DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

13 May 2021 C133840

s9(2)(a)

Tēnā koe s9(2)(a)

Thank you for your email of 29 March 2021, requesting information about suicides in prison for the years 2015 to 2020. Your request has been considered under the Official Information Act 1982 (OIA).

Corrections acknowledges that each and every death by suicide is tragic and has an immeasurable effect on the individuals whānau, friends, as well as an indelible impact on our staff.

Corrections is committed to preventing unnatural deaths and incidents of self-harm in prisons. The causes of suicide are multifactorial and complex and people in prison are a known high-risk group. Further, national and international experts agree that due to the complex and multifactorial nature of the factors that contribute to suicidal behaviour, risk assessment tools remain limited in their utility to assist in predicting who is most at risk. However, as we have become more aware of the level of significant mental health issues for people in prison, our role has expanded to strengthen our response to support the needs of this group. We make every effort to ensure people's mental wellbeing and physical safety during their time in custody. This can be extremely challenging for our frontline staff who work very hard to support people with complex needs.

Our research shows people in prison have higher rates of personality disorder, mental health and substance use disorders than the general population. It is estimated that 62 percent of those in prison have met the diagnostic criteria for either a mental health or substance abuse disorder within the last 12 months, and 91 percent will meet these diagnostic criteria at some time over the course of their lives. Our research also suggests that these psychological disorders tend to go undetected and/or untreated prior to prison.

We are doing more than ever in the area of mental health and are being proactive in ensuring people in prison have access to the specialist mental health support they need and that our staff have the appropriate tools and resources to keep people safe from harm.

When a person enters prison, our immediate priority is to meet their mental and physical health needs. They undergo an induction process, where health staff assess their health needs, including any mental health needs, whether they may be at risk of self-harm or suicide and whether they require a referral to a prison doctor.

Furthermore, in 2020 Corrections restructured its Health Services to align it with Corrections strategy, Hōkai Rangi. The new structure supports more agile ways of working and a stronger collaboration between national office, regional mental health and health leadership, and health centres.

Other changes include establishing specialist heads of profession, with a strong focus on delivering a model of care that best meets the needs of Māori as an overrepresented group in our prisons. As an example, a Chief Advisor Māori Health role was established to strengthen our approach to addressing health inequity issues for Māori. A Director Mental Health and Addictions position has also been created and appointed to strengthen and expand mental health and addiction services.

In Budget 2017 Corrections received funding to improve intervention and support for people in prison at risk of self-harm and suicide. The Intervention and Support Project introduced multi-disciplinary teams of psychologists, occupational therapists, mental health nurses, social workers and cultural support workers to provide earlier assessments, develop individualised plans and provide therapeutic interventions and support that is flexible to an individual's changing needs. The intention of these teams is to provide better and more enduring outcomes for psychological and physical well-being.

The Intervention and Support Practice Teams (ISPTs) were initially established at Christchurch Men's Prison, Auckland Prison and Auckland Region Women's Corrections Facility. The ISPTs initially worked primarily in Intervention and Support Units and the project team developed a prison-wide model of care for individuals vulnerable to self-harm and suicide. At these sites, clinical supervision and support were offered to health and custodial staff, and education was provided to staff to build awareness and knowledge of mental health and addictions-related behaviours. The clear and concerted focus on staff training reflects the need to support the wellbeing and upskilling of staff dealing with some of the most vulnerable people in prison.

Additional funding allocated through Budget 2019 has allowed us to continue improving services to meet the needs of people with moderate to severe mental distress. We are establishing three new ISP services in 2021 (with managers for these teams appointed at Rimutaka, Mount Eden and Springhill) and Clinical Nurse Specialists (Mental Health) positions have been created at 11 prison sites that have not previously had specialist mental health support.

We have also expanded supervision and training to custodial staff working in all of our Intervention and Support Units (i.e., not just the six sites that now have mental health teams). We have also started to deliver training on understanding and effectively engaging/working with people with complex behaviours and personality disorders. Foundational mental health training (Mental Health 101 training) is due to commence for all frontline custody staff in mid-2021.

You requested:

> *The number of suicides in prison cells in the years 2015-2020*
> *I would like this broken down by prison and unit*
> *With the units, I would like an explanation on what they are used for i.e. A unit for people with mental health concerns, a general population unit, seclusion unit etc*

All deaths in custody are reported to New Zealand Police and are subject to a coronial inquest and investigation by a Corrections Inspector, with any recommendations arising from the review being actioned appropriately. The Coroner, not Corrections, ultimately determines the cause of a person in prison's death. Where a death in custody is suspicious, Police can make the decision to investigate. Corrections reports on deaths in custody in two categories:

- Apparent Unnatural Deaths – this can include death as a result of self-harm, an accident, foul play, or a death where the cause is unable to be initially confirmed;
- Apparent Natural Deaths – the death while in custody of any prisoner, as a result of natural causes

Appendix One provides the number of apparent suicides in prison for the 2015/16 to 2019/20 financial years, broken down by prison and year. Appendix Two shows the number of suicides in prison for the 2015/16 to 2019/20 financial years broken down by unit type.

An overview of the units in which a suicide has occurred between 2015/60 and 2019/20 is provided below.

- Mainstream – units housing individuals who do not have any restrictions with others and are of a compatible security classification level to interact with others within the unit.

- Management – accommodate individuals who require a higher degree of supervision, this can be due to their challenging and/or violent behaviour, or a status of directed segregation for their safety and security of others.

- Intervention and Support – specialist Intervention Support Units that provide a high level of monitoring, care and intervention for individuals assessed as "at risk" i.e. of self-harm or forensic concerns

- Voluntary Protective Custody (VPC) – Units are not specifically identified as VPC. A prison may have units which only accommodate individuals who have requested and been placed on VPC due to concerns for their safety. This may be for any number of reasons.

- Youth – dedicated units which accommodate individuals between the ages of 18 and 24, thereby limiting contact with adults in prison and offering the opportunity for youth-tailored responsive approaches within a structured environment.

- Off-site – suicide that did not occur on prison grounds, eg hospital.

I trust the information provided is of assistance. Should you have any concerns with this response, I would encourage you to raise them with Corrections. Alternatively, you are advised of your right to also raise any concerns with the Office of the Ombudsman. Contact details are: Office of the Ombudsman, PO Box 10152, Wellington 6143.

Ngā mihi

Juanita Ryan
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Health Services