service delivery.

INVESTMENT SEVEN: ROLES AND RESPONSIBILITIES

"...Referrals from medical contain irrelevant medical history...triaging is differed to ISPT or other system as is done in other prison services...70% of the referrals are not appropriate to forensic criteria...Declines take a process in themselves...Some referrals lack information and so an initial assessment must be done by forensic mental health service...The primary for issue for this service [is the]...lack of clarity regarding roles and responsibilities..."

Providing care which is holistic and comprehensive will be key to delivering mental health outcomes which are both positive and enduring. Research, from a variety of

sectors, has highlighted the benefits of multidisciplinary teams and which often include nurses, psychiatrists, psychologists, occupational therapists, trauma counsellors, social workers, alcohol and drug specialists, and for New Zealand at least – cultural advisors, kairuruku hinengaro, and other support workers.[40]

The ability of these teams to operate in an integrated and coordinated manner will be essential to ensuring that the benefits of this type of approach are maximised. Further, that care is delivered in a way which meets the diverse needs and expectations of those in our care. While the efficacy of this approach is well considered, a number of those spoken to raised concerns about how these theories were applied in practice. How care and support was organised, the extent to which needs were being met, and how both clinical and non-clinical roles (including cultural) were coordinated to bring about mutually supported mental health outcomes. Additionally, how current contracting arrangements were not always able to support a comprehensive, coordinated, uniform or sustainable approach to the delivery of care.

Investment Seven: Discussion

The utility of having access to a team of specialists, with a range of skills, and who are able to meet the diverse mental health needs of those in our care will be critical to improving mental health outcomes. Access to a full suite of interventions, therapies, medications, resources, facilities, and cultural supports will be critical. While *Ara Poutama Aotearoa* has been eager to ensure that a comprehensive and holistic range of treatment and support options are available, the management and application of these investments has not always functioned in the way anticipated. In discussions with a range of different teams and staff, there was broad consensus as to the efficacy of this approach – however, the application of these concepts within *Ara Poutama Aotearoa* was often confounded by a range of challenges.

It was frequently expressed that access to multi-disciplinary teams (or staff) tended to vary across the estate, meaning that the type and range of care available would typically be uneven. Capacity issues, administration challenges, organisational and relational challenges would further impact how these teams would function and how care was delivered and accessed.

A number spoke about the utility of external contracts at spoke[41] sites vis-a-vis the option of building internal capacity and capability. Likewise, the opportunities and challenges of making mental health roles discipline specific or generic to clinicians. Additionally, whether or not direct sourcing was the best option as opposed to going to market – especially for hub site services. As well, and in this regard, how direct sourcing with local iwi (particularly those involved in mental health services provision) could be explored as a way of ensuring access to cultural expertise. Ideally, expertise that could help support the cultural/clinical interface and in order to drive enhanced mental health outcomes for Māori.

For nurses, many spoke of the fact that they didn't always work to the top of their scope and that there was confusion with regard to their role versus the role of health in 'nurse-led' tasks. Typically, many were not providing comprehensive nursing and instead undertaking brief mental health assessment and coordination. These issues were sometimes compounded due to their managers frequently not being nurses and directing clinical nurse specialists (mental health) not to engage in general nursing related tasks.

Other inefficiencies were likewise identified with examples of how some clinical psychologists (particularly those working in acute spaces) would only see some patients periodically and oftentimes just once. This caused some frustration in that (understandably) it was not possible to achieve any outcomes under these circumstances and may in fact have a negative impact on wellbeing.

"…sometimes we feel like the focus is on being seen to have done something, rather than doing something which is helpful or therapeutic. It's all about the

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40 Mason T., Williams R. and Vivian-Byrne S. (2002), "Multi-disciplinary working in a forensic mental health setting: ethical codes of reference", Journal of Psychiatric and Mental Health Nursing, Vol. 9 No. 5, pp. 563-72.

And, Nic a Bháird C., Xanthopoulou P., Black G., Michie S., Pashayan N. and Raine R. (2016), "Multidisciplinary team meetings in community mental health: a systematic review of their functions", Mental Health Review Journal, Vol. 21 No. 2, pp. 119-40. And, Orovwuje P.R. (2008), "Contemporary challenges in forensic mental health: the ingenuity of the multidisciplinary team", Mental Health Review Journal, Vol. 13 No. 2, pp. 24-34.

41 The 'hub and spoke' model for mental health services was implemented in 2022 and resulted in mental health staff based at prison sites which did not have an ISPT being brought under the line management of clinical managers of ISPTs in the same region.

numbers and outputs, rather than whether or not it's making a difference..."

"...We have traditionally focused on addressing mental health need in the ISU due to perceived acuity, relative ease of access (due to staffing) and public perception, however there is a large volume of unmet need in the wider prison - as evidenced by waitlists for IMH..."

Beyond these concerns were other, arguably more significant issues, which highlighted the fact that the deployment of staff, across the estate, appears to be inconsistent and not always based on the level of need. With little indication as to why and what formula was used to determine staffing ratios. The challenges created here are not insignificant. At best contributing to an inefficient use of staff and resource (at some sites) while promoting high levels of unmet need (at others). These are at least to some extent, a reflection of the desire to improve access to care, but without a clear and well-reasoned formula as to how and where this resource should be distributed.

Moving forward, it will be important that a more sophisticated, reasoned and transparent approach is adopted. One which is able to balance the level of need, alongside the quantum of resource available. The challenges here are that both need and resource are likely to fluctuate and therefore require a model or approach which is dynamic (and malleable) enough to accommodate both.

Investment Seven: Recommendations

There are a number of seminal recommendations attached to *Investment Seven.*

The first concerns the development and implementation of a mental health staff allocation model to ensure that appropriate staffing levels are available at each site to support the effective delivery of mental health services.

Secondly, that consideration is given to the development of ISPTs at prison sites which don't currently have these teams.

Thirdly, that a review is undertaken of the responsibilities of existing mental health resources to ensure effective delivery of mental health service delivery models, and that staff are delivering support which is appropriate to their scopes of practice.

Clinical nurse specialist - mental health (CNS) roles, for example, could be developed to be more specialist and nursing specific (e.g., include responsibilities such as providing and monitoring psychotropic medication, metabolic monitoring etc.) and be focused on the ISU. The advantages here are that health interventions within the ISU tend to be acute, brief and urgent. Needs range from complex physical health needs such as intoxication and withdrawal to acute mental health risks. Nursing skills and training lend themselves well to this environment due to their breadth across mental health and physical health domains. A CNS would be able to provide intervention and advice to other staff regarding the care and management of people with the highest acuity in the ISU, as well as providing direction and delegation to a small team of junior nurses to ensure the needs of the people on the ISU are met (medication administration, initial health assessment, wound dressing etc.) It is also recommended that a psychologists' role is predominantly in providing comprehensive assessment, formulation, diagnosis and talking therapies (i.e. Service Level C) for those with complex mental health needs in the wider prison, rather than providing brief interventions or responding to acute needs. This would ensure staff are utilising their specific skill sets to best meet the mental health needs of people in prison and may contribute to increased job satisfaction.

It is further recommended is that trauma counsellor and trauma-focused roles be phased out in favour of ensuring that all mental health staff have the skills in responding to trauma-related issues. At present, trauma counsellors are generally NZAC qualified - however role descriptions do not define what skills they would require or what work they will be undertaking. It is also unclear how their role differs from ACC sensitive claims counselling. Further, whether or not trauma counsellor roles should be converted to a wider range of mental health professionals. The specific role at times creates confusion in that staff should intuitively work in a trauma-informed way and work with people who have experienced trauma. If the issue is around support for issues such as severe post-traumatic stress disorder, it might be more appropriate for people to be referred to a clinical psychologist. In a similar way, the role of social workers within mental health teams could be better clarified or extended. Given that within the ISPTs they often undertake the same clinical work as others, however, may not be working to the top of their scopes or utilising all of their skills.

Finally, consideration should also be given to how a lived- experience perspective could be built into the

design, delivery and governance of mental health services.

Investment Seven: Timelines

The development and implementation of a mental health staff allocation model should be prioritised for immediate attention. All other recommendations within *Investment Seven* should be considered short-term investments.

INVESTMENT EIGHT: AOD AND MENTAL HEALTH

Co-existing mental health and addictions problems are common. Within community settings, approaches to treatment and care are typically complex and rely on integrated and multidisciplinary modes of support. Most often requiring assessments by skilled practitioners and who are able to discern the interconnected, dynamic and at times conflicting interplay between mental health and addiction issues. As with many of the issues previously discussed within this review, these challenges will be significantly amplified within a carceral setting. Not simply due to the availability of care and support, or various logistical barriers – but also because the prevalence of these types of issues will be higher, more complex, more difficult to treat, and with anticipated outcomes that are likely to be more modest and difficult to measure.

