Caring for mentally disordered offenders
About the Royal Australian and New Zealand College of Psychiatrists (RANZCP)

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care.

The Faculty of Forensic Psychiatry is a specialist area within the RANZCP whose role is to provide mental health care to people who have come to the attention of criminal justice services. Forensic mental health services (FMHS) provide mental health care on both an inpatient and outpatient basis. Due to the high level of security, patients who require admission to forensic hospitals have committed a serious offence and therefore require significant mental health risk management.

The core FMHS inpatient and outpatient work is the assessment, treatment and rehabilitation of people who have committed serious crimes in the context of their illness. Many mentally ill people within FMHS will be “special patients” after being found not guilty on account of insanity or being found unfit to stand trial. This population requires specialist risk management as part of clinical care and their progression is supervised by the Ministry of Health. Special patients spend long periods of time in hospital, however there are limited numbers of inpatient beds and few community rehabilitation options available when the person is ready to leave hospital.

Forensic psychiatrists also provide assessment and treatment of mentally disordered offenders in custody through prison clinics. People who require admission to hospital from custody for treatment of their mental illness can only currently be admitted to FMHS hospitals. There are no separate beds available for people being admitted from prison and special patients. Mentally unwell people who require inpatient assessment can also be directed to hospital from court, often at very short notice. This provides further pressure on the existing inpatient FMHS beds.

Forensic psychiatrists help courts determine criminal responsibility, assist in relevant civil matters and assess issues such as the risk of violence and reoffending. Aspects of forensic psychiatry include involuntary treatment, juvenile offending, competence, diversion of offenders from court to treatment and the provision of medico-legal opinions and expert evidence (RANZCP, 2016).

In summary, forensic psychiatrists provide voluntary mental health assessment and treatment to people in prison. They also provide voluntary and involuntary care and treatment to mentally unwell people admitted to hospital from prison or court. The term mentally disordered offender (MDO) will be used to cover both groups.

Summary of Recommendations

- Forensic mental health services require more resources to provide appropriate assessment, care and treatment for people with mental health problems in the criminal justice system. These resources include inpatient and community beds with additional personnel to provide timely care in prison and advice to the courts
- Additional resourcing is also required to meet the needs of specialist groups within forensic mental health services. This includes gender appropriate care for women, support for the

1 Defined under s2(1) Mental Health (Compulsory Assessment and Treatment) Act 1992
intellectually disabled and those with autistic spectrum disorders and investment in services for young and elderly offenders

- Consistent with the recommendations in the Mason Report, forensic mental health services need to be supported to remain the primary provider of specialist mental health care in custody
- Māori comprise 19% of the general population but 51% of the prison population. Further development of forensic mental health services within a Kaupapa Māori framework is required to address this over-representation
- Forensic psychiatrists support plans to address the social determinants of health that lead to injustice and offending. We note there is strong correlation between poor mental health and incarceration.

**Introduction**

The New Zealand Committee for the Faculty of Forensic Psychiatry (FFP) has developed this submission that supports and expands upon the themes expressed in the joint submission made by the New Zealand National Committee/Tu Te Akaaka Roa in consultation with the other New Zealand-based psychiatric committees.

The Faculty contends forensic psychiatry requires particular attention within the context of the Mental Health and Addiction Inquiry.

**Purpose**

The FFP welcomes the opportunity to provide a written submission to the Government Inquiry into Mental Health and Addictions (the Inquiry). The joint RANZCP submission briefly summarises the key issues that concern us with regards to forensic psychiatry. The purpose of the FFP’s submission is to provide additional commentary and solutions to the issues we have identified within forensic mental health services.

