Mental Healthcare in Prison:
A Right or a Discretion?

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

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Abstract

Mental health care within prisons has been deemed a categorical failure. The increasing number of self-harm incidents and the growing prevalence of untreated mental illness among prisoners raise concerns about the efficacy of the current system. This research explores the cracks in the mental healthcare system across Aotearoa prisons, attributing the issues to the responsibility of the Department of Corrections, the conflation of treatment and rehabilitation, and a short-sighted focus on a reasonably equivalent healthcare standard that fails to meet legal requirements and public health needs.

This paper aims to present a less-explored perspective on mental health care within prisons by advocating for a shift from the pursuit of equivalent standards to the attainment of equitable health outcomes. It argues that to fully comply with legislation in Aotearoa, mental healthcare in prisons should go beyond reaching parity with community standards and, instead, strive for outcomes comparable to those achievable in the community.

The research critically examines the concept of reasonable equivalence of health care. It reviews existing scholarship that surveys the scope of the problem and analyses new treatment developments. However, this paper goes further by proposing a reframing of the approach to mental healthcare in prisons.

The findings suggest that achieving equivalent health outcomes for prisoners requires a comprehensive overhaul of the mental healthcare system. This would involve enhancing individual capacity, improving general accessibility, coordinating stakeholders, and allocating additional resources beyond the current standards available in the community.

The paper concludes by highlighting the need for strategic and systemic change in order to address prevailing issues, uphold legislative requirements, and meet the wider public health needs. This research contributes to the ongoing discourse on improving mental healthcare for prisoners and offers a fresh perspective that can inform future policy in practise.

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ACKNOWLEDGEMENTS AND PREFACE

Although the genesis for this work began in a prison cell, the impetus came from the opportunity to intern for Deborah Manning at Landmark Chambers. Having been somewhat of a "fanboy" of hers since the early 2000s and the Ahmed Zaoui cases, I jumped at the chance to assist with a judicial review her team was working on regarding access to mental health treatment within prisons. Her client, a prisoner nearly universally loathed by both the public and other prisoners, had spent over twenty years incarcerated while suffering from a range of mental illnesses and barriers to rehabilitation. Although spending most of that time in some form of solitary confinement, he had not received one minute of psychological treatment. A good deal of the research that formed the foundation for this dissertation was read and recorded in the time at Landmark. Deborah is, in my opinion, one of the finest people the legal fraternity in Aotearoa has and, as a human rights lawyer, she is unmatched.

I need to more than acknowledge my supervisor, Professor Khylee Quince, Dean of Law at AUT. It goes without saying that this dissertation, as a culmination of three papers that went towards the LLM degree, would not have happened were it not for Professor Quince. But her contribution goes far beyond some (at times painful, I'm sure) readings of the works. Professor Quince is, quite simply, the kindest, most generous, most inspirational person I have ever met. From sitting in her classes a decade or more ago during my undergraduate degree to being a very small part of her teaching team this year has been an honour and a privilege, and I consider every minute spent with her moments I will treasure.

Professor Quince, may the force be with you.

I have been challenged more than once by people who have queried my "authority" to write on the topic of prisons, mental health, and the Department of Corrections' response to how it manages prisoners who need treatment while incarcerated. I do not claim an "authority", but my past has given me an insight I would suggest most readers may not possess. I decided to do an LLM after one of the staff at Kohuora, the Auckland South Corrections Facility printed out a brochure from the AUT website for me. By that point, I was already a few years into an 8+ year prison sentence for white-collar offending. Over the years, I have spoken with hundreds of prisoners for thousands of hours about everything from their whānau, their hopes and dreams, through to their favourite biscuits. Although these times were not formalised

interviews suitable for academic research, I can say that I know how prisoners think, that I understand the stresses and pressures they live with every day, and I know firsthand the wariness they have of engaging with those they see as "others" – the authorities. Whether that is the custodial officers, the prison management, or the prison psychologists … prisoners are not in the habit of revealing their vulnerabilities to those in charge of their imprisonment.

I was woken one morning to be told that a friend of mine, another prisoner, had taken his life overnight in a particularly violent and traumatic manner. He had one year left in an 18-year sentence, and throughout that entire time had "asked, begged and demanded" some help about the thoughts in his head. Every single time – for 17 years – he was told he was not "high priority" enough. His offending was not linked to his mental illnesses and therefore he was not eligible for assistance. He was not the only prisoner I knew to end their lives during the time I was incarcerated.

So, to my friend, Xue. Rest well.

Alongside the tens of thousands of hours of lived experience inside prisons, I also spent three and a half years in the late 2000s as the Regional Manager (Auckland) for Prison Fellowship New Zealand under the guidance of Tā Kim Workman. Getting to work with Tā Kim was an immense honour. His capacity for care and a seemingly endless reservoir of energy has seen him finally getting the rewards and honour he deserves for a life of service. But it was the prisoners and their whānau who were the focus of our efforts. A change in how prisons operated and, hopefully, a consequent reduction in the number of victims of crime was our ultimate goal … that dream is still alive a decade and a half later.

And, finally, my whānau. Thank you. For everything.

Prologue

The screams echoed against the dense concrete walls, as they had for the last 60 years men had been incarcerated in this prison. Screams reflective of unfathomable childhood abuse, of having witnessed unspeakable events, or declaring an internal pain that drives others to end their lives at the bottom of a noose or barrel of a gun. But day after day, year after year, those screams are muffled behind steel, concrete and razor wire. The billion-dollar industry that is the rehabilitative prison experiment fails the men and women suffering inside its walls … those prisoners fighting a war inside their own minds filled with despair, fear and an absence of hope. Mental illness is endemic in prison – a natural state for the majority of its inhabitants. However, unless a mental illness is identified as a contributing cause to any index offending, nothing will be done to intervene.

Our society will simply warehouse human souls … out of sight, out of their minds.

Introduction

Mental healthcare for prisoners is, despite fine efforts by some psychologists, a categorical failure.

In 2011 there were six self-harm incidents that were considered a threat to life in Aotearoa prisons. During the next year there were seven.[1] By 2018, there were 37 such incidents (seven of which resulted in death).[2] Two years later there were 83 reported.[3] Something was wrong. Yet the Department of Corrections (Corrections) was consistently promoting its prioritising of mental health and its ability (thanks to Government investment) to "change more lives than ever before"[4] despite having to simultaneously report in 2019 that one prisoner tried to kill themselves for every week of the past year.[5] It is a truism that prisons house people with complex and deep-seated mental health issues. The prison system in Aotearoa is, by quite some

[1] Department of Corrections *Annual Report 2012-2013* at 17.

[2] Department of Corrections *Annual Report 2017-2018* at 58.

[3] Department of Corrections *Annual Report 2019-2020* at 59.

[4] Department of Corrections *Annual Report 2018-2019* at 52.

[5] At 38.

distance, the largest mental health institution in the country.[6] Untreated mental illness in prison inevitably becomes untreated mental illness in the community, ultimately creating more victims of crime, damaging communities, and causing an economic cost far in excess of the cost of early intervention.[7] This has been reported as scandalous and with few options for reform in sight.[8] Nevertheless, strategic and systemic change could improve outcomes.

This research concludes the cracks endemic in the mental healthcare system within prisons are due firstly to Corrections (rather than the Ministry of Health) being primarily responsible for treatment provision; secondly, conflation of the terms "treatment" and "rehabilitation" in the context of psychological intervention; and lastly but most importantly, a short-sighted focus on a "reasonably equivalent" health care standard that fails to meet the objectives of both the relevant legislation and public health needs.

Internationally, the concept of "reasonable equivalence" of healthcare (the idea prisoners should receive a reasonably equivalent standard of care to that available in the community) is both widely accepted and, legislatively speaking, embraced by not only central governments but larger health and human rights bodies. Scholarship thus far has focussed on either surveying the scope of the problem[9] or analysing new developments in treatments that may yield better results.[10]

This paper will present the less-argued position: that to give full effect to the legislation in Aotearoa, the focus should evolve past attempting to reach equitable *standards* of healthcare to a pursuit of standards that achieve equivalent *outcomes* of health. This will mean, in the context of mental health treatment, the interventional capacity, general accessibility,

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[6] Department of Corrections *Change Lives, Shape Futures: Investing in Better Mental Health for Prisoners* (Department of Corrections, Wellington, 2017) at 4.

[7] Aaron Dahmen "Exclusive: 'Expensive failure' – New Zealand's cost per prisoner rises while jail population dwindles" *The New Zealand Herald* (online ed, Auckland, 28 March 2022).

[8] Erik Monasterio and others "Mentally ill people in our prisons are suffering human rights violations" (2020) 133 New Zealand Medical Journal 9.

[9] Devon Indig, Craig Gear and Kay Wilhelm *Comorbid substance use disorders and mental health disorders among New Zealand prisoners* (Department of Corrections, Wellington, June 2016).

[10] Brian McKenna and others "Prison mental health in-reach teams in Aotearoa New Zealand: A national survey" (2021) 28(5) Psychiatry, Psychology and Law 774.

coordination with stakeholders, and ultimately the resources applied may need to be greater than the standards currently available to those in the community. Despite understanding that requirement is a maximalist demand, in order to meet human rights obligations this reframing needs to begin.

> Mental illness is different from physical illness. Mental illness is a very personal thing, a personal experience. You can't see it, so you can't distance yourself from it. It's you. It's for life. It takes your soul. Sometimes it's like dying. No one else sees it, so they often don't believe you or they don't understand. You don't understand it yourself; often you don't understand yourself. The health professional can't really explain it, except in vague or incomprehensible terms of chemical imbalance. So relief is in the personal care and attention and time that are offered to you. They are just as important as the medications.[11]

This paper will examine to what extent and how, is Corrections upholding its legal obligations to provide equitable mental healthcare to prisoners in Aotearoa.

"Mental illness" or "mental disorder" are terms not easily defined. The Ministry of Health[12] describes mental illness as "any clinically significant behavioural or psychological syndrome characterised by the presence of distressing symptoms or significant impairment of functioning." It should be noted at the outset that it is no simple task collecting data on mental illnesses within the prison system. Prisoners are notoriously difficult to illicit information from and it is commonplace for prisoners to put on a figurative mask[13] as a protective device designed to project an image different from their real selves.

[11] Ministry of Health *Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services* (Report of the Ministerial Inquiry to the Minister of Health Jenny Shipley, May 1996). Quoting Dr Don Quick, Psychiatrist.

[12] Ministry of Health *Building on Strengths* (Ministry of Health, Wellington, 2002) at 49.

[13] Nick de Viggiani "Trying to be Something You Are Not: Masculine Performances within a Prison Setting" (2012) 15(3) Men and Masculinities 271.

Prison is an inherently dangerous place. Accurately described as violent and predatory,[14] there is a code of conduct – a series of unwritten rules – prisoners need to live by in order to survive.[15] Regulated by other prisoners, this code and the expectations it places on those subject to it is highly detrimental to, in particular, a person's mental health. Described as "prisonisation",[16] this culture is a struggle between "captor and caged".[17] Any mental health issues present upon incarceration are only exacerbated by the prison milieu.[18]

As a tool to "get tough on crime",[19] simply improving mental health outcomes will reduce reoffending.[20] Further, it is well established that untreated mental illness and serious violent offending are correlated;[21] reducing both is only a positive for the community. The World Health Organisation identifies two reasons for providing health care to prisoners – a public health rationale and society's commitment to social justice.[22]

This research will offer an analysis of the current legal obligations relating to prisoners' access to mental health care and argue there is a gap between what those obligations are and the outworking of them day-to-day, critique the responses Corrections advance, and in the context of human rights law, suggest a reformation of the term "equivalence of care" is relevant, timely and needed.