Investment Eight: Discussion

A systematic review and meta-analysis of reports looking at the current and lifetime prevalence of coexisting substance use and mental health disorders among people in prison across 21 countries was undertaken by Baranyi and colleagues [42]. Two studies from New Zealand were included in the 50 studies considered in the review. These being the investigation of the prevalence of psychiatric disorders among New Zealand inmates[43] and the more recent study of comorbid substance use disorders and mental health disorders among New Zealand prisoners.[44]

Overall, Baranyi's review found a high prevalence of coexisting disorders among people in prison with about half of the total studied population with non-affective psychosis (49·2%) or major depression (51·6%) also having a coexisting substance use disorder. The review highlighted the need to be cognisant of the relationship between mental health, substance use disorder and suicide risk. Further, that coexisting conditions were more common among survivors of adverse childhood events, physical and sexual abuse. Notwithstanding the utility of these findings, the study likewise warned against over-reading these data. Noting that the analysis often required significant nuancing. And for example that the needs and experiences of women are different to those of men and likewise the experience of substance use disorder and addiction will likewise be variable between women and men.

Having a co-existing substance use disorder can worsen the prognosis and increase the severity of symptoms of mental health conditions and is associated with poorer treatment responses and adherence to medication for mental health. Substance use disorders are associated with premature mortality for many with two or more coexisting mental disorders.

Compared with someone with a single disorder, those with coexisting conditions (including behavioural addiction) have been shown to have higher psychopathological severity, increased rates of risky behaviour (including suicidality), which can lead to infection with diseases such hepatitis C virus[45], psychosocial impairments (e.g. unemployment, homelessness) and criminal behaviour[46].

Studies have indicated compared with other people who are incarcerated, those with coexisting conditions have more serious criminal histories, including previous incarcerations and violent offences, and higher rates of serious institutional misconduct while in prison.

After release from prison, individuals with coexisting conditions have been found to have a higher risk of

42 Baranyi, G. et al. (2021). The impact of neighbourhood crime on mental health: A systematic review and meta-analysis. Soc Sci Med. Aug;282

43 Simpson, A. et al. (1999). The national study of psychiatric morbidity in New Zealand prisons. Auckland: Department of Corrections

44 Indig, D. et al (2016). Comorbid substance use disorders and mental health disorders among New Zealand prisoners. New Zealand Department of Corrections, Wellington

45 Khalsa, J. H. (2008), 'Medical consequences of drug abuse and co-occurring infections: Research at the National Institute on Drug Abuse', Substance Abuse 29(3), pp. 5–16

46 Greenberg, G. A., & Rosenheck, R. A. (2014). Psychiatric correlates of past incarceration in the national co- morbidity study replication. Criminal Behaviour and Mental Health, 24(1), 18–35

reincarceration, attempting suicide, and hospitalisation due to injuries than do those without.

Offenders with untreated mental health conditions have been found to have a higher recidivism rate and a greater number of criminogenic risk factors than those without mental health conditions[47]. Imprisonment offers an opportunity to identify and manage mental health conditions, substance use disorders and behavioural addictions which may not have been possible in the community. Thus, it is important that this opportunity is positively framed, and that the workforce maintain a positive attitude, hope and optimism.

Unlike substance use, mental health conditions are not considered risk factors for criminal behaviour according to the Risk-Needs-Responsivity (RNR) framework, but coexisting conditions can be a responsivity variable that impacts on the success of interventions to address criminogenic needs.

Given the over representation of Māori in the criminal justice system and prisons in particular as well as the number of Māori in prisons with a range of coexisting conditions it is important to understand 'culture' as an important part of engagement, responsivity and reintegration to community. *Te Ariari o te Oranga*[48] continues to be an excellent source to explore the role and function of culture in working in the coexisting condition space.

Even though screening and assessment might capture coexisting conditions, assessment of mental health, substance use and coexisting conditions is a process, not a one-off event. Some mental health symptoms may reduce over time with abstinence while others may develop after reduced use or abstinence.

Treatment of mental health conditions in prison can mirror treatment objectives within the community - albeit from a different perspective: ameliorating symptoms, minimising disability, supporting individualised recovery goals. While the environment of prison may not be therapeutically conducive, it can offer a controlled setting where ongoing substance use can be reduced (if not stopped) thus allowing a better opportunity to understand the nature of the relationship between the coexisting conditions, the role substance use plays in a person's life including its impacts on recidivism as a responsivity factor.

Further to the point above - and in relation to the environmental conditions within prisons, there is also some evidence to suggest incarceration can exacerbate previous traumatic experiences through situational triggers (e.g., discipline from authority figures, strip searches), institutionalised racism, separation from children or family, or further exposure to trauma in prison.[49]

There is general agreement that coexisting conditions should be addressed simultaneously taking an interprofessional approach with the different team members working towards common goals. The three ways coexisting conditions are often talked about being addressed are sequentially, in parallel or in an integrated way, depending on the type and severity of the conditions involved. Also making a difference will be the roles, education, training and experience of the workforce.

Sequential means the coexisting conditions are treated consecutively and there can be little communication between services. The most serious 'problems' are often treated first and then any other 'problems' are addressed. In this model people are often passed between programmes and services risking 'falling between gaps'.

The parallel model sees the various conditions being undertaken at the same time, with the mental health and AOD services liaising to provide services concurrently. Incarceration can exacerbate differences in approaches and goals with the need to take into consideration the physical location and custodial requirements.

Integrated care is potentially a way to reduce fragmentation, duplication and risk of 'falling between the gaps' with one service or team addressing coexisting conditions. This model lends itself to the 'no wrong door' philosophy which promotes the mental health and AOD treatment workforce understanding that addressing coexisting conditions is core business.

Regardless of which model is utilised by mental health or AOD services, care should be coordinated and connected to ensure screening, assessment and treatment is appropriate. If a programme or service is

47 Shishane K, John-Langba J, Onifade E (2023) 'Mental health disorders and recidivism among incarcerated adult offenders in a correctional facility in South Africa: a cluster analysis.', PLoS ONE, 18 (1), e0278194

48 Todd, F.C. (2010). Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems. Wellington: Ministry of Health.

49. Liu, H. et al. (2021). Trauma exposure and mental health of prisoners and ex-prisoners: A systematic review and meta-analysis, Clinical Psychology Review, 89

not available to someone they should be guided by active referral to the right service with follow-up to ensure that they receive the appropriate care.

Investment Eight: Recommendations

The issues and challenges described previously have highlighted the need for the provision of AoD care which is sufficiently nuanced from the delivery of mental health care. Moreover, and while sharing similar and oftentimes overlapping concerns, these are often contextually different and which is likely to impact on what treatment options are available, how these are delivered, and what outcomes are possible. One overarching recommendation arises from the discussion section, that is, to improve the integration of mental health and addiction services and initiatives where possible. This is likely to include a number of key steps, including:

- To better integrate community-based mental health services with community-based addiction services in order to provide more comprehensive care for co-existing mental health and addiction issues and maximise resources.
- To consider whether dedicated addiction support could be integrated into ISPT teams.
- To develop a more coordinated approach to assessment, formulation and treatment planning across mental health and addiction services.
- To better integrate prison-based mental health teams with prison-based addiction services (e.g., Drug Treatment Programmes).

Investment Eight: Timelines

Given the opportunities presented here. All of these recommendations should be flagged as <u>medium-term</u> investments.

INVESTMENT NINE: FORENSIC MENTAL HEALTH SERVICES

"…it appears that patients who would previously have been institutionalised in psychiatric hospitals prior to deinstitutionalisation, are now more frequently being reinstitutionalised in prisons without (or at a greatly reduced level of) access to treatment…"

Many of the challenges identified within this review are not entirely unexpected and are in part a reflection of the immense difficulty of providing health care within a prison setting. Beyond these challenges is the assertion that the prison population does not mirror the general population. And in terms of mental health, the issues encountered will almost certainly be more complex, chronic, acute, more difficult to treat, and accordingly lead to outcomes which are far more modest.

Notwithstanding these concerns, the challenges encountered by those within the Forensics space will often be amplified further. Particularly in terms of the expected level of acuity, the resources required to provide care, the additional demands on staff and facilities, the training required, the likely physical and behavioural challenges experienced as well as more measurable differences in what treatment outcomes are possible and the limitations on how care is provided.