**Context**

- It is well documented in the literature that the number of people incarcerated in New Zealand has ballooned to over 10,000 prisoners (Gluckman, 2018). The combination of an increased population and the introduction of a mental health screening tool in prison has meant that more prisoners with mental health needs are identified and require assessment and treatment from Forensic Mental Health Services (FMHS).
- The RANZCP is concerned with the high rates of imprisonment in New Zealand. **Punitive approaches to the management of the unwell MDO are counter-productive.** Focusing on MDO mental wellbeing should be the central consideration when providing a therapeutically based rehabilitative approach to these peoples’ welfare. In addition, we contend that prison may not always be the best environment for those living with severe mental illness and imprisonment can exacerbate symptoms of those already mental ill, including increasing the risk of self-harm and suicide (Bradley, 2009: Department of Corrections, 2018)
- People living with mental illness may be vulnerable within the justice system therefore they need protection to ensure that they are subject to fair process, receive appropriate treatment for their mental illness and are rehabilitated. The role of forensic psychiatrists is to manage these issues within a patient-centred model but to also consider the MDOs potential risk to society
(Sullivan, 2006). It is often a difficult ethical dilemma to manage the interface between community safety and effective models of treatment that best meet the needs of MDOs.

- The Faculty submits that the health and wellbeing of the prison population requires specific attention as **MDOs experience very high levels of mental health disorders and addiction** (Indig et al., 2016; Brinded, 2001). MDOs presenting with mental disorders such as major depression, bipolar disorders, psychotic disorders and obsessive–compulsive disorders require significant interventions from a multidisciplinary forensic service who are increasingly unable to meet the demand (Brinded, 2001).

- **Pressure on inpatient beds has meant a reduced ability to admit unwell people from prison to hospital**, potentially prolonging the episode of illness in custody. Similarly, a lack of community resources including accommodation and support services has meant discharge from hospital is also protracted. FMHS therefore struggle to meet the needs of MDOs in prison, hospital and the community in a timely fashion. Resourcing remains an ongoing issue.

1 What is Working Well within Forensic Services?

We provide care to highly vulnerable, marginalised and difficult to engage people who present with complex mental health conditions. FMHS continue to aim for the best care, treatment and outcomes for MDOs in the criminal justice system despite the limited resources available.

The intensive and assertive care provided by FMHS in hospital and in the community, particularly to special patients, is associated with lower rates of recidivism and good recovery. Our objective is to improve inpatient mental health, assist integration back into the community and improve community safety. FMHS deliver extensive input to the courts with nursing court liaison services and provide medicolegal reports that assist in the judicial process, including avoiding the criminalisation of the mentally ill.

Active efforts are made to ensure that psychiatrists working in this area hold appropriate forensic qualifications and knowledge of the specific needs of the MDO population. We contend expert input is required to assist people as they move through the criminal justice system.

The recent proof-of-concept threat assessment consultative group has been established, where FMHS practitioners work alongside the Police with involvement of the Ministry of Health and Parliamentary Security. This is an innovative model where there is an established evidence base, improved outcomes for MDOs and their communities; it is cost effective and deals with an identified area of risk. This model demonstrates cross-government collaboration can work well however there are difficulties with such initiatives due to the ongoing funding.

2 What are the Current Challenges?

The Faculty has identified the following issues that require further investigation by the Inquiry:

1. Increasing demand requires additional investment in Forensic Mental Health Services
2. Improving support for special prison populations
3. Strengthening mental health service delivery within the prison service
4. Improving the connection between forensic and general mental health services
5. Addressing mental health and addiction disorders experienced by the Māori prison population
6. Introducing ‘upstream’ strategies to reduce the prison population.
We outline the issues below and propose recommendations for change.

1 Increasing demand requires additional investment in Forensic Mental Health Services

Issues and context

There has been no significant change in forensic bed numbers, resourcing or staffing since FMHS was created in the 1990s despite the increasing prison muster. In 2016 the number of adults convicted and sentenced increased nine percent over the previous year (Lunt, 2017). There has been no notable growth in either general or Corrections²-based accommodation or community support with the muster increase. FMHS are chronically under-resourced in all areas where they provide assessment, care and treatment.

The pressure to provide adequate mental health services for MDOs has been well documented in the Controller and Auditor General’s report Mental Health Services for Prisoners published in 2008. The situation has worsened since this report was published. Inpatient FMHS tend to run at or close to capacity therefore mentally unwell patients are spending longer in prison waiting for admission into forensic care. Less unwell patients, who nevertheless have serious mental illnesses, have minimal chance for admission (Brinded, 2001: Controller and Auditor General, 2008).