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[14] James Cavney and Susan Friedman "Culture, Mental Illness, and Prison: A New Zealand Perspective" in Mills & Kendall (ed) *Mental health in prisons : Critical perspectives on treatment and confinement* (Springer International Publishing AG, Cham, Switzerland. 2018) 211.

[15] Taylor Gamble "Prison Inmates Reveal the Unspoken Rules of Prison" (19 January 2018) Tickld <tickld.com>; and Noah Bergland "11 Unwritten Rules of Prison" (19 September 2020) Resilience 2 Reform <resilience2reform.com>.

[16] Naderi Nader *Prisonization: The Encyclopedia of Criminology and Criminal Justice* (ebook ed, John Wiley and Sons, Ltd, 2014).

[17] Cavney, above n 14, at 223.

[18] Andrew Carroll and others "No involuntary treatment of mental illness in Australian and New Zealand prisons" (2021) 32(1) The Journal of Forensic Psychiatry and Psychology 1 at 3-4.

[19] As opposed to "getting tough on criminals" which is the what proponents of the clichéd "get tough on crime" really mean when they use the phrase.

[20] Peter Gluckman *Using evidence to build a better justice system: The challenge of rising prison costs* (Office of the Prime Minister's Chief Science Advisor, Wellington, 2018).

[21] Short, Thomas, Mullen, & Ogloff "Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls" (2013) 128(4) Acta Psychiatrica Scandinavica 306.

[22] Enggist and others *Prisons and Health* (World Health Organisation, Regional Office for Europe, 2014) at 2.

In Aotearoa, Corrections is responsible for providing primary health care, including mental health treatment. For prisoners toward the more serious end of the mental illness scale, the Ministry of Health forensic teams are referred in. This paper will not consider deeply the processes behind those interventions, beyond pointing out the gap between those afforded treatment within the prison system and those allocated a bed in a psychiatric hospital.

Part I of this paper will lay out the scale of the problem of mental illness within Aotearoa prisons, largely drawing on previous surveys, to identify any disparities between those incarcerated and those in the general community. It will then offer what can be described as the "four pillars" upon which poor prison mental health results are built: Intervention and Support Units; Māori imprisonment rates and the lack of Mātauranga Māori in treating Māori prisoners; the belief by Corrections it is best placed to provide mental health treatment; and, finally, the milieu of prison itself.

Part II will outline the legal obligations currently in place that govern decisions regarding mental health treatment provision. These include the relevant sections of the Corrections Act (the Act), Te Tiriti o Waitangi obligations, and human rights law (both local and international). The history of Corrections' soft policy is considered and grey literature in Aotearoa from the early 1980's to the development of *Hōkai Rangi*, Corrections' latest flagship strategy, is outlined as a backdrop to the assertions made later in the dissertation.

Part III analyses the history and rationale of the principle of "reasonable equivalence" in health care. Then, as a comparative tool (although acknowledging the shortcomings in relying on international data) the paper considers several of the approaches other jurisdictions apply to mental health issues within their prison systems.

In Part IV, the analysis turns to considering and critiquing the responses Corrections in Aotearoa offers. That is, how are the obligations described in Part II worked out in practice? It is suggested, although the wairua behind it is well-meaning, the outcomes are still inhibited by the framework of prison, both philosophical (control and security) and systemic (resource restriction and division of responsibility). Conflation of the terms "treatment" and "rehabilitation" in prison have contributed, it is argued, to a confusion about how best to work with prisoners with mental illness. Programmes designed solely to reduce re-offending,

although aspirationally worthy, are not suitable for *treating* mental illnesses. However, some initiatives suggest promise and attention will be directed to these.

Finally, Part V will outline three recommendations it is suggested may improve the current state of care:

(i) Adoption of the principle of "Equivalence of Outcome" to replace the current target of "reasonable equivalence of care"; and

(ii) Transferring responsibility for primary health care, including mental health treatment, to the Ministry of Health; and

(iii) Clarification of the delineation between the terms "rehabilitation" and "treatment" within the legislation, and a further commitment to work towards using correct terminology in future cases, Parole Board decisions and programme development. This will be aided by the Ministry of Health managing prison health care.

Part I Why Is There Even A Problem?

Before highlighting the legal obligations Corrections is required to uphold, an understanding of the scale of the problem facing Aotearoa is needed. Two studies, undertaken 15 years apart,[23] map the rates of mental illness and substance abuse (defined as "comorbidity" when both are present) and the patterns are disturbing. Most people in prison have been exposed to trauma during their childhood.[24] Although Corrections relies on the claim that childhood trauma is not causally connected to criminal offending,[25] other commentators have strongly asserted the link.[26] Moves towards a trauma-informed model of care are occurring especially within the female and youth prison environs. Although policy exists to incorporate trauma-informed

[23] Philip Brinded and others "Prevalence Psychiatric Disorders in New Zealand Prisons: A National Study" (2001) 35(2) Australian & New Zealand Journal of Psychiatry 166; and Indig, above n 10.

[24] Monasterio, above n 8, at 9.

[25] Marianne Bevan "New Zealand prisoners' prior exposure to trauma" (2017) 5(1) Practice: The New Zealand Corrections Journal 8.

[26] Mason Durie *Imprisonment, trapped lifestyles, and strategies for freedom* (Paper presented at the Indigenous people and Justice conference, Wellington, 1999).

practice in the day-to-day operations, the reality is often that the "management" of a prison is the foremost priority.[27]

Prisoners, in general, experience poor physical health although it has been shown to improve while they are in prison.[28] Such improvement in physical health is likely due to a restricted diet with limited sugar and saturated fats, combined with the opportunity to "work out" either in cells or yards. However, excess morbidity and mortality extends well beyond the eventual release from prison.[29] Further, the prevalence and long-lasting negative impacts of mental health disorders within prison contrast with the improving patterns seen in physical health statistics.

91% of prisoners have a lifetime diagnosis of a mental illness or substance abuse disorder,[30] while being three times more likely to have been diagnosed with a mental illness within the past year than someone from the general population. In comparison, only 20% of New Zealanders experience a mental illness in their lifetime.[31] One third of prisoners were identified as currently having a personality disorder. Suicide is the leading cause of death in prison. Several factors contribute to this, including recent suicidal ideation, a history of attempted suicide, an active psychological diagnosis (in particular, depression), substance abuse, and solitary confinement.[32]

Specialist forensic psychologist Erik Monasterio, the former clinical director of the Canterbury District Health Board area mental health team, has estimated hundreds of prisoners are currently sleeping in prison cells due to the lack of beds in appropriate mental health facilities.

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[27] Guyon Espiner "Use of Cell Buster pepper spray was unlawful – Judge" (1 July 2022) RNZ <rnz.co.nz>; and restrictions on sanitary products reported in Auckland Regional Women's Correctional Facility.

[28] Monasterio, above n 8, at 9.

[29] Monasterio, above n 8.

[30] Indig, above n 9.

[31] Oakley Browne, Wells and Scott (eds) *Te Rau Hinengaro: New Zealand mental health survey* (Ministry of Health, Wellington, 2006). Although noting the disparity, I appreciate that even 20% is a saddeningly high rate of mental illness in the community.

[32] Annette Opitz-Welke "Psychiatric Problems in Prisoners: Screening, Diagnosis, Treatment and Prevention" in Elger, Ritter and Stoever (eds) *Emerging Issues in Prison Health* (Springer, Berlin, 2016) at 135. Also see next section in this paper on solitary confinement.

When considering the impact of prison on mental health, he says "you could not design a more deleterious environment."[33]

Corrections has invested increased resources into mental health treatment. The planned construction of a 100-bed mental health facility within Waikeria Prison is a laudable effort although, as has been pointed out elsewhere, it will only service the Waikato region[34] and 100 beds is approximately 1% of the prison population. At any one time there are 30 times that number of prisoners with identifiable personality disorders … and up to 20 times that number suffering from post-traumatic syndrome disorder (PTSD).[35] It has been well stated that the role of prison psychiatrists should be as a treatment option and not as a support unit for correctional aspirations.[36] The potential impact of this unit in the context of whether prisons in the guise of psychiatric hospitals are the best path forward is considered in Part IV of this paper.

Psychiatric rehabilitation has been accepted as the most effective treatment[37] for people suffering from mental illness within the community. This encourages individuals to live independently by eliminating or, at least, minimising functional deficits.[38] Sadly though, the ability of forensic psychiatric services to meet demand from the prison system (in addition to the growing pressure from the general population) is causing unsafe measures to become commonplace. Prisoners in need of immediate in-patient care are placed on waiting lists, rather than being admitted (as would happen if they were general community members).[39] Treating prisoners involuntarily is not legal in Aotearoa.[40] Although calls have been made to consider involuntary treatment,[41] the Royal Australian and New Zealand College of Psychiatrists asserts

[33] Naomi Arnold "Mentally ill and behind bars: 'The poor guy shouldn't be in jail'" (20 June 2022) RNZ <rnz.co.nz>.

[34] Monasterio, above n 8, at 10.

[35] Indig, above n 9.

[36] Opitz-Welke, above n 32, at 133-134.

[37] Corrigan and others *Principles and practice of psychiatric rehabilitation: An empirical approach* (Guilford Publications; New York, 2007).

[38] Morgan and others "Treating Offenders with Mental Illness" (2012) 36(1) Law and Human Behavior 37.

[39] Monasterio, above n 8, at 10.

[40] Carroll, above n 18.

[41] At 17.

such a move would compromise clinical care, lead to inappropriate prisoner management and breach multiple international human rights conventions.[42]

Theories abound as to why mental illnesses are so prevalent across the prison network. Firstly, some posit the neo-liberal ideal of personal responsibility[43] has led to the criminalisation of socially disturbing behaviour.[44] Others point out that as access to institutionalised psychiatric care has become more restricted, the prisons have become the proverbial ambulance at the bottom of the cliff. Opitz-Wilke believes co-morbidities within the offender population, such as substance abuse or extreme social deprivation linked with serious mental illness, could contribute to a reluctance on the part of psychiatric care providers to accept such people for treatment – leaving the prisons as the only option.

It is argued there are four main contributing factors as to why, once imprisoned, prisoners tend to deteriorate in terms of their mental health across the term of a sentence. These are:

(i) The use of solitary confinement as a management and control tool;
(ii) the lack of Mātauranga Māori in treating Māori prisoners;
(iii) the belief by Corrections that it is best placed to provide mental health treatment; and
(iv) the milieu of prison itself.

A Intervention and Support Unit (ISU) aka At Risk Units

It is illegal to sentence someone to solitary confinement in Aotearoa.[45] Corrections claim such a device "is not used in New Zealand prisons".[46] This is not the experience of many prisoners.

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[42] Royal Australian and New Zealand College of Psychiatrists *Involuntary mental health treatment in custody* (Position statement, November 2017).

[43] Massimo Pendenza and Vanessa Lamattina "Rethinking Self-Responsibility: An Alternative Vision to the Neoliberal Concept of Freedom" (2019) 63(1) American Behavioral Scientist 100.

[44] Opitz-Welke, above n 32, at 134.

[45] Crimes Act 1961, s 17.

[46] Te Ao Maori News "Campaign launched against solitary confinement" (online ed, 16 October 2017) <teaomaori.news/campaign-launched-against-solitary-confinement>. Quoting Rachel Leota, National Commissioner for the Department of Corrections.

