The Royal Australian & New Zealand College of Psychiatrists

Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

Justice Select Committee

Corrections (Management of Prisoners, and Prisoners' Property) Amendment Bill

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Excellence and equity in the provision of mental healthcare

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists is the peak body representing psychiatrists in Aotearoa New Zealand and Australia. We are a binational college that trains doctors to become medical specialists in psychiatry. We support and enhance clinical practice, advocate for people affected by mental illness and addiction, and advise governments on matters related to mental health and addiction care. We represent over 9000 members, including more than 6,500 qualified psychiatrists and 2,500 trainees. Our training, policy, and advocacy work is led by expert committees of psychiatrists and subject-matter experts with academic, clinical, and service-delivery experience in mental health and addiction. Our members work across acute inpatient units, community mental health and addiction teams, child and adolescent services, perinatal and infant mental health, old age, forensic, consultation-liaison, intellectual disability, neurodivergent, rural, kaupapa Māori and private and primary care settings.

Our Position

We acknowledge that the Bill contains some positive elements. The explicit prohibition on prolonged solitary confinement, minimum meaningful human contact requirements, and strengthened natural justice provisions for designated-management prisoners (DMPs) reflect genuine progress. However, the Bill lacks clinical perspective in several critical areas, and we are concerned that without amendment, it will expose the most vulnerable people in custody, those with serious mental health problems, to significant and foreseeable psychiatric harm.

We are aware of the coronial review of the death of Antonie Dixon as a relevant New Zealand precedent illustrating the consequences of forensic mental health services not asserting adequate scope of involvement in the management of people in custodial settings with complex presentations. The Bill creates new high-security management pathways without a commensurate strengthening of the clinical architecture that should inform them. We urge the Committee to substantially strengthen the clinical architecture of the Bill in line with the recommendations we have made throughout this submission to protect the safety and rights of vulnerable New Zealanders.

This submission focuses on four areas of concern, all of which fall within the direct expertise of our membership:

- The inadequacy of protections for people with unidentified neurodevelopmental presentations or intellectual disability
- The inadequacy of protections for people with trauma histories
- The absence of safeguards for people experiencing acute alcohol and other drug (AOD) withdrawal
- The lack of explicit protections for rangatahi (young people) in custody
- The absence of a rehabilitation framework adequate to the clinical complexity of the DMP population.

1. Neurodivergence and Intellectual Disability

Our central concern in this section is not simply that vulnerable people may be misidentified within the DMP framework. It is more fundamental than that: mental illness, intellectual disability, and neurodevelopmental conditions should be identified, assessed, and treated as an alternative to

DMP designation — not as factors to be noted on the way to it. Designation is a custodial management tool. It is not, and should not become, a substitute for clinical care. Where a person's behaviour arises from an unmet clinical need, the appropriate response is treatment and accommodation, not restriction.

We wish to be explicit about what we are not recommending. We are not recommending that psychiatric or psychological assessment be incorporated as a criterion within the DMP designation process. We note with concern that this has already occurred in other New Zealand legal frameworks — including Public Protection Orders, preventive detention, and Extended Supervision Orders — where psychiatric assessment has been absorbed into punitive detention mechanisms in ways that compromise clinical independence and blur the boundary between treatment and punishment. We do not wish to see that pattern repeated here.

The Bill's DMP designation framework is built almost entirely on behavioural criteria, with no requirement to consider whether the behaviour in question is driven by an underlying and unmet clinical need. RANZCP members working in forensic settings have direct experience of cases in which unidentified autism or intellectual disability has resulted in behaviour that is misinterpreted by custodial systems as presenting extreme risk — when in fact the behaviour is a predictable response to an environment that has failed to identify or accommodate the person's needs. In extreme cases, this misidentification has resulted in decades of punitive escalation and profound psychiatric harm.

Specific examples include:

- Autistic people and/or those with an intellectual disability may present with behavioural rigidity, sensory distress, or communication differences that are misread as non-compliance or indicators of dangerousness
- People with low or average-low IQ, a far larger group than those with formally diagnosed intellectual disability, are similarly vulnerable to distress or behavioural disturbances that may be misinterpreted within a framework that does not require clinical assessment

We note that the Bill's requirement for Advisory Panel membership to include "suitable qualifications, knowledge or understanding" does not explicitly require any expertise in psychiatry, psychology, neurodevelopment, or disability. This is essential given the complexity and potential specialist needs of the population the Panel will be assessing.