The capacity of FMHS services has been overwhelmed by these pressures with a resultant negative effect on the ability to provide timely inpatient care for MDOs. The lack of FMHS inpatient beds means that fewer people are able to be admitted to hospital to receive appropriate mental health care. As an example, research in New Zealand has demonstrated that 2.5% of prison inmates are psychotic (Brinded et al., 2001). Prison transfers of MDOs to psychiatric hospitals in 2001 were 2.31% of the overall prison population, however by 2008 this had fallen to 1.04%. The latest figures from 2015 indicate that the admission rates are now down to 0.67% (Ministry of Health, 2016).

We strongly argue that MDOs, like any other population group, must receive appropriate interventions before their condition deteriorates. There is a legislative requirement that ‘the standard of healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.’³ It is, however, difficult to provide this care due to the resourcing issues we have identified in this paper. It will not be possible for FMHS to provide optimal services based on principles of recovery and rehabilitation without greater resources for all areas of care including inpatient and outpatient services, prisons and courts.

Recommendations

- We strongly recommend that as part of this review the Government increases the resources available to FMHS in prison, hospital and the community. The review should include examining if the physical buildings are fit for purpose and assessing the staffing deficits in order to reduce burnout experienced by personnel working within the sector.

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² Department of Corrections
³ Corrections Act 2004 s75(2)
We argue that the Government must develop strategies to reduce the growing prison population. At a macro level this includes making changes to social and law and order policies that effect cultural change.

Court Liaison Services, that provide advice to the judiciary, need to be much more focused on diversion. Implementing this policy requires multi-system change including enabling various agencies (housing, general mental health services, health, police and social work) to deliver a range of services to support the mentally unwell person who has entered the criminal justice system.

In order to reduce pressure on the current system we suggest the concept of Mental Health Courts is explored further. Further investigation of the recent research undertaken by Lunt (2017) could assist in diverting mentally ill people from prison and into treatment so they do not experience the negative impacts of incarceration. We recommend piloting this concept in New Zealand.

We note it is difficult to plan services in order to meet the increasing demand of both numbers and complexity of MDOs. We strongly advocate that the Ministry of Health continues with its work to undertake a five-yearly stocktake and planning cycle for FMHS as a focus on future planning and investment would greatly benefit the sector.

2 Improving support for special prison populations

Issue and context

The complexities of the mental health needs of special populations are outside the scope of this submission. We would however like to briefly highlight the needs of the following populations:

2.1 Female prisoners

Whilst the majority of prisoners in New Zealand are men; the female prisoner population has also increased dramatically. As noted by Corrections ‘…[t]he proportion of female offenders who started a prison sentence each year increased from 6 percent to 10 percent of the total between 1984/85 and 2014/15…’ (Department of Corrections, 2015). In addition to experiencing major psychiatric illness, female MDOs have their own specific mental health needs due to histories of trauma, abuse or neglect. There has been no significant increase in resources to assist the needs of unwell women in custody or hospital.

2.2 Prisoners with Intellectual Disability (ID)

New Zealand has unique legislation in the form of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 which provides a pathway for people with ID who have offended to be transferred to more appropriate services rather than prison. In order to be effective it requires appropriate identification of people with ID early in the court process and to then have available sufficient hospital and community resources to provide ID-specific care and rehabilitation. Despite this legislation, the interface between justice, disability and mental health services remains complicated.

2.3 Older Prisoners

In general prisons are not specifically equipped to manage physically frail, older-aged prisoners and those with cognitive impairment (Sullivan, 2006). It is acknowledged that older-aged prisoners experience ‘accelerated ageing due to the effects of substance use, poor nutrition and neglect of their health’ (Reutens, 2015). The high level of mental and physical needs of the ageing prisoner requires
greater collaboration between all health and justice systems to adequately accommodate these MDO individuals.

2.4 Prisoners with Autistic Spectrum Disorder (ASD)

ASD is a neuro-developmental disorder that affects how a person interacts with others. There is growing recognition that these individuals with social learning disabilities are vulnerable in the justice system. There is lack of awareness and training across the sector in mental health and FMHS regarding the specific needs of this particular population (Ministries of Health and Education, 2016).