Immediately after claiming solitary confinement is not used, Corrections states "prisoners may be lawfully denied association with other prisoners". Being denied association with other prisoners is the definition of solitary confinement. The Mandela Rules,[47] previously known as the United Nations Standard Minimum Rules for the Treatment of Prisoners, state anything longer than 22 hours per day in a cell meets the formal definition for solitary confinement.[48] The minimum requirement in the Act is for one hour out of cells in any 24 hour period.[49] However, a prison manager may deny that minimum entitlement if the prisoner is undergoing a penalty of cell confinement.[50] There must be some level of cognitive dissonance when it can be claimed "solitary confinement is not used in New Zealand prisons" yet have a legislative tool that allows (and is used) for exactly that.

One of the primary tools[51] Corrections relies on when dealing with difficult or disturbed prisoners are ISUs. Until very recently known as At-Risk Units, these units have a variety of nomenclature with prisoners providing the most descriptive ones – the "pound",[52] "management", "segs", or "separates. Section 60 of the Act states prisoners may be segregated for the purpose of medical oversight, which can include assessment of a prisoner's mental health.[53]

Lamusse has written a comprehensive and well-researched paper on the use of such units.[54] He describes ISU cells as "bare", "the most spartan cells in the New Zealand prison system", and "extremely dehumanising".[55] He points out ISUs are "entirely inappropriate for the treatment of people with mental illnesses and can be actively damaging to their well-being",[56] something

[47] See Part II for further discussion.

[48] Guyon Espiner "Prolonged confinement of prisoners could prompt legal action against Corrections" (9 September 2020) RNZ <rnz.co.nz>.

[49] Section 70.

[50] Section 69(4)(b).

[51] Deborah Alleyne "Transforming intervention and support for at-risk prisoners" (2017) (5)2 Practice: The New Zealand Corrections Journal 33.

[52] JustSpeak NZ "True Justice" (podcast, 2022) JustSpeak Spotify.

[53] Section 60(1)(b).

[54] Ti Lamusse *Solitary Confinement in New Zealand Prisons* (Economic and Social Research Aotearoa, 29 January 2018).

[55] At 6.

[56] At 7.

widely accepted by those outside the Corrections system.[57] ISUs are not psychiatric units but do provide the opportunity for safe observation and containment. Nevertheless, in the intensity of a prison setting, such decisions of necessity are reasonable. In conceding that, there is a corresponding cost to such necessity; any restriction to amenities and human contact can "contribute to a deterioration of mental state and behaviour in the longer term."[58]

As one prisoner said of his experience in the ISU, "after your first time you do everything you can to avoid it in the future."[59] Despite concerns ISUs may be seen as solitary confinement devices, Corrections has maintained they are not, citing the minimum entitlement of phone calls available to prisoners in ISUs as evidence. That minimum entitlement under the Act is five minutes in total per week.[60]

Although it may described as an overly liberal (and possibly extreme) view, Lamusse's research asserts that the use of ISUs to "treat" prisoners suffering from a mental illness is cruel and degrading, and may reach the threshold of torture.[61] It should be added[62] that Corrections' use of ISUs is evidence it is failing to meet the level of "reasonable equivalence of care" for prisoners, as there is no treatment equivalent to solitary confinement for people in the general population who present with serious mental illnesses. Corrections acknowledge this.[63]

B Māori and Prisons … Never a Good Mix.

Tāna wā, me titiro hoki ki ngā raranga I makere, nā te mea, he korero anō ki reira. In time, take a look at those dropped stitches, for there is a message there also.

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[57] Peter Boshier *A Question of Restraint: Care and management of prisoners considered to be at risk of suicide and self-harm: observations and findings from OPCAT inspectors* (1 March 2017); and National Health Committee *Health in Justice: Kia Piki te Ora, Kia Tika!* (Ministry of Health, Wellington, 2010).

[58] Beverley Wakem and David McGee *Investigation of the Department of Corrections in Relation to the Provision, Access and Availability of Prison Health Services* (July 2012) at 100.

[59] Lamusse, above n 54, at 7.

[60] Section 77(3).

[61] Lamusse, above n 54, at 8.

[62] In Part V.

[63] Kate Frame-Reid and Joshua Thurston "State of Mind: Mental Health Services in New Zealand Prisons" (2016) 4(2) Practice: The New Zealand Corrections Journal 38 at 40.

Some may argue that on the premise prisons exist in Aotearoa, they are therefore appropriate for all who live here. However, existence alone does not confer validity. Prisons, as part of the greater criminal justice system, undergird and promote the political ideology and cultural powerbases of the dominant class within any society.[64] Consequently, in Aotearoa, the capitalist ethic based on "individualism and the myth of efficiency"[65] resulted in the rejection of any Māori perspective or knowledge in terms of how societal wrongs could be addressed. This easy dismissal, as Jackson describes it, removed one of the key cohesive forces Māori society rested upon, impacting the "security, values, and self-esteem of the people themselves."[66]

Māori became a minority in Aotearoa in 1870 and until around 1910 were imprisoned at a rate lower than that of Pakeha (other than exceptions like Parihaka). But from there, the per capita rates of Māori incarceration skyrocketed, reaching seven times that of non-Māori in the mid-1900s.[67] From 1945 to 1970, Māori were subjected to what has been described as a "cruel natural experiment",[68] facing systemic discrimination from across the judicial spectrum. Although the rate of imprisonment of young Māori males has been falling year on year since 2007/08,[69] Māori continue to be dealt with, at all stages in the criminal justice process, more harshly than non-Māori.[70] It is a fait accompli that by the time the calculus of prison demographics is done, Māori dominate the numbers. Today, a Māori man is four times more likely to be imprisoned than a non-Māori male.[71]

Mātauranga Māori is about using kawa (practices) and tikanga (principles) to engage with and understand the world around us. It provides an insight into how Māori consider connections as central to their being – their relationship with things both living and not.

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[64] Angela Davis *Are Prisons Obsolete?* (Seven Stories Press, New York, 2003); Loic Wacquant *Punishing the Poor: The Neoliberal Governemnt of Social Insecurity* (Duke University Press, North Carolina, 2009); Michael Foucault *Discipline and Punish: The Birth of the Prison* (Allen Lane, London, 1979).

[65] Moana Jackson "A Maori Criminal Justice System" (1989) Race Gender Class 30 at 33.

[66] At 33.

[67] Len Cook *Examining the over-representation of Māori in prisons: 1910 to 2020* (Institute for Governance and Policy Studies, Working Paper 21/18, December 2021) at 10.

[68] At 36.

[69] At 4.

[70] Khylee Quince and others *Criminal Law in Aotearoa New Zealand* (LexisNexis NZ Ltd, Wellington, 2022) at 46.

[71] Māori Party "Māori Party Justice Criminal Policy" (August 6 2021) <maoriparty.org.nz>.

Māori want to know first "what is its whakapapa?" A Western paradigm contrasts that by isolating the person or thing and asking "what does it do? What is it for?"

Māori never used prisons. There was not even a concept of such … no word for prison even existed. Moana Jackson points out that although prisons are an entrenched part of Western society, they are still comparatively new devices.[72] He notes that since the first prison was built (shortly after Te Tiriti was signed) of flimsy raupō (bulrush), Māori have seen the prison system as both "racist" and "antithetical to everything that is tikanga". Under tikanga, when wrongs were committed, there were processes by which the wrongs were addressed[73] – at the forefront of which was the intent to mend the relationships that had been damaged. There was no need for prisons within such a justice system. Mātauranga Māori offered a generative and effective system that had functioned in Aotearoa for over half a millennium. Government policy has marginalised and actively suppressed mātauranga.[74] The question remains whether Mātauranga Māori can positively influence the prison system. Although outside the scope of this paper, it remains my position that such influence (and reestablishment of mātauranga as a primary knowledge source) cannot be left to Corrections. As was beautifully written, "a skin of tikanga lies over the justice system but the meat of it has been scraped away."[75]

In Part II, this paper will examine the impact and potential of Corrections' flagship tuakana strategy, *Hōkai Rangi*, as it tries to implement the not-radical (and definitely not new) concept that Māori prisoners need to have connection with support networks.

C Is Corrections Really the Best Placed Department to Deal with Mental Illness?

In 2012, the Office of the Ombudsman published a report on Corrections' performance as a primary health care provider. Although not scathing, it did note "the service was not without its problems" and made 20 recommendations – the most challenging one being that prison health

[72] JustSpeak NZ "Moana Jackson: Why did Māori never have prisons" (Speech given at Wellington Girls' College, 17 November 2017) YouTube <youtube.com>.

[73] By a process known as muru.

[74] D Broughton and K McBreen "Mātauranga Māori, tino rangatiratanga and the future of New Zealand science" (2015) 45(2) Journal of the Royal Society of New Zealand 83.

[75] Connie Buchanan "14 years and 33 seconds" (6 November 2022) E-Tangata <e-tangata.co.nz>.

services should be funded and delivered by an agency whose primary concern is health, not custodial management. Two years prior, the National Health Committee made the same recommendation and pressed for greater investment and focus on prisoner health. These reports will be discussed in the *History* section of Part II. It was made clear an investigative feasibility analysis should be undertaken, considering the costs, benefits and wider implications of such a change. The committee was then disbanded and no further action taken.

Corrections made changes by introducing a mental health screening tool and a health services manual. In fact, it addressed to some extent all of the Ombudsman's recommendations other than transferring health services away from its remit. However, prisoner advocates, such as Wellington addictions counsellor Roger Brooking, considered the moves "window dressing".[76] He and others noted health outcomes had not improved since those changes were made, and in term of suicide attempt rates, the situation worsened considerably in the years following.[77]

In 2012, the Wellington Regional Public Health Unit added its voice to the call for the Ministry of Health to take responsibility for prisoner health service provision. A literature review found England, Wales, France, Norway and a number of Australian states had all reported an improvement in measurable outcomes since health service provision was transferred from correctional authorities. The review reported there were significant costs savings to be made and such a transfer would provide "seamless care"; relieve isolation issues for staff; resolve competing agendas between health and custodial staff; and offer accountability in a more meaningful way than was currently available.[78]

Regardless, Corrections intends to retain its control of the primary health care services for prisoners.

Corrections' Director of Offender Health has stated:[79]

> There is no empirical evidence or international example that demonstrates that a change in the service delivery model would significantly improve health outcomes for prisoners. In addition,

[76] Lucy Ratcliffe "Healthcare behind the wire" *New Zealand Doctor* (New Zealand, 6 November 2013) 16.

[77] See the Introduction to this paper.

[78] Ratcliffe, above n 76, at 17.

[79] At 17.

> there are substantial benefits that derive from health services being delivered by the department – all staff share a common goal of contributing to a goal of reducing reoffending by 25 per cent.

In Part V, this paper will question two assumptions made in that quote, and challenge the relevance of the premise of the "common goal".