Moreover, and while issues associated with variations in care (within sites across the corrections estate) have already been discussed, these concerns are no less likely to occur across forensic services. The reasons for this are in part due to the manner in which each service has been set-up and in order to account for regional variations in treatment, access to staff and resources as well as broader philosophical differences in terms of how to best deliver care. Nonetheless, and in spite of these variations, there are a number of common features or characteristics of Forensic Mental Health Services across the country, challenges which are similarly held, and which likewise present options for future development and growth.

Investment Nine: Discussion

Over and above the issues and opportunities previously described, is the idea that the challenges and concerns experienced by Forensic mental health services are not uniformly expressed across the corrections estate. And that while there will be many features of common interest - there will also be areas of dissonance, and which are significant enough to warrant particular attention.

Insofar as there remains a need to develop new therapeutic models of care for mental health services within *Ara Poutama Aotearoa*- it is also worth contemplating how these might function within the sphere of services provided by Forensics. Whether or not these new models are suitable for Forensic Mental Health Service teams to adopt, what emendation might be needed (if any), or if in fact entirely new models (bespoke to Forensics) are needed. In this regard, there is a growing body of evidence to support the need for more nuanced approaches to the delivery of care by

Forensic Mental Health Services.[50] Ideas which were further supported and emphasised as part of various discussions with staff and leading clinical academics. Notwithstanding the fact that some unique models of care had developed (or evolved) over time – the concern was that these were not always standardised, documented, or assessed for efficacy. Likewise, considerable time invested into the design of model - less-so, their application. More was therefore needed to investigate the application of these, how they might be better or more formally implemented and what amendments may be required.

Other opportunities centred around how care was managed, accessed, and organised. In this regard, it was suggested that considerable benefit could be had by simply exploring alternative pathways and treatment options for prisoners. This would be especially relevant for those prisoners that met the criteria for the Mental Health Act but who (for whatever reason) were not treated for extended periods of time due to a shortage of inpatient beds.

Managing security requirements alongside therapeutic opportunities was again identified as an issue of concern. While touched on previously, particular challenges were noted when attempting to balance these requirements when delivering to support to those who require forensic-level care. Given that security levels can vary (and change) and that this would inevitably impact on the continuity of care across services, how resources are shared, and what outcomes are possible.

Concerns were also raised about the lack of information and research to better support data driven decisions. Further, that many facilities were not always suitable for safely housing and treating high-security prisoners. It was also noted that in some regions that 'special needs units' or 'vulnerable units' would be beneficial and as a space where prisoners who did not meet the criteria for compulsory assessment and treatment (under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the 'Mental Health Act')) could be safely housed without being placed in an ISU.

Another unique challenge is the inability to enforce the compulsory treatment element of the Mental Health Act within a custodial environment. There are of course ongoing debates as to the effectiveness of compulsory treatment, and the use of compulsory treatment within prisons. However, there is more uniform agreement on the implications here and that patients who come in under a community treatment order do not receive the same level of care in prison as what they would in the community.

Leading on from these issues were broader concerns as to the lack of acute mental health inpatient beds. An issue which was often exacerbated by the issues described previously and further compounded by the lack of robust data on bed availability. While it was noted that these types of concerns could not easily be resolved, it was at least proposed that they could be managed better through adaptations to existing models of care, rather than simply looking to increase resources which may not always be available.

Insofar as other issues were expressed, and potential solutions contemplated, a suite of opportunities (with multiple potential benefits) centred on process and procedural matters and in particular how admissions to forensic inpatient units were managed. The Criminal Procedure (Mentally Impaired Persons) Act 2003 provides a useful example of where potential challenges and remedial options exist.

As part of the administration of the Act, report writers may be required to determine a prisoner's fitness to stand trial. If remand prisoners are found unfit to stand trial they can be court ordered to receive inpatient treatment. Patients who are found to be insane may be made special patients and therefore ordered into the forensic inpatient unit for rehabilitation and treatment. In situations where report writers are not able to assess the person in custody or the community, a section 38 (2)(c) report may be ordered, and which requires that the court ordered assessment to take place within an inpatient facility.

While the need for these types of mechanisms and processes are founded on both clinical and legal concerns, the process inevitably reduces that capacity of the service to admit acutely unwell men from prison. Therefore, disrupting any planned admissions of people on the waitlist – largely due to the fact that court ordered admissions will typically take precedence over existing patients on a waitlist. Oftentimes irrespective of need and level of acuity.

The result is that prisoners are often left acutely unwell in a custodial environment while waiting for admission to a forensic inpatient unit - typically segregated and placed in the ISU to keep them safe. Often left waiting for weeks (at times a month or more) prior to admission

50 McKenna, B., & Sweetman, L.E. (2020). Models of Care in Forensic Mental Health Services: A review of the international and national literature. Wellington: Ministry of Health.

taking place. This results in various challenges for the unit staff, other prisoners who are vulnerable on the unit, and the mentally unwell prisoner who should be at the centre of our care.

Referrals (or at least the process for receiving these) was an additional source of frustration and concern. Noting that the majority of the referrals received from *Ara Poutama Aotearoa* come directly from the Health Team and that the mental health teams across all four sites do not have a single point of entry process set up for mental health referrals. To this end, referral to Forensic Mental Health Services continues to be the default position for Health staff- resulting in large numbers of inappropriate referrals but still requiring input from Forensic Mental Health Services to review mental health records. An issue which could in part be resolved by undertaking a secondary screen post use of the Mental Health Screening Tool[51] (MHST).

“…in MECF – we receive between 20 – 25 referrals a week taking a minimum of 30 mins. paper triage/ review – majority are closed without requiring even face to face assessment let alone admission on to the Forensic team’s caseload...”

“…We have noted the lack of communication with Ara Poutama mental health teams and Ara Poutama health staff and this can be problematic to navigate...”

It was noted too, that the remand population had increased across all sites and that this was predicted to continue. Likewise, that remand prisoners have high health care needs for both physical and mental health reasons. Acuity is often higher when taking into account other variables bought in from the community – substance misuse, homelessness, and a lack of engagement with the health sector.

“…An additional issue around the increase in need for remand beds is the transfer or movement of the prison population to manage the remand bed requirements- We have no influence over these movements despite Ara Poutama ‘Forensic transfer constraints’ being requested but still ignored…”

It was noted that across most sites access to review tāne and wāhine who have been referred has become increasingly problematic. Much of this was seen to be due to workforce resource issues across *Ara Poutama Aotearoa.* But likewise, because of access to non-contact booths, private interview space on wings, overloaded booking systems, Forensic Mental Health Service staff safety concerns and sharing space with staff, including other external contractors (e.g., IMHS clinicians etc.), *Ara Poutama Aotearoa* Psychological Services and other internal mental health teams (i.e., ISPTs).

“…the issues of access however do not mitigate when Ara Poutama make referrals or ask for additional input due to concerns – everyone asks why we have not reviewed but no one questions how we get to see them…”

“…Anyone on the Forensic waitlist for example are meant to be reviewed on a weekly basis (KPI) which relates to an update on how their individual urgency for admission is prioritised – we cannot access even some of these prisoners which have been identified as some of the most “high risk” on site as they meet criteria for admission under the Mental Health Act…”

It was further expressed that the lack of mental health inpatient beds led to longer periods in custody for prisoners requiring admission to both general mental health beds and secure beds. Longer periods of untreated serious mental illness could therefore be expected – impacting short - and longer-term recovery.

“…Forensics is definitely being impacted by the lack of beds for mental health service users in the Northern Region and unfortunately those identified as requiring a bed can find themselves remanded in custody due to the lack of anywhere else for their placement…”

“…These individuals are being cared for and managed by visiting Forensics staff but on the whole untrained mental health Custodial staff from Ara Poutama with identified risk to both services…”

Forensic Mental Health Service staff also expressed that they felt pressured to admit into secure beds prisoners that ordinarily would not have met the criteria for a secure bed. Those that ideally should have been admitted to the least restrictive option of their local general mental health unit. Prisoners in these situations would often cause a high level of disturbance and

51 The Mental Health Screening Tool (MHST) is a screening tool administered by Ara Poutama nursing staff during health screening processes with prisoners to screen for the presence of mental health need.

management issues in the custodial environment with pressure then placed on the forensic team to manage the forensic waitlist.

Resourcing and staffing issues were again raised as significant issues for forensic psychiatric teams. In spite of the fact that a multi-disciplinary approach was promoted and encouraged, majority of the caseload access, management and co-ordination would sit with nurses. Adding to these issues was that there was often no "cap" on caseloads with the majority of referrals accepted. While active recruitment was ongoing, there remained a shortage of highly experienced mental health staff.

Investment Nine: Recommendations

Many of the recommendations attached to *Investment Nine* are consistent with those described elsewhere within this review – albeit with the need to reframe these from the perspective of Forensic Mental Health Services.