2.5 Youth Offenders

Youth Forensic Mental Health services are operational within two prison youth wings and four youth justice residences. Reducing the reimprisonment rate of young offenders requires intensive investment from the first time they are incarcerated with a focus on those factors that lead to their offending and poor mental health. When they are transitioned from the custodial environment to the community, this process requires careful, well-resourced management. Many young MDOs are released into social circumstances which rapidly lead to almost immediate reoffending, substance abuse and deterioration in the MDO's mental state.

Recommendations

- We commend the Government on establishing units to accommodate the needs of special MDOs such as older prisoners and those with ID issues. The number of units available are however insufficient to cater for these populations and the specific needs of women are not been met
- Increase resources for hospital and community placements to meet the complex needs of people with ID and ASD, especially those who require long term support. There is also the requirement to review the training and support for front line staff, police and justice who have contact with people with ID and other disabilities such as ASD
- Expand the resources and workforce available for care of youth offenders. Ideally, forensic mental health service provision would be closely integrated with programs of education, vocational training and rehabilitation provided to incarcerated youth by Oranga Tamariki and the Department of Corrections
- We recommend that the Inquiry urgently establish a Ministry of Health-led independent review of these areas to properly assess the size of the unmet need. As noted elsewhere we encourage that a stocktake is made so resources may be allocated accordingly.

3 Strengthening mental health service delivery within the prison service

Issues and context

In New Zealand, mental health care for remand and sentenced prisoners is delivered by three agencies: the Department of Corrections, the Ministry of Health and Forensic Mental Health Services (run by the district health boards). It is our view that all specialist mental health services in prison should be provided by health providers. This is consistent with the Mandela Rules and the World Health Organisation

Prisons and Health guidelines. The recent development in Auckland Prison of 80 cells for inmates with ‘serious mental health and/or complex behavioural issues’ (Department of Correction, 2017) illustrates this concern; particularly as this is contrary to the outcomes of the Mason Report (1988) that first addressed specific needs of MDOs in New Zealand.

We contend the provision of specialist mental health services by Corrections creates administrative, epistemological, cultural and ethical conflicts which undermine the quality of health care delivered. At the moment there is insufficient coordination between FMHS and the Department of Corrections in terms of planning and service development. We contend that MDOs should be afforded the same care as the general population therefore in our view specialist mental health care for MDOs should be provided by health organisations (District Health Boards, Primary Care Organisations) rather than the Department of Corrections.

**Recommendations**

- We strongly advocate for greater coordination between the FMHS and the Department of Corrections in relation to service development
- We argue that not only are additional resources required to fund the FMHS but we want to see investment in clinical and epidemiological research that may contribute to better treatment options for forensic patients. We concur with Sullivan (2006) that current funding is based on prevention of adverse publicity and risk containment when funds should be focusing on improving the management of high risk patients when they enter the justice system and examining potential preventative strategies to reduce mental health risk factors (Sullivan, 2006).

### 4 Improving the connection between forensic and general mental health services

There are a number of challenges facing forensic services that are a result of fragmented services across the mental health continuum. As an example, it is difficult to divert a mentally unwell offender to General Adult Mental Health (GAMHS) inpatient units as GAMHS have their own demands on beds.

We note that social support services and accommodation are often unavailable for MDOs, meaning that bail may be unlikely even for those on low level offences. As a result, people who are often very unwell, including already being subject to the Mental Health Act in the community, are remanded to custody. GAMHS services are often reluctant to admit these people prior to remand due to their own resource constraints. This causes further blocks in FMHS as these individuals take up valuable forensic beds and can be difficult to move on due to the lack of accommodation and support available.

**Recommendations**

- We contend that FMHS and GAMHS services both need additional resources to provide more cohesive care for MDOs in the justice system (Sullivan, 2006). For health professionals to deliver timely and optimal care to forensic patients there must be a more streamlined process and additional funding is required to break-down silos within mental health services
- We highlight the need for more joined-up services across the mental health continuum that includes developing collaborative approaches to care with social services outside of mental health e.g. Housing New Zealand, Ministry of Social Development and the New Zealand Police.
5 Addressing mental health and addiction disorders experienced by the Māori prison population

Issues and context

The proportion of Māori in the prison population⁵ is highly concerning. Evidence indicates that recidivism rates remain a significant issue for Māori released from prison. Five years after release from prison 77% of Māori were reconvicted and 58% were back in prison (Department of Corrections, 2009).