Corrections is committed, it seems, to the Mental Health and Reintegrative Services[80] (MHRS) model of care. Within that model, only the Improved Mental Health (IMH) service is relevant to serving prisoners with mental illness. In 2016, it secured $14 million in Government funding to improve access to mental health and reintegrative services for prisoners and the general offender population. There were four pilot services to MHRS: the IMH; a "wrap-around family / whānau service; a supported living service; and counsellors and social workers in women's prisons.[81] There was to be a two stage evaluation process. The first review in 2018 (and the only one to date) claimed results were "overwhelmingly positive" as Kessler10[82] reports showed a reduction in psychological distress by IMH participants. However, two qualifications to this assessment exist. Firstly, it is only used for prisoners exhibiting mild to moderate mental illness (anxiety or low level depression) as opposed to personality disorders or PTSD. Although this is nonetheless encouraging as any intervention is better than none, the greater risks lie in untreated mental illness at the moderate to acute levels. Secondly, and more concerningly, is that only 20% of participants were even assessed at all.[83]

D Prison and Why it is Terrible for Mental Health

> At the very least, prison is painful, and incarcerated persons often suffer long-term consequences from having being subjected to pain, deprivation, and extremely atypical patterns and norms of living and interacting with others.[84]

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[80] Gilbert Azuela "Development of Mental Health and Reintegrative Services in the New Zealand Department of Corrections" (2018) 6(1) Practice: The New Zealand Corrections Journal 13.

[81] At 13-14.

[82] A psychological distress questionnaire tool.

[83] Sonia Barnes "Evaluation of the Improved Mental Health service" (2018) 6(1) Practice: The New Zealand Corrections Journal 19 at 22.

[84] Craig Haney *From Prison to Home: The Effect of Incarceration and Reentry on Children, Families, and Communities: The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment* (National Policy Conference paper presented to US Department of Health and Human Services, January 30-31 2002).

Dr Seymour Halleck described the prison environment as "almost diabolically conceived to force the offender to experience the pangs of what many psychiatrists would describe as mental illness."[85] Broadly speaking, there are four overarching reasons prison either exacerbates or causes mental illness:

(i) disconnection from whānau;
(ii) loss of agency;
(iii) loss of hope and purpose; and
(iv) the ever-present but nevertheless erratic danger of prison itself.

The removal of an offender from society is intended to serve multiple purposes. Denunciation, deterrence, accountability, and incapacitation feature in a non-exhaustive list. Commentators may disagree on the effectiveness or utility of these objectives, but one outcome is certain – prisoners find themselves separated from the community. If they have whānau, they are separated from them. If they have wider support networks, regardless of the level of prosocial attributes possessed by the individuals in that network, prisoners are separated from them. The World Health Organisation identified "isolation from previous social contacts" as a reason mental illnesses develop in prison – described as the "deprivation model", in contrast to the importation model (in which offenders arrive in prison with pre-existing illnesses).[86] Māori are particularly susceptible to the scars left from being distanced from whānau and hapū. A telling comment was noted as "heard" by Corrections in its *Hōkai Rangi* document:[87]

> We supported our nephew as much as we could. We had been told there was a safety net. But in reality we were his safety net.

When the safety net of whānau is not a reality in the lives of prisoners, mental health suffers.

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[85] Katie Rose Quandt and Alexi Jones "Research Roundup: Incarceration can cause lasting damage to mental health" (13 May 2021) Prison Policy Initiative <prisonpolicy.org>.

[86] Cherie Armour "Mental Health in Prison: A Trauma Perspective on Importation and Deprivation" (2012) 5(2) International Journal of Ciminology and Sociological Theory 886 at 888-889.

[87] Department of Corrections *Hōkai Rangi: Ara Poutama Aotearoa Strategy 2019-2024* (Department of Corrections, Wellington, 2019) at 12.

A sense of autonomy about one's life is often seen as a philosophical ideal based on the notion one can act voluntarily according to one's best interests or as a reaction to a personally held value.[88] In prison, very little takes place that could be described as voluntary, independent action by prisoners. Doors are opened by remote access, prisoners are moved around the prison in units with strict processes for such, lockdowns are enforced, food is served at set times and uniforms are provided.

Hope has been described as having the capacity to bring to life a person's "moral ambitions to do better and be better".[89] Definitionally, it could be described as a desire combined with an expectation such desire will be satisfied.[90] Brownlee's paper on hope is a worthwhile and effective analysis of the term, and argues that in order for a system to be morally justifiable, the forms of punishment used must allow a reasonable person to retain hope throughout. She points out self-harm in prison is not only an identifier for mental illness but is also often a plea for help and hope.[91] Like autonomy, hope is inherently valuable and vital in order to experience a meaningful human condition.

Prisons are not a homogenous collection of buildings staffed by the same people, run in the same way, with identical rules and expectations. A maximum-security prison operates in a different way than a minimum security "camp" prison site. Granted, they both house prisoners (many of whom have committed the same crimes) but the privileges and opportunities available to those prisoners differ drastically. The contexts of each prison experience are important in understanding the results of surveys or statistics within, in particular, the social sciences. Nevertheless, even minimum security prisons are inherently unsafe.[92] Forensic psychologist, Dr Barbara Kirwin, noted the stress hormone, cortisol, is elevated 20 to 30% above a normal

[88] James Moore "What Is the Sense of Agency and Why Does it Matter?" (2016) 29(7) Frontiers in Psychology 1272.

[89] Julie Laursen "Radical hope and process of becoming: Examining short-term prisoners' imagined futures in England & Wales and Norway" (2022) Theoretical Criminology 1.

[90] Kimberley Brownlee "Punishment and Precious Emotions: A Hope Standard for Punishment" (2021) 41(3) Oxford Journal of Legal Studies 589 at 591.

[91] At 590.

[92] Jeremy Travis, Bruce Western and Steve Redburn (eds) *The Growth of Incarceration in the United States* (National Academies Press, Washington DC, 2014) at 161.

base rate simply because the individual is in a prison environment[93] – without a noticeable threat being present. The effect on someone's mental health of continually having to monitor one's surroundings for signs of danger (not to mention actually witnessing or being involved in violence) is only negative.[94]

In conclusion, with the contribution untreated mental health has to offending and the damage prison does to those already suffering from mental illness (not to mention prison *causing* such illness), there is a need for clear, consistent legislation and soft policy that does more than offer token solutions. The overwhelming numbers of those with poor mental health in prison demands attention.

The next part of this paper investigates the legislative system health care in prison operates within, both in term of domestic and international human rights law, and asks whether it is indeed "clear and consistent". It then considers the history and current position of soft policy within the correctional environment.

Part II Legal Obligations to Provide Mental Health Care

A Corrections Act 2004

Coming into force on 1 June 2005, the Corrections Act 2004 and its accompanying Corrections Regulations 2005 completed the reforms of the criminal justice sector that began with the Sentencing Act, Parole Act and Victims' Rights Act.[95] The Act was intended to provide a "modern framework for the management of Corrections and a clear set of principles to guide and inform"[96] decisions, and to replace the five decade old Penal Institutions Act 1954. With an emphasis on fair treatment of prisoners, it imposed upon Corrections an obligation to create an individualised sentence management plan for each offender,[97] designed to provide them a pathway towards eventual reintegration back into the community.

[93] Dena Ross Higgins "This is your Brain in Jail" A&E TV "60 Days In" <aetv.com>.

[94] Quandt, above n 85.

[95] Sentencing Act 2002, Parole Act 2002 and Victims' Rights Act 2002.

[96] Department of Corrections *Annual Report 2004 -2005* at 7.

[97] Section 51 of the Act.

Section 5(1) of the Act defines the purpose of the corrections system as being to "improve public safety and contribute to the maintenance of a just society" by ensuring:

(a) all sentences are administered in a "safe, secure, human, and effective manner"; and
(b) ensuring correctional facilities are operated in accordance with rules established under the Act and its regulations, which are "based … on the United Nations Standard Minimum Rules for the Treatment of Prisoners"; and
(c) assisting in the rehabilitation and reintegration of offenders and "so far as is reasonable and practicable in the circumstances and within the resources available" provide interventions to achieve this; and
(d) provide information to the courts and New Zealand Parole Board.

Section 6 of the Act codifies the principles by which the corrections system is to be guided, requiring anyone exercising any relevant power or duty to take into account such principles so far as practicable in the circumstances. The paramount consideration in all decisions relating to the management of prisoners is "the maintenance of public safety",[98] relegating the "fair treatment" of prisoners and decisions being made in a "fair and reasonable way"[99] to a secondary consideration.

Upon reception at a prison, Corrections are required to identify any mental health needs (via an "at-risk" assessment of potential for self-harm) and address any immediate concerns.[100] Two sections of the Act then play intertwined roles in how Corrections appear to manage prisoners with identified mental health needs: ss 52 and 75.

1 Section 52: The discretion

Rehabilitative programmes are provided to prisoners who, "in the opinion of the chief executive, (of Corrections) will benefit from those programmes". This is nearly entirely

[98] Section 6(1)(a).

[99] Section 6(1)(f).

[100] Section 49. I further consider and critique the screening process in Part IV of this paper.

discretionary[101] and includes any medical or psychological programme.[102] *Smith* defines the conditional nature of any discretion, however. In that case, Doogue J confined the s 52 discretion as being subject to the resources available and the "competing pressures" on those resources by the needs of other prisoners (as well as the particular circumstances of the prisoner in question).[103]

It is telling Doogue J recognised that Corrections' duty to provide rehabilitative programmes, even within the parameters of a wide discretion, may be influenced by principles found in art 9(1) of the International Covenant on Civil and Political Rights (the ICCPR).[104] Qualifying that somewhat, it was noted Parliament had explicitly chosen ss 5, 6 and 52 of the Act to give voice to the ICCPR and any other international law instruments. Doogue J was clear no absolute right to rehabilitative treatment existed.[105]

It is accepted there is a reasonable limit to the idea prisoners are entitled by right to receive rehabilitative programmes. It is a resourcing argument well made that prisoners who, at the time they are eventually released, pose the greatest risk to the community should receive priority in terms of access to such programmes. The problem is when Corrections conflate psychological *treatment* with a rehabilitative programme that includes elements of psychological intervention. The latter is, I argue, a s 52 discretion that, provided the decision making process was reasonable, should rightly be allocated to prisoners based on need. However, psychological treatment is medical treatment no different to getting an X-ray for a broken arm. There is no room for discretion.

2 Section 75: The right

[101] *Ericson v Chief Executive, Department of Corrections* [2015] NZHC 1157; *Genge v Chief Executive, Department of Corrections* [2018] NZHC 1447; and *Smith v Attorney-General* [2020] NZHC 1848.

[102] Section 3.

[103] *Smith*, above n 101, at [122].

[104] At [123]. Article 9(1) of the ICCPR states that "no one shall be subjected to arbitrary arrest or detention". The cases of *Smith*, *Ericson* and *Genge*, above n 101, all involved prisoners claiming they were being arbitrarily detained as the inaccessibility of rehabilitative programmes meant they were being declined parole.

[105] *Smith*, at [123].

Every prisoner is entitled to receive reasonably necessary medical treatment and for the standard of that health care to be "reasonably equivalent" to the standard of health care available within the community. Mental health treatment is included in "medical treatment".[106] Corrections consistently points out it is funded only to provide primary health services, with secondary and more acute needs being the duty of the Ministry of Health and asserts it meets its statutory obligations in this regard.[107] It is a rare occasion Corrections concedes its approach has not achieved outcomes it would hope for.[108]

Section 75 raises the question of "what is a reasonably equivalent standard of health care?" This is considered further in Part III. This must be a fluid answer – dependent on both the time of the query and the place where it was asked. Whether the postcode lottery[109] (the concept that access to health care is different depending on where in the country you live) would shift how courts approach the question has not been raised. In fact, there is a dearth of case law relating to s 75 breaches. It may be suggested this is because Corrections does, in fact, meet its obligations. It is more likely the answer lies in considering the question "if Corrections is failing its prisoners and their mental health needs, who is going to complain?"