There is currently no legislative mechanism to transfer a sentenced prisoner with intellectual disability to a more appropriate setting once they are in custody. This places the onus squarely on Corrections to identify prisoners with intellectual disability and to ensure their needs are met through appropriate intervention, rehabilitation, and accommodation — rather than defaulting to restrictive management. The Bill does not require this identification or this response, and that is a significant gap.

Recommendations

- Require that, before DMP designation is considered, clinical assessment for mental illness, intellectual disability, and neurodevelopmental conditions be completed — with treatment, reasonable accommodation, or clinical transfer pursued as the primary response where clinical need is identified. Designation should not be reached for where a clinical pathway exists

- Require Corrections to actively identify prisoners with intellectual disability and ensure their needs are met through appropriate intervention and rehabilitation, rather than defaulting to restrictive management or DMP designation
- Require the Advisory Panel to include at least one member with relevant psychiatric or clinical psychology expertise, with a mandate to identify clinical pathways away from designation
- Introduce an explicit requirement that the designation process document whether treatment, reasonable accommodation, or clinical support has been considered and offered

2. Trauma-Informed Care

People in custodial settings in Aotearoa have extraordinarily high rates of trauma exposure. Research consistently demonstrates that adverse childhood experiences (ACEs), including abuse, neglect, household dysfunction, and exposure to violence, are significantly overrepresented in prison populations. For Māori, this trauma is compounded by intergenerational and colonial harm, structural disadvantage, and the ongoing impacts of breaches of Te Tiriti o Waitangi. RANZCP has particular standing to raise this, and particular obligations to do so.

The Bill does not consider the impact of trauma on people living within a correctional setting in the assessment and designation of a DMP. This is a critical omission, because trauma is not merely a background factor, but is frequently the direct driver of the behaviour that would trigger DMP designation or segregation under this framework.

RANZCP members working in forensic settings have direct experience of cases in which unidentified and untreated trauma has resulted in decades of punitive custodial escalation. A person who becomes aggressive during a strip search or pat-down is not necessarily — or even primarily — posing a security risk. They may be experiencing an acute trauma response to a procedure that directly replicates the conditions of prior abuse. That response, in the absence of trauma-informed assessment, is liable to be read as dangerous behaviour warranting restriction. Restriction then compounds trauma. Compounded trauma produces further behavioural disturbance. The cycle escalates, sometimes across years or decades, without the underlying clinical reality ever being identified or addressed.

The Bill's DMP designation framework, as currently drafted, has no mechanism to interrupt this cycle. There is no requirement to consider whether behaviour has a trauma aetiology. There is no requirement for trauma-informed assessment before designation or to provide an alternative intervention. The Advisory Panel has no mandatory expertise in trauma. The result is a legal framework that is structurally capable of producing — and entrenching — exactly the kind of long-term harm that monitoring bodies have consistently criticised Corrections for failing to prevent.

We note that this concern applies with particular force to tāngata whai ora Māori in custody. The overrepresentation of Māori in prison, and the likelihood that they will be overrepresented among those designated as DMPs, means that the lack of a trauma-informed framework is also an equity failure and a Te Tiriti failure. RANZCP NZ has previously argued, including in our submission on the Mental Health and Wellbeing Strategy, that tikanga-centred, trauma-informed practice is not an optional enhancement but a structural obligation. That argument applies with equal force here.

Recommendations

- Introduce a requirement that a trauma-informed assessment be completed before DMP designation is considered, and that the results be provided to and considered by the Advisory Panel

- Require that the Advisory Panel include at least one member with expertise in trauma and its intersection with custodial settings
- Introduce an explicit requirement that segregation decisions consider whether the behaviour precipitating the direction has a trauma aetiology, and whether trauma-informed alternatives to restriction have been explored and documented
- Require that Corrections' operational guidance on DMP management and segregation be developed in partnership with trauma-informed and kaupapa Māori clinical expertise
- Ensure that the minimum meaningful human contact provisions are implemented in a manner that is trauma-informed — recognising that for some people, certain forms of contact (including face-to-face contact in confined spaces) may themselves be re-traumatising without appropriate relational safety

3. Alcohol and Other Drug Withdrawal

The Bill does not engage with alcohol and other drug (AOD) withdrawal as a distinct clinical risk in the custodial setting. This is a significant omission.