Māori prisoner numbers continue to grow and whilst this is not necessarily an issue the Faculty can address directly we do have a role in ensuring Māori prisoners are treated in a culturally appropriate way and their mental health and addiction needs are addressed. Research reveals that Māori prisoners have the highest prevalence of two or more mental health or addiction disorders, indicating they require a greater level of intervention to address their mental distress (Indig, 2016). It has also been reported that Māori living with psychotic illness in forensic units do not receive optimal treatment (Rangihuna, 2018).

Recommendations

- The Department of Corrections and the Ministry of Health need to embed a Te Ao Māori approach to address Māori prisoners’ health needs. Modelling the kaupapa Māori approach to mental health being developed in Gisborne could prove effective in the prisons (Rangihuna, 2018).
- We support further research to develop evidenced-based approaches to establish culturally appropriate frameworks that might improve mental health outcomes for Māori in prison. At the same time we need more information that might cast light on those structures within the criminal justice system that lead to high rates of Māori imprisonment. Social determinants, for example poverty, poor education (including illiteracy and drug and alcohol use), contribute to high rates of Māori imprisonment but these risk factors arise from colonisation and Māori experiencing alienation from their land. We concur with the Gluckman report that solutions to these wide-ranging issues require working in partnership with Māori to develop cross-sectorial strategies (Gluckman, 2018). Forensic psychiatrists are able to contribute to this dialogue by providing research around best practice for Māori in the criminal justice system and promoting activities that contribute to better mental health wellbeing within the whānau.
- We note that Māori prisoners have the highest prevalence of lifetime drug dependency so we argue substance disorder treatment for Māori must be made a priority to reduce reoffending and improve their mental wellbeing (Indig, 2016).

5. Introducing ‘upstream’ strategies to reduce the prison population

Issues and context

The reasons people end up in the justice system are multi-factorial and include poverty, poor educational outcomes, childhood trauma, violence, exposure to and/or dependency on drugs and alcohol and poor emotional resilience (Gluckman, 2018).

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⁵ Māori are 18.8% of the population but account for 51% of the prison population (Department of Corrections, 2013). If Māori had the same proportion of their population in prison as non-Māori then the prison population would be 44% smaller (Gluckman, 2018)
All psychiatrists have a role in promoting mental wellbeing and reducing stigma. People living with mental illness experience discrimination but MDOs experience this two-fold: being people living with mental illness and having a criminal record. As such many MDOs find once they are released from custody they are unable to integrate back into the community and with limited social support they often reoffend. Forensic psychiatrists and FMHS need Government support and resourcing to advocate for the needs of this highly vulnerable population.

**Recommendations**

- We support the Gluckman report’s view that the justice system’s ‘resources are overwhelmingly directed to those already in the criminal justice system not to the prevention of their getting there’ (Gluckman, 2018). We strongly urge the Government to invest in social programmes to address poor literacy, parenting programmes to improve care to children, and examine ways to support children living in poverty and in social deprivation.
- We contend that the money being spent on building new prisons should be diverted to social programmes that improve people’s health and life chances. Evidence suggests prisons have a negative impact on reoffending and ‘may be expensive training grounds for further offending and building offenders’ criminal careers’ (Gluckman, 2018). We are cognizant that implementing social programmes would take a generation before they showed positive outcomes but action needs to be taken to reduce the prison population and resolve the current burden experienced by FMHS.
- We draw the Inquiry’s attention to the current legislative framework for Special Patients which sees them subject to political oversight through the Ministry of Health and the Minister of Health. This is inconsistent with best practice and the recommendations of the RANZCP (RANZCP, 2016). We recommend review of the legislation with a shift in oversight by a judicially chaired tribunal or Court in line with international best practice.
References


Department of Corrections (2009) *Reconviction Patterns of Released Prisoner: A 60 Month follow-up analysis*. Wellington, New Zealand: Department of Corrections.