McKenna wrote in 2021 that the 1988 Mason Report[110] moved the responsibility for mental health treatment provision towards a health response rather than a correctional one, with that shift placing an emphasis on equivalency of care – a standard he says has "yet to be fully realised."[111]

B Te Tiriti o Waitangi

As previously described, Māori are disproportionately incarcerated compared to non-Māori. This fact, along with further barriers to healthcare and the isolation from whānau Māori in

[106] *R v Hemopo* [2014] NZHC 2950 at [68].

[107] Department of Corrections and Ministry of Health *Management of Prisoners Requiring Secondary Mental Health Services and Hospital Level Care* (Memorandum of Understanding, 2017).

[108] Corrections, above n 6, at 4.

[109] Liz Craig "Fixing the postcode lottery in health" *Southland Times* (online ed, 5 May 2021).

[110] See Part II section on *History*.

[111] McKenna, above n 10.

prison experience, has been described as a "blatant breach"[112] of Te Tiriti. The Principle of Equality guaranteed in Article Toru of Te Tiriti provides Māori and all citizens of Aotearoa the assurance they possess legal equality and will receive equal access to social rights – which includes healthcare. Te Tiriti also imposes a duty on the Crown to act reasonably and in good faith.

Article Rua of Te Tiriti guarantees Māori tino rangatiratanga (sovereignty and self-determination). Regardless of the high bar of such an ideal, it is indisputable Māori do not have even a substantial say in how, and by whom, mental health services are provided to Māori prisoners, let alone sovereignty in the decision. Mātauranga Māori, as discussed earlier, is a glaring absence from Corrections' system of screening, diagnosing and treating mental illness. Despite significant changes in Māori community healthcare in 2022[113], the prison system did not experience the same transformation as Corrections continued to be the provider of such care rather than the Māori Health Authority.

Hauora Māori is built on four cornerstones – whānau (family health); tinana (physical health); wairua (spiritual wellbeing); and hinengaro (mental health). I would argue the lack of appreciation of, in particular, taha wairua, has meant Māori health statistics lag Pakeha. In 1999 Mason Durie suggested[114] five interrelated strategies would improve Māori mental health: the securing of an *identity* through greater access to whenua, reo, whānau; active *participation* in society and the economy; *alignment* of mental health services with primary health care systems; accelerated *workforce* development; and increased *autonomy* and control. All of these are encompassed in Te Tiriti guarantees – particularly tino rangatiratanga. Twenty years later the Waitangi Tribunal recommended the following principles to guide the wider health and disability system:[115]

- *Tino rangatiratanga*.

[112] Monasterio, above n 8, at 10.

[113] Peeni Henare "A heath system that takes care of Māori" (press release, 19 May 2022) <beehive.govt.nz>.

[114] Mason Durie "Mental Health and Māori Development" (1999) 33(1) Australian & New Zealand Journal of Psychiatry 5.

[115] Waitangi Tribunal *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wai 2575, 2019) 163–164.

- *Equity* – this requires the Crown to commit to "achieving equitable health outcomes for Māori". Note the difference between this standard and the "reasonable equivalence" of s 75 of the Act.
- *Active protection* – this requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring both the Crown and its agents are well informed as to the nature, extent and responsibilities related to the provision and outcomes of Māori health and its targeted equity with the general community.
- *Options* – this requires the Crown to resource kaupapa Māori health services, that are to be delivered in a way that honours and supports hauora Māori models of care.
- *Partnership* – Māori must be co-designers with the Crown in the governance, delivery and monitoring of health services.

It will be an interesting topic of research over the next decade to consider the extent of the effectiveness *Hōkai Rangi* has on recognition (beyond "mentions" in strategy documents) of Te Tiriti guarantees regarding Māori mental health within prisons.

C Domestic Legislation

Prisoners in Aotearoa have their rights protected by a variety of domestic standards. The Human Rights Act 1993 (protects people from unlawful discrimination), Crimes of Torture Act 1989 (prohibits torture), the Corrections Act 2004 and the Corrections Regulations 2005 all play a part in setting the parameters Corrections must operate within in order to ensure those in its care are treated with humanity and dignity. In addition, the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 establishes the rights consumers have when accessing health and disability services. If prisoners (or anyone associated with the prisoner) has a concern about their healthcare, they can make a complaint to the Health and Disability Commissioner under that Act.

The New Zealand Bill of Rights Act 1990 (BORA) requires the Government to protect the rights of prisoners, including the right to not be subjected to cruel treatment,[116] and the right to

[116] Section 9.

be treated with humanity and dignity.[117] Despite this, Ombudsmen visits consistently uncover human rights breaches in contravention of BORA.[118] As mentioned in Part I, the use of ISUs are regularly criticised for failing to meet standards expected under BORA – including being described as meeting the threshold of "torture" in s 9.

D International Instruments

In 2015,[119] a unanimous vote of the United Nations General Assembly saw adopted a revised version of the Standard Minimum Rules. The revision included a prohibition on torture and was branded the "Nelson Mandela Rules". Made up of 122 Rules, states often regard it as the primary (if not only) source of standards in terms of how prisoners are to be treated while incarcerated. They include both remand and convicted prisoners and are supplemented by the United Nations' Bangkok Rules, a series of 70 Rules specifically designed for women offenders and prisoners.[120] The Universal Declaration of Human Rights of 1948, although not specifically citing prisoners, laid out various rights that nonetheless included those behind bars. The right not to be tortured and the right to a fair trial implicitly covered those incarcerated and only seven years later, the General Assembly adopted the Standard Minimum Rules. This was a good start, especially considering the relatively new initiative of the United Nations itself.

The Mandela Rules emphasises the provision of effective health care for prisoners,[121] demanding that as a State obligation, the standards (both professional and ethical) of care must not be different to that offered to all people. The Rules do not purport, or even seek, to bind member states to blindly adhere to every rule in all circumstances; rather they "set out what is generally accepted as being good principles and practice in the treatment of prisons and prison management."[122] The Act makes specific mention of the Rules in that corrections facilities are to be "operated in accordance with rules set out in this Act … that are based on, amongst other

[117] Section 23(5).

[118] Monasterio, above n 8.

[119] The Standard Minimum Rules for the Treatment of Prisoners was initially adopted in 1955 and approved by resolution in 1957.

[120] *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders with their Commentary* GA Res 65/229, (16 March 2011).

[121] Rules 5, 24, 25, 26, 27, 30, 31, 32, 33, and 34.

[122] Nelson Mandela Rules, Preliminary Observation 1.

matters, the United Nations Standard Minimum Rules for the Treatment of Prisons".[123] There is no statutory demand to adhere to such Rules however, and although consistency is a worthy goal, there does not appear to be any right of redress should a breach of the Rules occur.

E The Path to Hōkai Rangi

1 History

2018 saw the Mental Health and Addictions Inquiry[124] report provided to the Labour Government, recommending improving communications between health and justice departments, increasing accountability across leadership positions, and advising on the role of the Mental Health Commission. It was the latest in a long series of inquiries. Some were triggered by public fear as psychiatric hospitals were closed and thousands of people with mental health problems suddenly became a community problem rather than being confined in asylums. Others happened in response to police killing men with mental illnesses and alarm about youth suicides.

Prior to 1972, large mental hospitals offered long-term care and sometimes lifetime "incarceration" for those suffering mental illness. Durie noted these facilities, while attractive to idealise, had significant failings – including abuse of patients in their care.[125] Those who experienced life in such "hospitals" would not wish for a return to such a system. Throughout the 1970s, change began with the wholesale discharge of patients and the establishment of community care programmes through the general hospitals. Far from solving the problem of how to integrate people with mental illnesses, such programmes simply offered an "illusion of integration"[126] while retaining the typical barriers of stigmatisation and discrimination. Between 1983 and 1987 in Aotearoa there were a series of homicides committed by people with serious mental illnesses, all of which attracted widespread public attention. The general community response was one of deep concern that patients released from psychiatric hospitals were not being adequately monitored. It has since been shown deinstitutionalisation did not

[123] Section 5(1)(b).

[124] *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (November 2018).

[125] Durie, above n 114.

[126] At 8.

cause an increase in homicides.[127] Nevertheless, what was to be known as the Mason Report[128] was the outcome of those few profiled incidents.

The 1988 Mason Report was particularly scathing of the Auckland Health Board and commented extensively on previous inquiries. One of these was the 1983 Gallen inquiry[129] which recommended the merging of Oakley and Carrington Hospital (both of which were on the site of the current Mason Clinic in Mt Albert, Auckland) and the establishment of a secure unit for prisoners suffering from mental illness. The inquiry "vehemently opposed" plans to construct a prison hospital for psychiatric patients, whilst at the same time Oakley Hospital moved to rapidly discharge its patients back to prison and further tighten its admission criteria.[130] "We do not believe that a hospital is compatible with a prison as such and we do not support any proposal to construct a hospital which is effectively a prison with hospital overtones," the Gallen inquiry said.[131] Further, " … prisoners requiring psychiatric treatment should receive it in a psychiatric hospital … and not be subject to or incorporated in the prison system." The 1988 Mason Report asserted it was their "firm belief" that had the recommendations made in the Gallen inquiry been adopted "there would be no need for our inquiry".[132] Corrections are now constructing within Waikeria Prison a unit that is "effectively a prison with hospital overtones".[133]

Between 1983 and 1987, 13 prisoners committed suicide whilst incarcerated at Paremoremo Prison. Senior Auckland Health Board staff believed prisoners with serious mental illnesses

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[127] Alexander Simpson and others "Homicide and mental illness in New Zealand, 1970-2000" (2004) 185 British Journal of Psychiatry 394.

[128] Ministry of Health *The Mason Report" Report of the Committee of Inquiry into Procedures Used in Certain Psychaiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients* (August 1988). Judge Mason also authored a report in 1996 so I will refer to the original report as the "1988 Mason Report".

[129] Ministry of Health *Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters* (January 1983). Known as the "Gallen Inquiry".

[130] Keren Skegg and Brian Cox "Impact of psychiatric services on prison suicide" (1991) 338 The Lancet 1436 at 1437; Jess McAllen "History repeating – New Zealand's mental health inquiries" (27 October 2018) RNZ <rnz.co.nz>.

[131] McAllen.

[132] McAllen, quoting the 1988 Mason Report.

[133] McAllen, quoting the Gallen Report.

should be treated in prison … the Mason Report rejected this. It stated that the "simple fact of the matter [was] that prisoners with psychiatric disorders, who needed to be in hospital, were denied admission."[134] It also recommended improving cultural services would better serve Māori. Regional forensic mental health units were established – Auckland's Mason Clinic being one of them – across the country. The 1988 report has been described as one that "heralded a new era, and the potential for a more empathetic approach in treating offenders with mental illness."[135] In 2016, a prisoner who had been denied admission to the Mason Clinic was restrained on a tie-down bed for 37 consecutive nights (sixteen hours per day) and at least once a spit-hood mask was forced onto him. He spent a total of 592 hours[136] secured by his wrists, torso, and ankles which itself was in contravention of Schedule 5 of the Corrections Regulations.[137] It appears "empathy" had a long path to walk.

The National-led Government of 1995 commissioned the Ministry of Health to again investigate mental health services; the report was presented in May 1996.