Alcohol withdrawal can cause life-threatening presentations including delirium tremens and seizures. Methamphetamine withdrawal produces severe behavioural disturbance — currently recognised as a 'toxidrome' presentation requiring urgent emergency medicine management. Work is currently underway nationally, led by Te Whatu Ora │ Health New Zealand's Clinical Network to develop ED-based methamphetamine withdrawal protocols. No equivalent approach exists in the prison setting, and the Bill does nothing to address this gap.

Under the DMP framework, behaviourally disturbed presentation during withdrawal could plausibly meet the threshold for extreme risk designation. The Bill contains no requirement to consider whether an acute AOD presentation has been identified and clinically managed before restrictive escalation occurs.

We note the relevance of section 75(2) of the Corrections Act 2004, which sets out the health care entitlement of prisoners. The Bill's silence on AOD withdrawal sits in tension with this entitlement and with New Zealand's obligations under the Nelson Mandela Rules, which the Bill itself relies on as a foundation for the meaningful human contact provisions.

Recommendations

- Introduce a requirement that evidence of AOD assessment and, where clinically indicated, withdrawal management be documented before a DMP designation is made or confirmed
- Ensure that prison health frameworks have access to current clinical protocols for alcohol and methamphetamine withdrawal management, with appropriate resourcing

4. Rangatahi — Young People in Custody

The Bill applies no higher threshold, explicit protections, or distinct framework for rangatahi in custody. This is a serious gap.

The meaningful human contact minimum of 10 hours per 14-day period is drawn exclusively from the Nelson Mandela Rules, which are adult-focused. The equivalent international standards for young people — including the United Nations Rules for the Protection of Juveniles Deprived of

their Liberty (the Havana Rules) and the Beijing Rules — set considerably higher expectations, and the developmental science on the harm of isolation to adolescent brains is qualitatively different from the adult evidence base.

Rangatahi in custody in Aotearoa are disproportionately Māori. Many have complex trauma histories, neurodevelopmental presentations, and sit within the youth-to-adult transition age range where developmental vulnerability is greatest. The Bill contains no reference to UNCROC obligations, no engagement with the Oranga Tamariki Act interface, and no requirement to consider developmental age or stage in either the DMP designation process or segregation decision-making.

The only youth-specific amendment in the Bill is a minor provision (clause 38) requiring prisons to contact a nominated person if a young prisoner becomes an at-risk prisoner. While welcome, this is wholly insufficient as a protective framework for this population.

Recommendations

- Introduce an explicit exclusion or significantly higher threshold for the DMP designation of rangatahi, consistent with UNCROC obligations and the Havana Rules
- Require that age and developmental stage be considered in all segregation decisions involving young people
- Review the minimum meaningful human contact standard in light of international youth-specific standards and the developmental evidence base
- Ensure explicit engagement with the Oranga Tamariki Act interface within the Bill

5. Rehabilitation, Risk, and the Limits of Restrictive Management

For designated-management prisoners, the Bill's own provisions make rehabilitation explicitly discretionary. Regulation 65AAA(2A), inserted by clause 36, requires case management plans to reflect rehabilitation opportunities only "if it is appropriate, and to the extent that it is reasonable and practicable, in the circumstances." No equivalent qualifier applies to the rehabilitation requirements for the general prison population under regulation 65AAA(2). The effect is that the prisoners with the highest and most complex needs — those whose behaviour has been assessed as posing extreme risk — are the only group for whom rehabilitation is formally optional. This is clinically and strategically incoherent, and it sits in direct tension with the commitments of Hōkai Rangi.

Hōkai Rangi, Ara Poutama Aotearoa's strategy for 2019–2024, places rehabilitation, reduced reoffending, and Māori-centred approaches at the centre of the corrections system's purpose. It explicitly recognises that meeting the needs of people in custody — including their health, cultural, and wellbeing needs — is not separate from public safety outcomes but foundational to them. The Bill, as drafted, sits in tension with that commitment. A management regime that treats rehabilitation as discretionary for the highest-need prisoners in the system is not a logical extension of Hōkai Rangi — it is a departure from it.