It is worth ensuring that clear agreements are developed between *Ara Poutama Aotearoa* and Forensic Mental Health Services outlining the roles of responsibilities of both organisations with respect to the delivery of mental health services within prisons.

Secondly, it is recommended that *Ara Poutama Aotearoa* work alongside Forensic Mental Health Services to consider additional options for improving mental health service delivery within prisons and addressing issues such as challenges with accessing mental health inpatient beds. This may require innovative and creative thinking about how to best utilise limited fiscal and staffing resources. What resources are needed to support this, and how regional variations in care can be accommodated within any options proposed, will need to be carefully considered.

It is further recommended that *Ara Poutama Aotearoa* collaborate with Forensic Mental Health Services to ensure that effective data and information sharing practices are occurring, particularly with respect to people in prison who are receiving forensic-level support, and those who are receiving, or are requiring, mental health inpatient admission.

A further recommendation is that *Ara Poutama Aotearoa* work with Forensic Mental Health Services to improve the referral processes to these services. This is likely to overlap with the opportunities already made about the development of a single point of entry mechanism for mental health referrals.

A final recommendation is that that Ara Poutama collaborates with Forensic Mental Health Services on initiatives to address workforce issues which affect this level of service delivery. This recommendation is again likely to overlap with others identified as part of this review, and in particular those focused on developing and implementing mental health workforce develop and retention strategies.

Investment Nine: Timelines

The development of an updated service level agreement with Forensic Mental Health Services should be prioritised for immediate completion.

The process of investigating workforce related issues should be completed in concert with other workforce-related initiatives and be prioritised as a short- term investment.

Improving the process of referral to Forensic Mental Health Services with prisons should be completed alongside other work to streamline processes of referral to mental health services and should therefore be considered a medium-term investment. Increasing the availability of data relating to forensic service delivery and inpatient mental health bed availability is likely to be a short-term investment.

Improvements to service delivery models and identifying and implementing solutions to mitigate challenges with accessing inpatient support will take longer (medium-term investment) and again could be included as part of a broader programme of work to develop and implement improved models of care for mental health service delivery within *Ara Poutama Aotearoa.*

INVESTMENT TEN: YOUNG PEOPLE (EMERGING ADULTS)

A number of meetings and hui (both online and in person) were organised to explore the particular issues faced by young people within prison. These discussions were largely centred on the more specific issues and challenges they were likely to encounter, how these might differ from the adult population, and what remedial or focused solutions might be possible. Justice issues, background and environmental catalysts often featured as part of these conversations. However, particular emphasis was placed on understanding the specific mental health challenges likely to be encountered and what supports (not currently

available) might be possible or should at least be considered for future consideration.

Investment Ten: Discussion

Research into youth imprisonment has often focused on criminogenic drivers, environmental catalysts, and longer-term outcomes. Typically highlighting the importance of socioeconomic factors, family/whānau environment, peer influences, substance abuse, poor experiences of education, neighbourhood environment, limited recreational opportunities, and the impact of social media.

Once in prison, a range of other concerns are likely to emerge. Which, while not necessarily unique to young people, were likely to have an impact which was disproportionately more significant when compared to the adult population. Including – concerns over safety, the removal of educational opportunities, heightened feelings of isolation and loneliness, ill-suited rehabilitation programmes, greater risk of exploitation, and family strain.

Insofar as mental health issues are concerned, many of these have already been expressed – and include anxiety, depression, stress, and trauma. But which will similarly have a greater and more profound impact on young people. Moreover, requiring solutions which are better targeted and resonant.

"...In their 1990/1 reconviction study, Bakker and Riley (1994) found young offenders (aged 24 or less) did not respond as well to psychological treatment as older offenders....follow-up studies of young offenders show the most effective treatments involve people significant to the young offender – family, educational institutions, employers, peers and all the offender's social networks. Institutional programmes here must try to involve such people, and be extended into the community on release..."

"...The psychological treatment the Psychological Service provides to young offenders is, as discussed above, less effective than with older offenders. One reason for this may be that the service has not developed or implemented specific psychological treatment programmes for the young..."

Within the various discussions and interviews, it was noted that in spite of what was known about youth mental health and wellbeing, access to appropriate care and support remained challenging. Moreover, that the specific mental health concerns of youth were seldom considered in relation to security status and which could further aggravate already existing challenges. An inability for young people to "settle" or to be "managed" into a prison environment was also seen as a major risk and missed opportunity to mitigate immediate challenges which could manifest into more significant mental health concerns.

It was further noted that mental health, attention deficit hyperactivity disorder or other neurodiversity- related issues, in combination with hypervigilance/ hyperactivity, is a common presentation for young people coming into prison. Further, that these can significantly influence initial presentation, but which may lessen given time and once the young person has adjusted to this environment.

Investment Ten: Recommendations

There are a number of recommendations attached to *Investment Ten* – some call for high-level change or strategic support. While others are more specific and directly connect to service delivery or clinical engagement.

The first is that processes are developed for ensuring that young people in our care are prioritised in relation to accessing and receiving mental health support.

A further recommendation is that security classification processes as they relate to young people are revised, including consideration of the role of mental health services in these processes.

An additional recommendation is that settings are provided to allow young people time to settle before discerning placement/security class decisions in initial presentation. This is particularly relevant given that the prison environment can be incredibly destabilising for young people.

Options for facilitating early engagement for young people with mental health services should also be offered during the settling in and adjustment phase. This will help combat concerns which are likely to emerge during this period and mitigate the risk of these developing further or into more serious concerns.

There also appears to be a lack of research and insight into the specific health needs and concerns of young people within prisons. Undertaking bespoke, targeted, and translational research will be required to better

understand these issues and to create better informed solutions.

Investment Ten: Timelines

Positioning young people as the focus on mental health care should be seen as a priority and short-term investment.

While including mental health as a key consideration in relation to the placement of under 25's in maximum security should be prioritised. The implementation of this will take time to complete and should be seen as a medium-term investment.

Due to a range of structural, logistical and resource considerations, the provision of secure settings will likely be a long-term objective. However, exploring how early access to counselling might be facilitated (specifically for young people) need not be so cumbersome and can be implemented reasonably quickly – through prioritisation/reallocation and the utilisation of existing systems, processes, or services.

Research into the specific needs of young-people in prison should align with the research investments described later in this review - but should be positioned as a research priority area and once a programme of research investment is developed.

SUMMARY TABLE: POU RAUTAKI: MENTAL HEALTH INVESTMENTS

Table 8: Investments and Descriptions

Investment	Description
Therapy within prison setting	Developing new models of mental health treatment and care which are suitable to a prison setting.
Women in Prison	Ensuring that approaches to treatment and care are cognisant of the particular needs and concerns of women. Likewise, that health promotion and education initiatives are reflective of these needs.
Cultural Catalysts	That new models and approaches are developed which are able to utilise culture within therapeutic settings. Particular emphasis will need to be placed on the role in culture in promoting clinical outcomes.
Workforce Development	That a suite of initiatives are established to build the mental health workforce within Ara Poutama
Workforce Retention	The introduction of a range of measures to support, develop, and retain mental health staff within Ara Poutama
Logistical and Resources Challenges	A focus on addressing multiple logistical and structural issues which impede service delivery and mental health outcomes.
Roles and Responsibilities	Better clarity and integration of the roles and responsibilities of the various mental health services that provide support to people under the care and management of Ara Poutama.
AoD and Mental Health	Further integration of mental health and addiction services and initiatives within Ara Poutama.

Forensics	Strategies to better support the delivery of forensic mental health services within Ara Poutama.
Young People (Emerging Adults)	A focus on the particular mental health needs of young people in prison. More bespoke approaches to treatment, early intervention, and mitigation of long-term harms.

POU KOKIRI: MENTAL HEALTH CATALYSTS

Beyond the service and delivery related Investments described above were other factors which were seen as essential to improving mental health outcomes. While some of these were detailed within the *Mental Health Platforms* (and as part of various population health initiatives) - other opportunities were also identified - but which did not always sit well within this context. To a great extent, these were seen as mental health supports, or scaffolds, and essential to establishing a foundation upon which various service delivery initiatives could be developed, sustained, and potentially extended.

In this regard, *five Catalysts* for mental health have been identified.

CATALYST ONE: MEASURING SUCCESS

Catalyst One: Measuring Success is in many ways connected to *Investment One: Therapy within a Prison Setting* but is sufficiently different enough (and significant enough) to warrant its elevation as an independent area of interest. To this end, and notwithstanding the desire to better investigate and implement more bespoke methods of treatment and care, the ultimate success of these interventions will likely depend on the extent to which positive progress is achieved. Moreover, how outcomes are measured and whether or not these tools/measures are relevant and fit-for-purpose. There are a number of potential solutions here.