Of personality disorders, it quoted John Gunn of the London based Institute of Psychiatry in noting:[138]

> Patients with severe personality disorders should have just as much access to in-patient services as patients with other diseases. Such access should include access to compulsory care as well as to voluntary care. British Mental Health law allows, indeed encourages, such an approach. Prison care for personality disordered patients has an important role to play in their management, but prison management should not be the mainstay of treatment for personality disorders any more than it is for any other disease … . Furthermore, prisons are NOT established primarily as therapeutic institutions; that is a role for hospitals.

Professor Gunn wrote that people with personality disorders can pose a threat to others but a "powerful reason for preferring hospital to imprisonment" is that while the threat is "almost

[134] Mason Report, above n 128, at 79.

[135] McAllen, above n 130.

[136] Boshier, above n 57.

[137] At 25.

[138] Ministry of Health, above n 12, at 150.

never reduced by imprisonment; it may be increased.[139] The report authors recommended adopting the approach of Professor Gunn,[140] pointing to successes in prison environs like Grendon Prison in the United Kingdom.

It is also telling that the authors deemed it necessary to comment on the sensationalism surrounding mental health, perpetrated by both the media , politicians and "self-interested lobby groups".[141] The willingness to "sell papers"[142] by stigmatising people with mental illness,[143] especially when matched with behaviour society deems unacceptable, can not only provide a barrier to seeking treatment, but becomes a public safety issue as relapses increase due to an individual's loss of hope and alienation.[144]

Corrections and the Ministry of Health released the findings of a comprehensive survey on mental illness in prisons in 1999.[145] This report was, largely, a reaction to a disturbing lack of information. Since the Mason Report, Regional Forensic Psychiatric Services had been providing prisons with tertiary level intervention and, when necessary, transferral of mentally ill prisoners to medium secure hospital facilities. Although undoubtedly a positive step, no data existed as to how to make best use of those resources. It was also clear no real understanding (outside anecdotal impressions from lawyers) existed that could explain whether the closure of most large psychiatric hospitals had, in fact, changed the demographic of the prisons. There had been an apparent increase in the rates of suicide and self-harm, but no quantifiable explanation for this. And finally, the actual "size and nature of the incidence of mental disorder amongst inmates" had not been investigated.[146]

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[139] At 154.

[140] At 155 and 156.

[141] At 161 – 163.

[142] At 161.

[143] Kimberlie Dean and others *The Justice System and Mental Health: A review of the literature* (Australian Government National Mental Health Commission, August 2013) at 9.

[144] Ministry of Health, above n 12, at 163.

[145] Simpson and others *The National Study of Psychiatric Morbidity in New Zealand Prisons: An Investigation of the Prevalence of Psychiatric Disorders among New Zealand Inmates* (Department of Corrections, Wellington, 1999).

[146] At 3.

The 1999 survey showed the rates of several conditions were considered "significantly elevated" when matched against the general community: major depressive disorder, bipolar disorder (especially mania), schizophrenia, substance abuse, PTSD, obsessive-compulsive disorder and personality disorders.[147] Further, 20.5% of the prisoners had frequent suicidal thoughts.[148] It was resolved such rates meant there was a strong argument for increased service provision for prisoners, both "to treat the treatable mental disorders these inmates suffer *and* to contribute to reducing the risk of re-offending".[149]

Major depression was identified in approximately 10% of prisoners – some 500 people at the time – which required either inpatient care or ongoing therapy by psychological or medical intervention (or both). Nearly 200 prisoners were identified as needing "probable hospital admission"[150] which, when considering the inpatient bed capacity was already overrun,[151] was somewhat problematic. Providing such a level of service was described as "quite beyond the capacity of current forensic psychiatric services, Department of Corrections Psychological Service or prison nursing and medical officers."[152]

In 2001, an academic study into the prevalence of mental illness in Aotearoa prisons was published,[153] reiterating the need for urgent action through increased beds being made available within secure psychiatric hospitals, increasing resources to forensic psychiatric services to provide secondary care, a complete review of service provision, and the development of a mental health screening tool for use with existing prisoners and new receptions.[154]

(i) 2010 National Health Committee

[147] At 1.

[148] At 2.

[149] At 2. Emphasis added.

[150] At 58, for schizophrenia and related disorders.

[151] Brinded, above n 23, at 172.

[152] Simpson, above n 145, at 59.

[153] Brinded, above n 23.

[154] At 172.

The *Health in Justice*[155] report opens with a Bible verse from Hebrews 13:3: *Remember those who are in prison, as though you were in prison with them.* A series of hui over several years were held around the country with experts, community advocates and stakeholders to examine the state of mental health care within prisons and provide advice. Upon publication of the report in 2010, the National Health Committee (NHC) identified three steps to improve prisoner health:[156]

(i) provide significant additional investment in services; and
(ii) make improvements to protect against the negative effects of incarceration; and
(iii) most importantly, to consider the "strong case for transferring responsibility for prison primary health care from the Department of Corrections to the health sector."

It was noted both primary and secondary mental health care are the responsibility of the state health agencies in England and Wales, France, Norway and in five states of Australia. Where this shift in care has occurred, "outcomes have improved demonstrably,"[157] with one of the primary reasons for this being that health care is not the core driver of Corrections.[158] The NHC made a formal recommendation that the Minister of Health direct officials to undertake a complete feasibility study for such a shift to be made in Aotearoa.[159] As mentioned earlier in this paper, Corrections maintained its position it was best placed to provide primary care.

The NHC advocated for the development and maintenance of a therapeutic approach to prisoner health rather than a primarily custodial one, highlighting the unmet need across the spectrum in mental health and addiction services. It quoted the annual cost of incarceration (at the time, $91,000 per prisoner) as being an expense Aotearoa "cannot afford".[160]

[155] National Health Committee, above n 57.

[156] At viii.

[157] At 8.

[158] At 41. The "core driver" is either defined within the relevant legislation or exhibited as a result of Corrections' normative culture.

[159] At 9.

[160] At 47.

There was recognition of the risk that should the Ministry of Health assume control of all prisoner health needs, such needs may be subsumed within other competing priorities of the health sector. The NHC recommended policy to address such risk is developed by a specialist team that sat within the Ministry of Health.[161] This will be commented on further in Part V.

(ii) 2012 Ombudsmen Report

The Ombudsmen reported there were deficiencies in the care of mentally unwell prisoners. It was highlighted there needed to be a distinction between "treatment" which, "suggests intervention that may lead to improvement", and the concept of "care" which amounts to simple physical containment.[162] The prison reliance on care via physical containment was described as "sad". It was pointed out, although Corrections was responsible for primary mental health care, some prison healthcare teams had no mental health nurses, let alone any who specialised in mental health.[163] It is understandable in terms of the expectation placed on these staff to perform generalised roles but, as the Ombudsmen note, services are therefore "insufficiently responsive to the diverse needs of prisoners with mental health problems."[164]

The report briefed the responsibilities of the Ministry of Health, in terms of funding and directing the Forensic Mental Health Services and the transfer of prisoners into hospital facilities (under ss 45 and 46 of the Mental Health (Compulsory Assessment and Treatment) Act 1992).[165] Ideally, in-prison forensic teams assist with those with severe and long-term problems (as in the community). In practice, however, those teams' resources are diluted as they become the sole contact for prisoners with lower-level issues rather than the specialist teams they were designed to be. The failure by Corrections to adequately resource the primary need and a "lack of clarity about the role of secondary mental healthcare in prisons"[166] were identified as concerns. For their efforts in attending to the needs of prisoners with personality disorders the custodial staff were rightly praised … but they did so under sub-optimal conditions and faced "almost insuperable difficulties". Custodial staff were not trained and

[161] At 109.

[162] Wakem, above n 58, at 93.

[163] At 94.

[164] At 94.

[165] At 94.

[166] At 95.

with Health Services staff not being mental health specialists, management of such prisoners was ad hoc at best.[167]

Lastly, the report noted the primary function of Corrections' Psychological Services was to provide risk assessments to the New Zealand Parole Board and courts – not to offer treatment services for prisoners struggling with mental health concerns. The "bottom line" was prisoners suffering from mental illness should be treated not in a custodial environment, but a therapeutic one.[168] By this point, a generation had passed since Judge Mason wrote the same thing.

In 2016, Corrections published the results of a survey[169] that formed the basis for how it approached mental health services in the years ahead.[170] Kate Frame-Reid, a policy adviser for Corrections, stated it intends to "focus on providing increased services" to prisoners with mental illnesses.[171] She noted that an appropriate level of care is both a practical and an ethical consideration, and Corrections' "new" mental health services would result in better overall wellbeing.

One of the stressors on the mental health system highlighted by the 2018 Government inquiry, *He Ara Oranga*,[172] was the "lack of forensic services to meet the needs of a growing number of prisoners with serious mental illness."[173] It is clear many of the issues that plagued the prison system in the 1980s still lingered 40 years later – from seemingly insignificant matters that indicate a general systemic malaise[174] to more serious issues.[175]

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[167] At 101.

[168] At 102.

[169] Indig, above n 9.

[170] Frame-Reid, above n 63.

[171] At 38.

[172] *He Ara Oranga*, above n 124.

[173] At 69.

[174] Peter Boshier *OPCAT Report: Report on an Unannounced Inspection of Spring Hill Corrections Facility Under the Crimes of Torture Act 1989* (August 2017) at 33, in which it was noted consultations with a forensic nurse took place in the main visits room.

[175] Peter Boshier *Final Report on an unannounced inspection of Auckland Prison under the Crimes of Torture Act 1989* (December 2020) at 42, in which it was noted prisoners were handcuffed during consultations even whilst in non-contact rooms.

Simply adding substantial government funding or making minor adjustments near the periphery of the issue will not be enough to achieve lasting and significant change. It would require an entirely new way of viewing the purpose of prison and the interventions required to create and sustain pro-social pathways in the lives of the prisoners while incarcerated and post-release. Corrections believed it found the right tool in *Hōkai Rangi*.

(iii) Hōkai Rangi

In 2019, Corrections launched a five-year strategy designed to support the Government goals of safely reducing the prison population with a particular focus on addressing the overrepresentation of Māori in prison. The name *Hōkai Rangi* was gifted to Corrections by Te Poari Hautū Rautoki Māori[176] – words taken from the karakia "Kete o Te Wānanga", describing Tāne's ascent to the heavens to retrieve the three kete (baskets) of knowledge. The Minister of Corrections, the Hon Kelvin Davis, wrote of *Hōkai Rangi* in his foreword to the strategy document:[177]

> it is so overdue and so necessary. …[It] carries the voices of our people [and] the system is not working for our tāne, our wāhine, our rangatahi, or our whānau. It needs to change, and it needs to change now. The current state is a social and economic cost that we as a country cannot afford.

In recognising and acknowledging Māori are disproportionately over-represented across the criminal justice spectrum, Corrections adopted the *Hōkai Rangi* strategy in an attempt to lower that statistic. As the "final point" of the justice system,[178] Corrections committed to "focus on prioritising the wellbeing of both the people who come into [it's] care … and of their whānau" and produce "great outcomes"[179] for Māori. It will measure the success through an improvement in wellbeing outcomes and a consequential reduction in recidivism.[180]

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[176] The Māori Leadership Board of Corrections.

[177] Corrections, above n 87, at 1.

[178] At 4.

[179] Rachel Leota *Corrections response to Dr Sharon Shalev's report* (Department of Corrections, 4 November 2021). Rachel Leota is Corrections National Commissioner.

[180] At 4.