This tension is compounded by what the clinical evidence tells us about highly restrictive custodial environments. Prolonged restriction, isolation, and loss of agency are known to worsen the mental health conditions, trauma responses, and behavioural dysregulation that most commonly drive the extreme risk presentations the Bill targets. A framework that responds to those presentations by imposing conditions known to exacerbate them — without requiring any assessment of the underlying clinical drivers — is not only clinically inappropriate. It is internally incoherent.

New Zealand corrections already operates a risk-needs-responsivity framework that explicitly links criminogenic need to rehabilitative intervention. The DMP designation process, as currently drafted, bypasses that framework entirely. There is no requirement to assess need before designation, and no requirement to address identified needs as an alternative to designation. This is inconsistent with the principles that underpin the rehabilitation programmes Corrections already delivers, and with the vision of Hōkai Rangi for a system that reduces harm by addressing its causes.

RANZCP urges the Committee to ensure that the Bill is brought into alignment with the commitments of Hōkai Rangi and with the evidence base on rehabilitation and risk reduction. Meeting the clinical and cultural needs of people in custody is not at odds with public safety — it is one of the most effective tools for achieving it.

6. Overarching Concern: The Bill is Clinically Inappropriate

Across all of the areas identified above, our core concern is the same: the Bill establishes a significant new high-security management framework with robust legal process — panels, reviews, natural justice provisions — but with thin and largely reactive clinical architecture. This imbalance is not a technical drafting issue. It reflects a fundamental conceptual problem with how the Bill frames risk.

The Bill treats risk as intrinsic to the person rather than recognising a person's vulnerabilities potentially being triggered within the prison environment. It does not adequately engage with the substantial body of clinical evidence demonstrating that what presents as extreme risk in custodial settings is very frequently a symptom of unmet need — unidentified trauma, undertreated mental illness, undiagnosed neurodevelopmental conditions, acute AOD withdrawal, or the cumulative psychiatric harm of prolonged restrictive management itself. A framework that is designed to manage risk without being designed to understand its origins will, in our members' experience, consistently misidentify clinical need as security threat. It will then apply restrictions in response to that misidentification, compounding the very conditions that generated the behaviour in the first place.

The consequences of this are not hypothetical. RANZCP members working in forensic settings in Aotearoa have witnessed — and in some cases been called to account for not preventing — exactly this pattern of escalation. Monitoring bodies have raised repeated concerns about the adequacy of mental health oversight in New Zealand's custodial settings. The coronial review of the death of Antonie Dixon stands as a stark New Zealand example of what can happen when clinical services do not assert sufficient scope of involvement in the management of people with complex presentations in custodial settings. The Bill, as currently drafted, creates new and more powerful management pathways without addressing the clinical infrastructure gaps that have generated those concerns.

We are also concerned about the resourcing reality that sits behind this Bill. Forensic mental health services in Aotearoa are already stretched. The Bill will create new obligations — advisory panels, designation reviews, case management planning for DMPs — without any apparent resourcing commitment to ensure that the clinical expertise those processes require is actually available. A legal requirement for clinical input is meaningless if the clinical workforce to provide it does not exist or is not funded. We urge the Committee to seek explicit advice from Health New Zealand on the workforce and resourcing implications of the Bill's clinical requirements before it proceeds.

The health professional consultation provisions are reactive rather than proactive. Rehabilitation for DMPs is explicitly framed as discretionary — required only where "appropriate" and "to the extent

reasonable and practicable" (regulation 65AAA(2A)). The Advisory Panel has no mandatory clinical membership requirement. Taken together, these gaps mean that the most consequential decisions the Bill enables — decisions that may result in years of highly restrictive management — can be made without any requirement for clinical understanding of the person at the centre of them.

The result is a framework that is well-designed to process legal risk but poorly designed to identify when that legal risk is a symptom of unmet clinical need. In our members' experience, for the population this Bill targets, it very frequently is.

We urge the Committee to substantially strengthen the clinical architecture of the Bill in line with the recommendations we have made throughout this submission. We further urge the Committee to hear directly from forensic psychiatry, disability, trauma, and AOD clinical expertise — including Māori clinical voices — before this Bill proceeds. The people most likely to be designated as DMPs are among the most clinically complex and most marginalised in our society. They deserve a framework that is as rigorous in its clinical thinking as it is in its legal design.

Ngā mihi,

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