Adopting a population-based approach, for example, has some appeal and could be derived from epidemiological or prevalence data. Ideally by collecting base-line information and before subsequently (and routinely) administering follow-up studies. By comparing data, across a range of variables (including demographic, ethnic, site, and classification) and across various mental health disease categories, it may be possible to detect changes in prevalence (within prisons) and to likewise map progress.

There are however a number of challenges with this approach – both technical and logistical. The first is that the logistical challenge of routinely undertaking these types of studies are likely to be immense. And, that in order to secure a sufficiently robust sample size a great deal of organisation and interruption will be required. Only compounded by the requirement to routinely implement these processes every few years.

Individual, patient, or treatment-centred measures of outcome are therefore more often preferred. As most of these tools simply require the completion of a questionnaire post-intervention and periodically thereafter. Likewise, information is less cumbersome (comparatively) to collect and analyse and is more able to inform clinical and treatment related decisions.

For these reasons, *Ara Poutama Aotearoa* currently supports the use of mental health outcome measures such as the Kessler-10. Tests on these measures have routinely attested to their reliability and validity and capacity to effectively assess general psychological distress and treatment efficacy. Recent analysis of the Kessler-10 data is encouraging (from a clinical perspective) and shows statistically significant improvement scores. Likewise, that there was little difference in the scores between ethnic groups. The fact that many did not receive a post-intervention Kessler-10 assessment does however suggest issues with administration and potentially broader logistical challenges.

Catalysts One: Discussion

Notwithstanding the utility of the outcome measures currently employed by *Ara Poutama Aotearoa*, many staff raised concerns as to the application of these instruments in settings they were not originally designed to operate. Fundamentally, that the items used to assess outcomes and levels of psychological

distress (and health gains) were ill-suited to a prison environment.

"…[there are] issues with outcome measures - not being applicable to prisons, some of the things measured are good, others not so much…"

"… [we] need to reconsider how corrections conceptualise and sequence interventions to allow greater fluidity in interventions - tailored to need of person in front of you..."

By way of example, a facsimile of the Kessler-10 is shown on the following page. Questions 2 and 3 explore "nervousness" – frequency and management. Within a community setting, these may be seen are reasonable issues to explore as an indication of abnormal levels of psychological distress. However, within a prison environment, feeling and expressing these types of behaviours and tensions may not only be normal, but an entirely expected reaction to the setting. Asking about "hopelessness" (question 4) and "restlessness" (question 5) present similar challenges when contextualised from the perspective of a prisoner, as would feelings of depression, listlessness, worthlessness, and apathy (questions 7, 8, 9, and 10).

Table 9: Kessler-10

In the past 4 weeks	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out of no good reason?	1	2	3	4	5
2. How often did you feel nervous?	1	2	3	4	5
3. About how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. How often did you feel hopeless?	1	2	3	4	5
5. How often did you feel restless or fidgety?	1	2	3	4	5
6. How often did you feel so restless you could not sit still?	1	2	3	4	5
7. How often did you feel depressed?	1	2	3	4	5
8. How often did you feel that everything is an effort?	1	2	3	4	5
9. How often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. How often did you feel worthless?	1	2	3	4	5

The implications here are similar to what has been discussed within *Investment One: Therapy within a Prison Setting* in that conventional mental health tools, while useful, are unlikely to function well within a prison. New tools are required and so that success and outcomes are measured in ways which are more

cognisant of a prison environment and the needs of those in our care.

Catalyst One: Recommendations

Measuring outcomes in mental health has always been difficult. Due in part to the fact that indicators of success (or otherwise) are difficult to quantify. Often being derived from the administration of surveys or questionnaires and where their validity and accuracy can likewise be compromised by variations in interpretation, logistical challenges, environmental externalities, and (as discussed) how and what questions are posited.

The fact that more than 100 measures of mental health outcome have been developed highlights the challenge of designing tools which are able to effectively function within a range of settings. In spite of this, no tool has been designed to meet the mental health needs of those who receive care within a carceral setting. While existing measures and data collections can provide useful insights to effectively inform clinical decision making and measure progress, the tools themselves are not fit-for-purpose and are limited in both utility and functionality.

It is recommended that particular emphasis be placed on improving the ways in which *Ara Poutama Aotearoa* collects, analyses and reports on outcomes data. To this end, the design, implementation, and collection of outcomes data will be less relevant than the extent to which this information is used to inform treatment and enhance mental health outcomes.

As part of improving outcomes data, a new measure of mental health outcome should be developed to specifically account for the unique situational and environmental characteristics of prison. To expedite this process, it is suggested that this tool draw upon existing discourse and theory and which in the first instance would result in the design of a draft tool for piloting, assessment, review and emendation - and before a final instrument is developed and implemented. To enhance the utility of the tool it is recommended that it should complement, rather than replace current measures (such as the Kessler-10).

Further, that these should be used in unison with each other. Additional work will be required to prepare an appropriate methodology for this process, likewise to consider logistical, data collection, and cultural imperative or perspectives.

Additional efforts should be made to investigate and develop other methods of collecting service user's perspectives and levels of satisfaction with mental health service delivery within *Ara Poutama Aotearoa*.

Catalyst One: Timelines

The recommendations described above, including the development of a bespoke outcome measure, are likely to be a medium-term investment.

CATALYST TWO: RESEARCH ACTIVITY

There is a considerable pool of research which has investigated the health needs and concerns of prisoners. Many of these studies have been conducted in other jurisdictions (internationally) and oftentimes through dedicated academic programmes or centres of research excellence – such as the *Prison Research Centre: Oxford University*. While these investigations have brought clarity and insight into a range of pressing and typically challenging issues, these studies have infrequently been cognisant of our local environment. Meaning that the findings and recommendations have not always been helpful or relevant.

The more general insights into the challenges of providing care within a prison setting have been important to providing context. As too have studies which have highlighted the disproportionately high levels of mental illness within prisons, some of the unique drivers associated with this, the role of environmental factors, the limited treatment options, diagnostic and co-morbidity challenges.

However, and in spite of efforts to increase our understanding of local issues and challenges, there remains a relative dearth of quality research, and an associated lack of coordination in terms of how research activity is organised, supported, assessed, and prioritised. Meaning that activity is often driven by the particular interests of individuals (or teams) or likewise academics and scholars. Further still is the idea that the research has too often been reactive, haphazard or opportunistic. The result being that research endeavour and investment may not necessarily match the needs of *Ara Poutama Aotearoa*. Moreover, the ability of research findings to be translated into meaningful research outcomes, can be significantly compromised.

Catalyst Two: Discussion

Without timely and accurate information, it will be difficult for *Ara Poutama Aotearoa* to understand need

and to likewise explore potential solutions. The recent creation of a new Mental Health Dashboard has supported the capturing, reporting, and integration of outcomes and performance information relating to mental health service delivery. And, which has the potential to inform both strategy and service delivery. However, and notwithstanding, the data is not currently being used to its full potential, nor is it sufficiently broad enough to answer some of the more fundamental or pressing questions – such as the level of need, access to care, and outcomes.

Ara Poutama Aotearoa has recently updated its mental health data reporting systems to enable the capture of more detailed data about mental health service delivery. On an individual patient basis, the new data reporting forms capture information about relevant presenting concerns and treatment targets, relevant diagnoses, types of support being delivered and by whom. When aggregated, data across all forms paints a broader picture of mental health service delivery within *Ara Poutama Aotearoa.* This includes (but is not limited to), an indication of the number of referrals received by mental health services, the number of clients actively under the care of a mental health service, service waiting times, as well as more detailed information about the specific types of support that is being delivered and to whom.

Given the focus for *Ara Poutama Aotearoa* on ensuring equitable outcomes for Māori, data gathered via the Mental Health Episode of Care forms also provides an indication of how access to, and outcomes from, mental health service delivery may differ between different groups, which may then assist with future service planning

Periodic investments into mental health research, organised and initiated through *Ara Poutama Aotearoa*, has been well considered and aligned with the needs of the organisation. The recently supported Neurodiversity Study is a good example of this. However, there is a lack of strategic research planning or intent. And accordingly, little guidance in terms of how mental health research is planned, prioritised, integrated, and ultimately translated into mental health gains.