Designing and implementing culturally appropriate (and effective) interventions is both complex and challenging. The impact of colonisation cannot be understated and, without traversing the troubling history, such acculturation and disenfranchisement have been identified as precursors to Māori criminalisation, imprisonment and poor mental health[181] – a term Mason Durie refers to as "trapped lifestyles". Overarching this, the loss of mana through such cultural trauma is a deeper scar Māori wear as they find themselves being dealt with by a Pākehā criminal justice system.

Māori were identified in Devon Indig's 2016 survey[182] as having higher rates of psychotic symptoms than other communities.[183] Additionally, Māori are more likely to experience comorbidities and more serious disorders than other groups.[184] Compounding these issues is the observation Māori present late to forensic mental health services and often are not diagnosed with any mental illness until well after conviction and sentencing. Other barriers for Māori accessing mental health care exist. Rangihuna's research showed Māori with a psychotic illness do not, in general, receive optimal treatment.[185]

Mental illness may be considered an ethnocentric social construct[186] predicated on a Western worldview which could, despite the best efforts of screening tools, miss (or at least misdiagnose) an illness. As an example, matakite (psychic visions or prophesy) is evidence of Māori faith in omens and such divination played (and still does play) an important part in Te Ao Māori.[187] Viewed through a Pākehā lens, this may be identified as a symptom of psychosis, rather than an honour bestowed by atua (gods). Despite an attempt to raise the number of Māori trained in psychology and psychiatry, most practitioners are Pākehā which, anecdotally at least,

[181] Durie, above n 26.

[182] Indig, above n 9, and commented on in Part I above.

[183] Although it should be noted that the study, rather than using a clinical diagnosis, used the symptoms of "hearing voices and seeing visions" as evidence of psychosis. However, cultural factors may well suggest Māori hear voices or see visions that have no connection to a psychotic episode.

[184] Oakley Browne, above n 31.

[185] D Rangihuna, M Kopua, and D Tipene-Leach "Mahi a Atua: Pathway forward for Māori mental Health?" (2018) 131(1471) New Zealand Medical Journal 79 at 79.

[186] M T Walker "The social construction of mental illness and its implications for the recovery model" (2006) (10)1 International Journal of Psychosocial Rehabilitation 71.

[187] Elsdon Best *Māori Religion and Mythology: Part 1* (A.R Shearer, Wellington, 1976) at 280.

is considered a source of mistrust by incarcerated Māori.[188] An appreciation of different cultural identities is therefore vital for any mental health professional working within prisons – not only in diagnosis and treatment, but in development of screening tools, programme implementation, and policy advice. In addition to understanding the seeming overlap between genuine spiritual experiences and mental illness, access to a cultural advisor throughout the treatment process should also be prioritised.

Cavney points out the simple practice of establishing whānaungatanga:[189]

> …will often break down barriers and instil a degree of trust and engagement which may be beyond the ability of a non-Māori mental health worker. Cultural advisers also help in understanding the patient's mental health condition … [reducing] the chance of misdiagnosis or missing a diagnosis.

The *Hōkai Rangi* strategy document identifies that in 2015, 93% of Māori in prison had been diagnosed with a mental illness at some point in their lifetime, while some 80% had contact with mental health services within the previous decade.[190] This is not to suggest prison-based health providers were responsible for that level of contact, but rather the vast majority of people entering the prison system have previous connection with mental health services within the community.[191] Reflecting this, Corrections has committed to "co-design a kaupapa Māori health service, including resourcing the services of rongoā Māori practitioners" as one of its "do now" strategies.[192] Rongoā Māori is the traditional healing system of Māori, utilising herbal remedies, physical therapies and spiritual healing, passed down through oral tradition to a select few as knowledge of such matters was considered tapu (sacred).

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[188] Cavney, above n 14, at 223.

[189] Cavney, above n 14, at 226. Whānaungatanga is the foundation for tikanga, the connection that people have with others cited in Hirini Moko Mead *Tikanga Māori: Living by Māori Values* (Huia Publishers, Wellington, 2003) at 45.

[190] Corrections, above n 87, at 10.

[191] Cavney and others "Patterns of mental health service contact before and after forensic mental health contract in New Zealand" (2012) 20(3) Australasian Psychiatry 225.

[192] Corrections, above n 87, at 21.

Incorporating a Te Ao Māori worldview into a prison setting, long the domain of Victorian era punishment systems and latterly a United States-styled human warehouse,[193] is, arguably, a bold but long overdue acknowledgment that persisting with a non-Māori solution to a problem facing Māori is pure folly. Rightly put, Corrections do cede access to culture "is a fundamental right, not a privilege,[194] regardless of … therapeutic needs."[195] The existence of prisons at all, from a Te Ao Māori paradigm is outside the scope of this paper – although my personal position is alternatives to prison should be sought.

An early example of the disconnect between *Hōkai Rangi* concepts and the realities of Corrections' practice occurred when 47 wāhine incarcerated at Wellington's Arohata Prison were informed they were to be transferred to either Christchurch or Auckland due to shortages of 10-15 staff at Wellington's male prison, Rimutaka. Due to Covid-19 lockdowns, the wāhine had not seen their children for over two years and such a transfer would only extend that time. The wāhine imprisoned at Arohata are predominantly Māori. Lawyers contacted Corrections requesting a pause on the transfer and to commence discussions about other options. Less than a week later, Corrections notified the prisoners they would still be sent hundreds of kilometres from their home.[196] A High Court injunction was sought but was declined. A substantive case hearing was ordered, but the wāhine were still transferred. Nearly a year later, in August 2023, Cooke J ruled that Corrections had unlawfully transferred the wāhine – such unlawfulness arising from the "unjustified discrimination" of the prisoners in contravention of s 19 of the New Zealand Bill of Rights Act 1990.[197]

Corrections stated the "priority was the welfare and wellbeing of the women" but "at the same time [it] needed to respond to staff shortages."[198] It is not a failure of logic to suggest therefore that the "welfare and wellbeing" of the prisoners is clearly not the priority. *Hōkai Rangi* was labelled the "tuakana strategy"[199] for Corrections, from which "all other departmental strategies

[193] John Irwin *The Warehouse Prison* (Roxbury Publishing, Los Angeles, 2005).

[194] One of the comments given to Corrections in its "discussions" was that access to culture was treated as a privilege to be earned by prisoners, rather than a human right. See *Hōkai Rangi*, above n 87, at 12.

[195] Corrections, above n 87, at 24.

[196] Erin Gourley "Legal case over moving inmates" *Dominion Post* (Wellington, 17 September 2022) at 3.

[197] *Wallace v Chief Executive of the Department of Corrections* [2023] NZHC 2248.

[198] Gourley, above n 196, at 3.

[199] Tuakana is the "elder brother".

will flow from and align" with.[200] In that case, however, *Hōkai Rangi* was relegated below operational objectives.

A further example of the prioritisation of operational management over *Hōkai Rangi* purposes was the handling of the wider reintroduction of in-person visits after the Covid-19 pandemic. Throughout the pandemic period, prisoners were unable to have visits with their whānau, with some noting such restrictions had tragic outcomes on mental health.[201] During the pandemic Corrections had allowed its staffing levels to drop considerably (with a number leaving as vaccination mandates were enforced).

In April 2022,[202] all of Aotearoa entered the "orange phase" of restriction, which meant schools and workplaces were open, there were no capacity limits on events, and life was nearly back to normal. Except for prisons. Six months later, Corrections was still "scrambling"[203] to replace 500 staff. Although it was well pointed out that during previous prison officer strike situations, the armed forces were used to ensure visits were continued, [204] Corrections remained firm in its decision to continue to deny prisoners their visits – something the Act[205] states is one of their few rights. The Chief Human Rights Commissioner, Paul Hunt, has warned Corrections of its obligations and described the denial of visits as a "human rights issue".[206] Nigel Hampton KC agrees with that assessment.[207] The Deputy National Commissioner for Corrections

[200] Corrections, above n 87, at 4.

[201] Laurent Getaz and others "Suicide attempts and Covid-19 in prison: Empirical findings from 2016 to 2020 in a Swiss prison" (2021) 303 Psychiatry Research 114107; Sean Mitchell and others "Considering the impact of COVID-19 on suicide risk among individuals in prison and during reentry" (2021) 11(3) Journal of Criminal Psychology 240; and Will Trafford "'Blood bath from hell': Inmates at private prison tell of suicides, allege negligence amid Covid outbreak" (9 March 2022) Te Ao Maori News <teaomaori.news>.

[202] Stuff "Covid-19 live: Chris Hipkins announces all of New Zealand will move to orange setting"(Media Conference, 13 April 2022) Youtube <youtube.com>.

[203] Radio New Zealand "Prison visitors ban 'unconscionable' – advocacy group" (10 October 2022) Radio New Zealand <rnz.co.nz>.

[204] Anneke Smith "Prisoners desperate for face-to-face visits: 'We're not going to commence visits ... until it's safe'" (10 October 2022) Radio New Zealand <rnz.co.nz>.

[205] Section 73, Corrections Act 2004.

[206] Smith, above n 204.

[207] Maiki Sherman "Thousands of prisoners denied visits due to Corrections' Covid policy" (14 September 2022) 1 News <1news.co.nz>.

disagrees though, claiming Corrections is not "denying connection between prisoners and their family" as phones are available to be used. The cost of Corrections' inaction in the latter days of the pandemic restrictions is, as international research has shown, the mental health of the people in its care.

The challenge facing Corrections in its implementation of *Hōkai Rangi* falls, in large part, at the feet of the seemingly immutable nature of prisons. The tension and mistrust between prisoners and authority, the political football of being seen to be "tough" or "soft" on crime, the "unwritten rules of prison", and the inevitable strain on resources will all play a part in whether the ideals of *Hōkai Rangi* will be seen as a watershed in Aotearoa prisons – or simply another tokenistic nod in the direction of "what could have been". At this point, Emmy Rakete's description of *Hōkai Rangi* appears most accurate: [208]

> A wish list of stuff that would be nice if someone will do it, but there's no concrete plans to put any of it into practise. There's no independent oversight to ensure that any of it is actually being done and there is no meaningful work being done to ensure that any of this stuff ever happens … ever. Ombudsman's reports continue to come out finding that prisons are falling well below even the legal standards for how they should be maintained let alone all the aspirational stuff that's in *Hōkai Rangi*.

Part III Reasonable Equivalence & International Comparisons

A Reasonable Equivalence

The construct of "equivalence of care", simply put, is the principle by which prison health services are obligated to provide prisoners with a level of care equivalent to that which members of the general community would receive for the same ailment. As noted earlier, Aotearoa has legislated such equivalence must be measured within the parameters of reasonableness – that is, *reasonably* necessary medical treatment must be provided to prisoners to a standard *reasonably* equivalent to that available to the public.[209]

[208] The Spinoff "Who are prisons really helping?: Alice Snedden's Bad News" (27 September 2022) Youtube <youtube.com>.

[209] Section 75, Corrections Act 2004.