Catalyst Two: Recommendations

There is no simple solution to the issues identified above. Likewise, it is also fair to say that research is not a primary function of the Department. Nonetheless, improvements in care, delivery, and outcomes must be supported by accurate, timely and well-informed inquiry. Research which complements existing decision-making process, and which supports innovation and positive change. It is therefore proposed that a strategic mental health research agenda is developed which includes the following:

- Research needs and opportunities
- Research priorities
- Research translation (i.e., connections to Departmental initiatives and priorities)
- Funding requirements and options
- Workforce issues and potential collaborations, and;
- Recommendations (including a road-map) for implementation

Catalyst Two: Timelines

The implementation of a strategic mental health research agenda for *Ara Poutama Aotearoa* is likely to be a long-term and ongoing investment. Notwithstanding, the first step will be to design a research plan, to ensure that this is fit-for-purpose, and consistent with the broader aspirations of *Ara Poutama Aotearoa.*

CATALYST THREE: ORGANISATIONAL CULTURE

One of the more challenging issues to explore as part of this review has also been the most difficult to quantify and assess. Nonetheless, these did appear to have a discernible impact on how care was delivered, and by extension, the outcomes achieved. In sites, settings, or environments where there was high levels of collegiality, professionalism, and adherence to policies and procedures, the care provided appeared to be more organised, seamless, and efficacious. Conversely, some services were less well positioned and often expressed concerns that internal tensions or external relationships would compromise care and outcomes. The extent and nature of these issues were difficult to measure or validate but were expressed frequently enough to warrant inclusion as a particular area of concern.

Catalyst Three: Discussion

There will be a number of reasons as to why cultural or relational issues or tensions can manifest. These will likely vary across sites, but will have a universally negative impact on service delivery and outcomes. High workloads, staff capacity and capability, training, and environmental pressures (such as working within a prison) will be contributing factors. So too will be

logistical and clinical concerns. The nature of providing care to individuals with high and complex needs and which will be compounded further by the availability of resources and options for therapy. Moreover, the frustrations associated with not always being able to provide the type of care needed due to structural or logistical challenges.

"...most people who work for the Department do so because this is the path they have chosen. This is especially true for those of us who work in mental health. There are much easier options outside of the wire - so this is a choice. However, you can really see the frustration of those who come into the sector. People who are passionate about mental health and who have trained for a long time to provide care. Then arriving here and being told that you can't deliver the care you want, that you can't see people who need help, or that other things are more important than health. This is the reality of our situation. Mental health is important to us - but not necessarily the most important thing to other working here..."

Impacting these issues further, will be the extent to which mental health and wellbeing is prioritised and valued. Concerns which appear to be highly variable (across sites) but which again influences how teams are able to function and operate. For external mental health providers, it was frequently expressed that their roles and the services they offered were not always valued - and at times seen as an impediment or distraction from the day-to-day operations of the prison. Further still, that the coordination of care – how prisoners were seen and the process for this, was at times unclear, subject to change without warning, or dependent on factors which created both confusion and consternation. While similar types of issues are discussed elsewhere within this review, the point here is that these challenges seem to be in part connected to inter-personal or relational factors, as opposed to any system or policy related concern. While an outlier to some extent, a number of comments/concerns were raised as to the needs of the trans, gender diverse, Fa'afafine, and Takatāpui communities. Moreover, the Departments general response to their mental health needs.

Catalyst Three: Recommendations

There are no easy solutions to the issues described within *Catalyst Three* suffice to say that many of these will be ameliorated through activities contained within other investment areas. For example, supporting workforce growth, development and retention, creating clearer and more consistent guidelines and policies, as well as raising awareness of mental health and mental illness. To this end, efforts to foster the development of a healthy and supportive organisational culture must be viewed within the broader context of the need to address a range of other systemic, environmental, behavioural, and relational issues. And, while there may not be one single solution or approach, significant cultural change can be brought about through more comprehensive, organised, and consolidated investment into mental health.

Catalyst Three: Timelines

Given the range of issues and challenges expressed, a long-term approach to addressing these concerns will be necessary. Moreover, that the interplay between this *Catalyst* and other Investments are explored and promoted. Further consideration will need to be given to sustainability and so that any gains are supported, and potential risks mitigated.

CATALYST FOUR: TRANSITION INTO THE COMMUNITY

While much of this review has centred on the delivery of mental health services within prisons, a range of concerns were also raised about those who transitioned into the community - notwithstanding the availability and utility of reintegration services. It was noted, in particular, that opportunities for reintegration will be significantly compromised when the ability to seamlessly access community mental health services are impacted. Further, that the chances of recidivism will be enhanced when mental health issues are not addressed. To this end, facilitating and supporting access to community mental health services should be viewed as a priority investment area for Ara Poutama.

Catalyst Four: Discussion

"...For the majority of the men we see, it's really difficult to reintegrate back into society. It's the same for all of them actually, but there are some additional complications for those with mental health problems. The health problems are one-thing and causes all sorts of engagement issues for them - just with people in

general. But adding to this is that they have just come out of prison, and it gets even more messy for them..."

"...sometimes it's really hard just to find people and to support them once they get out. They have lots going on and sometimes their health is just another pressure they don't want to deal with. The system on the outside is scary for them and at the same time frustrating. It's easier to just "tap-out". The sad thing is that in the end it all catches up with them..."

In discussions with service providers, it was clear that issues with post-release system navigation were significant. Moreover, that although a broad range of supports and dedicated reintegration services were available – these were not always well coordinated or seamlessly delivered. Communication between various agencies was often fractured and inconsistent. Frequently dependent on personal relationships or connections, rather than any formal or organised system or process. Assessments of need could be ad-hoc, not always reviewed in priority order, but simply according to what services were available or most easily accessed.

For mental health support services, the ability to engage in a timely manner was often compromised by communication and coordination challenges. Meaning that individuals were often "lost" to or within the system. If they were able to be contacted, many did not always embrace the support available and preferred to disengage from the mental health services altogether. With mental health problems being unmanaged, and broader social issues inadequately addressed, the outcomes and consequences were not unsurprising - with many eventually returning to prison.

Catalyst Four: Recommendations

Many of the systemic or organisational challenges described previously are not solely the responsibility of Ara Poutama, nor can the Department be expected to resolve these issues on its own. Many are (in fact) frustrations which will be expressed across most social service providers – where coordination of effort is problematic and especially when dealing with high-risk and complex cases. Notwithstanding, and irrespective of where the responsibility for resolution sits, current coordination challenges have significantly impacted the utility of support provided and what outcomes can be expected. A primary recommendation therefore centres on the urgent need to more fully understand the shape and extent of these challenges. To investigate the implications for *Ara Poutama Aotearoa,* and to detail what potential pathways for resolution (or at least improvement) are possible.

Catalyst Four: Timelines

There is no reason why this review could not be expedited and prioritised. While it would necessarily take some time to design an appropriate methodology, and certainly more time to collect and analyse this information (before preparing recommendations) a short-term time-frame would seem appropriate.

CATALYST FIVE: TE ARA WHAKAMUA

In 2023, the Department of Corrections released a major proposal for change - *Te Ara Whakamua*. The proposal was broadly designed to create the systems and structures upon which the future goals and aspirations of *Ara Poutama Aotearoa* could be advanced. To better take into account contemporary issues and challenges and to ensure that the organisation was able to effectively respond to these. To this end, there were six primary drivers of *Te Ara Whakamua.*

1. Creating a structure that supports local decision-making and gives regions and sites more control over the outcomes you can deliver
2. Providing greater role clarity and decluttering our policies and procedures so you can place a stronger focus on the things that matter
3. Empowering you to make more decisions about the people you are responsible for and give leaders time to focus on what you need to do for your people
4. Breaking down silos so all our teams can work together, and you can more easily draw on skills and knowledge from across the organisation
5. Providing increased and direct support to sites at a local level through our enabling support functions, and;
6. Ensuring strong partnerships with iwi, Māori, and our communities remain essential in how we deliver and tailor services to the people we manage.

Catalyst Five: Discussion

Consultation on the proposal took place over a four-week period – throughout May and June of 2023. More than 1000 staff submissions were received and which

were then used to reshape and refine the discussion document. While not all of the staff feedback, concerns, and recommendations were incorporated. Significant changes to the initial proposal were made. While a number of the proposed recommendations have the potential to directly impact on the outcomes of this review, others were more peripheral and less certain in terms of their long-term implications.

Catalyst Five: Recommendations

The recommendations as they relate to *Catalyst Five* are unlike those previously, in that (and at the time of writing) there are no firm foundations upon which a suite of robust and informed recommendations can be made. However, it is nevertheless possible to highlight issues for future consideration and when a less turbid picture of *Te Ara Whakamua* emerges.

To this end, it will be important that potential shifts in the funding of internal teams at the locality level are examined and reviewed. Likewise the idea of divulging the internal mental health staff budgets to the regions themselves and how these might be administered by the Pae Ora General Managers. According to what is being proposed, there is the potential for mental health teams to be negatively impacted due workforce shortage and subsequent vacancies. Further, a possible misalignment between national strategy and local operational need. For example, how workforce needs are prioritised.

If there is reduced national oversight, this could possibly lead to increased variation in practice – an issue which is already problematic. It should be highlighted as well that mental health services are in their infancy compared to other services within *Ara Poutama Aotearoa.* And which makes them particularly vulnerable. The structures are not currently fit-for-purpose, service delivery models are variable, and outcomes unclear – or at the very least, difficult to measure. In this regard, and while it is currently unclear how and where *Te Ara Whakamua* might eventually land – there are aspects of what is proposed that will disproportionately impact on the delivery of mental health services. As the pressures on staff and the demand for mental health care is likely to increase, the implications of these proposed changes (even at this level) will need careful consideration and review.

Catalyst Five: Timelines

There are now particular timelines attached to Catalyst Five. Save for the fact that both the <u>short</u> and <u>long-term</u> implications of *Te Ara Whakamua* are not yet completely understood and will require additional review and assessment from a mental health perspective.

SUMMARY TABLE: POU KOKIRI: MENTAL HEALTH CATALYSTS

Table 10: Catalysts and Descriptions

Catalyst	Description
Measures of Success	Development of new measures of mental health outcome suited to a corrections environment.
Research Activity	Developing, implementing, and supporting a bespoke and translational mental health research programme for Ara Poutama.
Organisational Culture	Building an estate-wide culture to support (as much as possible) mental health and wellbeing.
Transition into the Community	Better coordination of services and people to support the mental health and wellbeing of recently released prisoners.
Te Ara Whakamua	Reviewing the impacts of the recent organizational changes within Ara Poutama, particularly with respect to the implications for mental health service delivery.

TE ARA HINENGARO:
SIX PRINCIPLES, FOUR PLATFORMS, TEN INVESTMENTS, AND FIVE CATALYSTS

Table 11: A brief summary of the key sections and findings from this review

Six Principles	Four Platforms	Ten Investments	Five Catalysts
Transformation Change	Environmental Catalysts	Therapy within a Prison Setting	Measuring Success
Pragmatic Solutions	Mental Health Training and Awareness	Women in Prison	Research Activity
Nuanced Approaches	Mental Health Promotion and Education	Cultural Catalysts	Organisational Culture
Complexity and Diversity	Coordination and Integration	Workforce Development	Transition into the Community
People Centred		Workforce Retention	Te Ara Whakamua
Culturally Framed Solutions		Logistical and Resources Challenges	
		Roles and Responsibilities	
		AoD and Mental Health	
		Forensics	
		Young People (Emerging Adults)	

POU HUA: RECOMMENDATIONS AND PRIORITIES

Table 12: Pou Hinengaro: Mental Health Platforms (Recommendations)

Pou Hinengaro: Mental Health Platforms	**Summary Definition**	**Recommendations**
Platform One: Environmental Catalysts	Impacts of Prison on Mental Health	1. Review prison sites to assess where opportunities to create more therapeutic environments exist. **(Medium-Term Investment)** 2. Continue to ensure that mental health is integrated into all parts of the Corrections system (e.g., policies, procedures, training). **(Medium-Term Investment)**
Platform Two: Mental Health Training and Awareness	Highlighting the Role Custodial Staff have in Supporting Wellbeing	3. Review and update of the current training programme for custodial staff to ensure there is sufficient training in mental health and trauma- informed care. This will include consideration of incentives that can be offered to staff to complete mental health training, consideration of the option of credentialling staff, and work to ensure that staff are given sufficient time to attend mental health training. **(Medium-Term Investment**)
Platform Three: Mental Health Promotion and Education	Mental Health Promotion and Education Opportunities for people in prison	4. Develop a mental health promotion and education framework and innovative approaches to mental health promotion/education for people in prison are explored. **(Medium-Term Investment)**
Platform Four: Coordination and Integration	Enhanced Coordination of Treatment, Care, and Service Delivery	5. Implement a single-point-of-entry model for mental health referrals to ensure better integration and coordination between mental health services. **(Medium-Term Investment)** 6. Enhance the integration of services delivered by Psychological Services and Mental Health Services within *Ara Poutama Aotearoa*. **(Medium-Term Investment)**

Table 13: Pou Rautaki: Mental Health Investments (Recommendations)

Pou Rautaki: Mental Health Investments	**Summary Definition** *These are more operational, clinical, service delivery issues*	**Recommendations**
Investment One: Therapy within a Prison setting	Highlights the need for models which are better suited to the realities of a prison setting	7. Review the evidence base to understand how mental health services can be delivered more effectively within the prison context and update the current service delivery to reflect this. **(Medium-Term Investment)**

Investment Two: Women in Prison		8. Examine what enhanced (and more bespoke) models of mental health care for women might be possible and implement any subsequent opportunities. **(Medium-Term Investment)** 9. Improve training and information on the specific challenges faced by women in prison and the implications for mental health. **(Medium-Term Investment)** 10. Ensure that any health promotion and education initiatives that are introduced consider the needs of women (also refer recommendation 4.) **(Short-Term Investment)**
Investment Three: Cultural Catalysts	Utilising culture and cultural practices as a driver of mental health and wellbeing	11. Investigate, develop, and support the implementation of culturally- inspired mental health approaches within a bicultural delivery model. **(Priority Investment)** 12. Increase access to cultural supports (e.g., tohunga) and develop a clear framework for how these supports can assist with the delivery of mental health care. **(Priority Investment)** 13. Improve access to cultural activities and services which promote hauora (such as rongoā Māori), including a framework for delivering these types of support alongside existing mental health services. **(Priority Investment)** 14. Investigate factors which may contribute to inequitable access to mental health services for Māori and implement any opportunities that arise from this investigation that address any identified inequities. **(Short-term investment)** 15. Develop a framework to support improved whānau engagement as part of mental health service delivery. **(Short-term investment)**
Investment Four: Workforce Development	General workforce issues and challenges	16. Undertake a comprehensive review of mental health workforce development strategies that focuses on the specific needs of *Ara Poutama Aotearoa* (aligned to existing internal initiatives, as well as initiatives led by other agencies). **(Short-Term Investment)**
Investment Five: Workforce Retention	Focus on retaining existing staff	17. Develop a formal and comprehensive workforce retention strategy which considers factors such as mitigation of environmental and clinical challenges, professional development pathways, job security and renumeration. **(Long-Term Investment)**
Investment Six: Logistical and Resource Challenges	Logistical challenges impacting the delivery of mental health services	18. Increase access to therapeutic spaces within prisons and enhance the quality of currently available spaces (i.e., fit-for-purpose therapy rooms). **(Short-Term Investment)**

		19. Improve use of existing systems to ensure greater access and continuity of care for people who require mental health support (e.g., mental health alerts, transferability constraints etc.) **(Medium-Term Investment)** 20. Develop mental health-focused therapeutic communities within prison units (including in high and maximum security). **(Long-Term Investment)** 21. Review processes by which medication is administered to identify areas for improvement, efficiency and flexibility (particularly with regard to the timing of medication administration). **(Medium-Term Investment)** 22. Consider how mental health services can be more effectively delivered for people with high security classifications, acknowledging safety challenges and custodial supervision requirements. **(Medium-Term Investment)** 23. Explore how technology (e.g., video-technology, online courses, prison televisions, phones or tablets) might be used more effectively to support prisoners in accessing mental health care and resources. **(Medium-Term Investment)**
Investment Seven: Roles and Responsibilities	Focus on the organisation of the workforce. Integration, coordination of professions and responsibilities	24. Develop and implement a mental health staff allocation model which ensures appropriate baseline staffing levels at each site, to enable the effective delivery of mental health services. **(Priority Investment)** 25. Establish Intervention and Support Practice Teams at prison sites that do not currently have these teams. **(Short-Term Investment)** 26. Review the roles and responsibilities of existing mental health staff to ensure effective delivery of mental health service delivery models, and that staff are delivering support which is appropriate to their scopes of practice. **(Short-Term Investment)** 27. Phase out trauma counsellor and trauma focused roles (with a focus on strengthening all clinicians' skills in responding to trauma related issues). **(Short-Term Investment)** 28. Explore ways in which a lived experience perspective can be built into the design, delivery and governance of mental health services. **(Short- Term Investment)**
Investment Eight: AoD and Mental Health	AoD specific issues	29. Integrate the roles of mental health staff and addiction staff working in the community. **(Medium-Term Investment)** 30. Integrate addictions clinicians into Intervention and Support Practice Teams. **(Medium-Term Investment)**

		31. Develop a more coordinated approach to assessment, treatment and training across mental health and addictions services. **(Medium-Term Investment)** 32. Provide mental health support for people undertaking existing prison based intensive AoD treatment programmes (i.e., Drug Treatment Programmes). **(Medium-Term Investment)**
Investment Nine: Forensic Mental Health Services	Alignment and coordination issues relating to Forensic Mental Health Services	33. Develop a service level agreement with Forensic Mental Health Services which clarifies key roles and responsibilities with respect to mental health service delivery within *Ara Poutama Aotearoa*. **(Priority Investment)** 34. Collaborate with Forensic Mental Health Services on initiatives to address workforce issues (also refer recommendation 16). **(Short-Term Investment)** 35. Improve the process of referral to Forensic Mental Health Services within prisons (also refer recommendation 5). **(Medium-Term Investment)** 36. Collaborate with Forensic Mental Health Services to ensure that effective data and information sharing practices are occurring, with respect to people in prison who are receiving forensic-level support, and those who are receiving, or are requiring, mental health inpatient admission. **(Short-Term Investment)** 37. Collaborate with Forensic Mental Health Services to consider additional options for improving mental health service delivery within prisons and addressing, or identifying innovative solutions to mitigate, issues such as challenges with accessing mental health inpatient beds. **(Medium-Term Investment)**
Investment Ten: Young People (Emerging Adults)	Young People	38. Develop a process for ensuring that young people in our care are prioritised in relation to accessing and receiving mental health support. **(Short-Term Investment)** 39. Review and update security placement processes for young people, including consideration of the role of mental health services in these processes. **(Medium-Term Investment)** 40. Develop settings which allow young people time to settle before discerning placement/security class decisions. **(Long-Term Investment)** 41. Provide opportunities for early engagement for young people with mental health services during the settling in and adjustment phase. **(Short-Term Investment)**

		42. Undertake targeted, translational research into the mental health needs of young people in prison (also refer recommendation 44.) **(Medium-Term Investment)**

Table 14: Pou Kokiri: Mental Health Catalysts (Recommendations)

Pou Kokiri: Mental Health Catalysts	**Summary Definition** *These are non-service delivery issues*	**Recommendations**
Catalyst One: Measuring success	Need for better measures of outcome	43. Improve the ways in which outcomes data is collected, analysed and reported within *Ara Poutama Aotearoa*, including: • the development of a new bespoke mental health outcome measure, and • investigation into additional ways to collect service user's perspectives and levels of satisfaction with mental health service delivery. **(Medium-Term Investment)**
Catalyst Two: Research Activity	Focus on mental health research activity. Bespoke to corrections and which is translational	44. Prepare a strategic mental health research agenda which details research needs and opportunities, research priorities, research translation, funding requirements and options, workforce issues and potential collaborations, recommendations (including a roadmap) for implementation. **(Medium-Term Investment)**
Catalyst Three: Organisational Culture	Organisational culture enhancements to better support the delivery of mental health services and outcomes	No specific developmental opportunities are proposed. This area is to be addressed within and alongside other investment areas and which consider workforce development and retention, mental health training and awareness, and the better integration of mental health into Corrections' broader policies, procedures and strategies.
Catalyst Four: Transition into the Community	Improved mental health arrangements post-release	45. Implement improvements to relevant policies and procedures to ensure greater continuity of mental health care for people who transition between prison sites or are released. **(Short-Term Investment)**
Catalyst Five: *Te Ara Whakamua*	Implications of *Te Ara Whakamua*	46. Conduct a review following the implementation of Te Ara Whakamua to understand the impacts that this has had on mental health service delivery within *Ara Poutama Aotearoa*, and what improvements can be made. **(Short-Term Investment)**

NGA WHAINGA MATUA: PRIORITY INVESTMENTS

Given the large number of recommendations identified, it has been necessary to organise these into various categories. Investments which should be considered quickly (in the short-term) or viewed as longer-term/aspirational goals or targets. The outcomes of which may not immediately manifest, but which are likely to bring-about more transformational gains.

Given the dynamic environment within which mental health services within *Ara Poutama Aotearoa* are currently being delivered, it has also been necessary to further elevate a smaller number of recommendations. These are described as 'priority investments' and

should be actioned or contemplated as a matter of urgency. While some of these priority investments are framed as a direct response to particular challenges or concerns, others are designed to take advantage of recent developments or strategies within *Ara Poutama Aotearoa* and where the window-of-opportunity may only be short- lived.

To this end, it is worth highlighting again the *six priority investments* as seminal outcomes of this review.

1. Investigate, develop, and support the implementation of culturally-inspired bicultural mental health approaches within a bicultural delivery model.
2. Increase access to cultural supports (e.g., tohunga) and develop a clear framework for how these supports can assist with the delivery of mental health care.
3. Improve access to cultural activities and supports which promote hauora (such as rongoā Māori), including a framework for delivering these types of support alongside other types of services and supports.
4. Develop and implement a mental health staff allocation model which ensures appropriate baseline staffing levels at each site, to enable the effective delivery of mental health services.
5. Develop a service level agreement with Forensic Mental Health Services which clarifies key roles and responsibilities with respect to mental health service delivery within *Ara Poutama Aotearoa*.
6. Implement improvements to relevant policies and procedures to ensure greater continuity of mental health care for people who transition between prison sites or are released from prison.

Finally – and beyond these priority investments, will be the imperative to consider what resources are needed to discern, sequence, and implement these opportunities. Given the scope of what has been suggested, these considerations are likely to determine both the appetite for change as well as the long-term success of this review.

CONCLUSION AND FINAL COMMENTS

Above all else, this review has highlighted the complex and often unique challenges of delivering mental health services within the New Zealand prison system. Many of these challenges cannot easily be ameliorated, and which reflect the enduring tensions between the delivery of healthcare, on the one-hand, and the removal of liberty (and confinement) on the other.

In spite of these challenges, *Ara Poutama Aotearoa* has introduced a broad range of initiatives (over a number of years) in order to enhance the delivery of services, and to improve access to care. These initiatives have not always fulfilled their potential, and have encountered various challenges. Many of these challenges - be-they logistical, structural, or resource related - are common throughout the sector, and will not be unfamiliar to any mental health service operating within the community. However, these issues will be significantly amplified within a carceral environment. And likewise reveal a range of other challenges (and barriers to care) which are entirely unique and considerably more difficult to control.

Having detailed and described these issues, the point of this review is not to simply reflect on what these tensions are, or where these challenges are most prevalent or disruptive. Rather, to explore where options for growth and development are possible, and how these might reasonably inform how mental health services can be delivered better. Key to this process has been to reflect upon existing strategies and initiatives and to explore where opportunities for alignment and mutual gain might be possible. Likewise, to accept existing parameters and restrictions as operational or environmental realities. Realities which constrain the type of care provided, but not necessarily the types of outcomes possible.

With these central tenants in mind, the recommendations generated from this review speak to the fact that transformational change will not be possible through philosophical posturing or contemplation. Rather, through the implementation of comprehensive, ambitious, and above all else, pragmatic and nuanced solutions. The 46 recommendations contained within this review are designed for this purpose and deliberately draw attention to opportunities (both immediate and long-term) which are both reasonable and possible to introduce. Notwithstanding the effort and resources required to do so.

Finally, and in spite of the numerous (and not entirely unexpected) challenges to emerge from this review – there remains much to be optimistic about. With few exceptions, those involved in the delivery of mental health care within *Ara Poutama Aotearoa* are incredibly committed to this role, and in spite of the environment

and conditions they are required to operate within. Further, there is significant untapped potential to better explore how culture can be used to achieve better health outcomes for Māori and in ways which may not always be possible within community settings. Similarly, will be the opportunity to introduce a more comprehensive and world-leading approach to the delivery of mental health services within prisons. Opportunities which might only be possible within Aotearoa/New Zealand and which are likely to generate outcomes which extend far beyond mental health.

That fact that this review has been commissioned suggests that the appetite for change is real and that the opportunities to improve care are significant. The test however will be the extent to which these opportunities are introduced, amended, or re- framed – and how the potential for health gains is translated into meaningful health outcomes. The report has received endorsement, pending broader consultation within *Ara Poutama Aotearoa* to assess our capacity for addressing the findings.

KUPU HEI WHAKAKAPI

Aku mihi maioha tenei ki a koutou ra kua ta koha mai ou kotou whakaaro Rangatira hei whakamanahia tenei purongo.

Ahakoa te taumaha o te mahi, nga raru maha hei taumahatia nga pakihiwi o nga kaimahi o Ara Poutama - ka kimihia tonu koutou I nga huarahi hei hapai te hauora hinengaro o nga hunga e mauheretia ana.

TE ARA TIKA

THE DELIVERY OF MENTAL HEA LTH SERVICES WITHIN THE DEPARTMENT OF CORRECTIONS