Cited in the Health in Prisons Project by the World Health Organisation (WHO), equivalence of care is one of the strategic objectives – to "reach standards equivalent to those in the wider community."[210] Within USA jurisprudence, in the 1976 case of *Estelle v Gamble*[211] it was recognised that the right of prisoners to receive healthcare was enshrined in the 8th Amendment to the United States Constitution. The Council of Europe issued a Recommendation[212] that identifies four vital elements in terms of health care for prisoners: professional independence, access to a doctor, patient consent and equivalence of care. Although many countries have codified the principle within their laws, it is far from being applied consistently.[213]

Niveau makes the point that adopting an equivalence of care model necessarily means confronting the question of choosing a reference standard. In many countries, the disparities between the advantaged and the disadvantaged are so great that prison is the only place the less fortunate can access adequate health care.[214] Ethically speaking, this is also reflected in the concept of autonomy, a value not always easily exercised from within a correctional setting. Prisoners do not have a "choice of doctor" or therapist. They can refuse treatment, but such a decision may have unintended consequences[215] beyond what the general citizenry face for the same choice. As the National Health Committee pointed out, "[t]he nature of incarceration means prisoners cannot protect and promote their own health or access health care for themselves, so the Government is obliged to provide it".[216]

It should be remembered that primary care needed within prison is both quantitively and qualitatively different from that required by the same demographic in the general community. Such care should therefore be oriented to address the specific pathologies endemic within

[210] Gerard Niveau "Relevance and the limits of the principle of 'equivalence of care' in prison medicine" (2007) 33 Journal of Medical Ethics 610 at 610.

[211] *Estelle v Gamble* 429 U.S 97 (1976) (Supreme Court).

[212] Niveau, above n 210, at 610; and Rick Lines "From Equivalence of Standards to Equivalence of Objectives: The Entitlement of Prisoners to Health Care Standards Higher than Those Outside Prison" (2006) (2)4 International Journal of Prisoner Health 269 at 272.

[213] Niveau, above n 210, at 610.

[214] At 611.

[215] Niveau cites gaining "remission or parole" as factors that may impact on a prisoner's freedom of choice in deciding whether or not to accept medical treatment, at 611.

[216] National Health Committee, above n 57, at 42.

prison – mental health being top among those.[217] As previously noted, prison is the warehouse where people who have been failed by the community's mental health system often end up.[218] Often justified by acts of violence, the incarceration of mentally ill offenders is then viewed through the lens of them being a danger to the public. This weighs on their assessment and treatment, leading to service providers focussing on the most urgent or risky situations: suicide danger, major behavioural disorders or acute psychopathy. Clearly, the security requirements of a prison and the complexity of treating such patients, coupled with limited resources means equivalence of care is rarely, if ever, achieved. One of the barriers to this is that in the community, a doctor will advise a patient with mental illness to pursue stable relationships and family connection, fulfilling work and to enjoy their freedom … all things not available to a prisoner.

There is a well-made argument that careful management of health care resources within a prison can provide an overall economic benefit to the public. As marginalised, disenfranchised citizens typically slip through public health nets, imprisonment offers the chance for an average outlay to give higher than normal returns in terms of public health outcomes.[219] There are, however, caveats to that: certain techniques or treatment plans may have to be discontinued after release or are interrupted by transfers to another prison. In the case such treatments were available post-release, most prisoners return to the community which they left (which often cannot offer such therapies) thereby "escaping" the control and benefits of the health services.[220] This is partly a result of prisoners being released without either a plan or necessary resources to access treatment pathways – but also reinforced by a general distrust of and desire to maintain independence from state intervention.[221] The United Kingdom has identified the issue of continuity of care with the National Health Service commissioning a pilot programme, RECONNECT, which is addressing "at least part of this need."[222] Such a programme is

[217] Niveau, above n 210, at 611.

[218] H Richard Lamb, Linda Weinberger and Bruce Gross "Mentally Ill Persons in the Criminal Justice System: Some Perspectives" (2004) 75(2) Psychiatric Quarterly 107.

[219] Niveau, above n 210, at 612.

[220] At 612; National Health Committee, above n 57, at 38.

[221] National Health Committee, at 38.

[222] Graham Durcan *The future of prison mental healthcare in England: a national consultation and review* Centre for Mental Health (Report, 2021) at 3.

unlikely in the Aotearoa context where primary services in prison and those in the community are provided by different government departments.

The peril of prison has also been known to impact treatments, with prisoners reporting not taking mental health medication in order to stay alert to possible threats.[223]

Initiatives like telemedicine, which could work well within the prison environment, may improve not only economic efficiency but also increase access to treatment for prisoners.

In Aotearoa, it is well established that delivery of health care into the prison system does not currently meet the principle of equivalence.[224] The duty of care owed to prisoners is derived from the concept that with the right to remove a person's liberty, certain obligations fall on the Government. The National Health Committee notes one of the implications of the principle of equivalence of care is, as prisoners often have limited financial resources and heightened risk of health problems, "some services should be provided free to meet the state's duty of care."[225] It is this duty of care, the enhanced relationship between the state and its prisoners, that gives rise to a greater obligation than has previously been considered. The argument will be made in Part V to shift the focus from a "principle of equivalence" to "Equivalence of Outcome" … reflecting the deeper duty owed by the cager to the caged.

B International Practice

According to the World Health Organisation, governments owe prisoners a "special duty of care … including the right to health".[226] This claim will be analysed in Part V, noting Aotearoa courts have rejected the idea of a "special duty".

It is important to note caution is required when placing reliance on international models – let alone importing results into an Aotearoa context. The particular cultures, penal and health sector environs, and differing legislative authorities and structures all play a part in shaping

[223] National Health Committee, above n 57, at 31.

[224] At 42.

[225] At 43.

[226] World Health Organisation *Prisons and Health* (2014) at 1.

specific responses. Nevertheless, certain characteristics can be reasonably inferred and transcribed into the Aotearoa setting. These include mental illness epistemologies, impacts of specific prison environments (such as solitary confinement) on those with mental illness, and moral imperatives regarding public health. Also interesting to note is the differing legislative wordings (and the consequent application of those interpretations) in the light of both international human rights law and overarching principles like "equivalence of care".

Despite obstacles in terms of a direct comparative analysis, a consideration of the approaches taken by other jurisdictions is warranted. Canada has identified similar issues to Aotearoa in terms of stressors its correctional service faces when dealing with the increasing number of prisoners with mental illness issues. It has maintained the status quo, however, in that mental health services are still provided by the prison system itself – rather than Health Canada. Despite increased resources being directed at the effort by the Canadian government, similar barriers to wellbeing exist to those faced by prisoners in Aotearoa. England and the Australian state of Victoria have both adopted external providers (one simply its National Health Service and the other a specialist mental health care provider) rather than require the prison authorities to provide primary care. And Europe, under the ECHR framework, spans multiple jurisdictions and legislative ideals. The overarching authority of the ECHR and the European Prison Rules offers some degree of insight into how similar countries apply concepts like "equivalence of care", whether they use their health departments or correctional services to provide treatment, and how successful such approaches are.

1 Canada

The delivery of essential health care to the federally-held Canadian prisoners falls to the Correctional Service Canada (CSC). Much like Aotearoa, as demand for mental health care and treatment increased,[227] pressure was placed on the capacity levels for access to specialist beds. The CSC responded to this pressure by improving intermediate care, looking to intervene before hospitalisation becomes necessary. The multijurisdictional context of the Canadian health system makes planning, implementation and direction of mental health services to

[227] Frame-Reid, above n 63, at 40.

prisons a complex task.[228] Further, the Canadian prison system operates across two distinct strata – provincial jails (for remand prisoners or those sentenced to less than two years) and the federal system (for prisoners serving sentences of two years or more). The provincial system functions across 13 different jurisdictions and operate "very differently"[229] from one another.

The Corrections and Conditional Release Act[230] codifies the obligations of the corrections system to provide mental health care. Section 86(1) states each inmate shall be provided with (a) essential health care; and (b) reasonable access to non-essential health care. Health care in this context includes mental health treatment. It is worth noting the difference to Aotearoa's s 75 reasonable equivalence test. Section 75(1) of our Act only obligates Corrections to provide medical treatment that is "reasonably necessary" … not extending to "non-essential".

It was not until 2007 that the Canadian government directed the Mental Health Commission to develop a national strategy for mental health care, which was finally released in 2012. It included recommendations to reduce the overrepresentation of people living with mental health needs in the criminal justice system and to provide appropriate services, treatment, and support to those who are in the system. Despite progress in meeting the mental health needs of Canadian prisoners, further resources and planning are necessary. One of the "historic transformations"[231] of a "new correctional model" was the 2019 introduction of the Structured Intervention Unit (SIU). The move was designed to abolish administrative and disciplinary segregation which supposedly "no longer exist" in federal prisons in Canada. [232] Operating at 15 sites across the country, they were intended to have an interventional focus while still considering the "safety and security needs of the institution".[233] As the CSC trumpets the use of the SIUs, Justin Ling argues they are no more than a rebranding exercise of what were

[228] Alexander Simpson, Jeffrey McMaster and Steven Cohen "Challenges for Canada in Meeting the Needs of Persons with Serious Mental Illness in Prison" (2013) 41(4) Journal of the American Academy of Psychiatry and the Law Online 501 at 507.

[229] Watson and others "Addressing the complex substance use and mental health needs of people leaving prison: Insights from developing a national inventory of services in Canada" (2022) 100 International Journal of Drug Policy 1.

[230] S.C. 1992, c. 20.

[231] Correctional Service of Canada *2022-23 Departmental Plan* (2022) at 3.

[232] Correctional Service of Canada *Structured Intervention Units* <csc-scc.gc.ca>.

[233] Correctional Service of Canada *Structured Intervention Units* (fact sheet, October 2021) accessed at <csc-scc.gc.ca>.

solitary confinement units –[234] ruled illegal (after being found unconstitutional) and outlawed under Trudeau-government introduced legislation. Criminologist Anthony Doob found over a quarter of the SIU stays were simply solitary confinement with another 9.9% qualifying as "torture or other cruel, inhuman or degrading treatment."[235] Much like the Aotearoa experience (see Part I), the CSC Commissioner claimed there is no solitary confinement in Canada.

Ling has written that by "nearly every metric", the prison system in Canada is not just failing, "but making things worse." Citing the surveys that paint an alarming picture of mental illness rates (which fall roughly in line with similar studies across the world), Ling laments that the system is "warehousing" those struggling with their mental health.[236]

2 Victoria, Australia

There are notable differences in the mental health statistics (of both lifetime diagnosis rates of mental illness as well as outcomes) between Australia and Aotearoa. Of people released from prison in 2018, only 40% reported having been diagnosed with a mental illness in their lifetime. Comparatively, this is less than half the rate of Aotearoa's prison system.[237] This may be explained by either different diagnostic methodology; that mental illness in Australia is less prevalent; or simply that Aotearoa is better at identifying such issues (due to public health messages etc). Alternatively, it may just be wrong. The Mental Health Council of Australia, in a 2010 press release, wrote that "up to 80% of inmates in Australian prisons have a mental illness",[238] bringing it more in line with the Aotearoa experience. Following a prison sentence, 39% of all prisoners reported an improvement in their mental health whilst incarcerated, while less than 10% reported a deterioration.[239] That survey was self-reported, however, and may reflect simply "happier" prisoners who had reached the end of their prison sentence. It is worth

[234] Justin Ling "Houses of Hate: How Canada's prison system is broken" (February 28, 2021) Maclean's <macleans.ca>.

[235] Linda Mussell and Marsha Rampersaud "Solitary confinement by any other name is still torture" (November 19, 2020) The Conversation <theconversation.com>.

[236] Ling, above n 234.

[237] Australian Institute of Health and Welfare *The health of Australia's prisoners* (2018) at 27.

[238] Mental Health Council of Australia "Lack of services mean mentally ill sent to prison, not treated" (press release, 19 January 2010).

[239] Australian Institute of Health and Welfare, above n 237, at 33.

considering whether differences in approaches to mental health treatment in Australian prisons contribute to these disparities in outcome. However, the rate of incarceration of Indigenous Australians places it amongst the worst in the Western world. In Western Australia, for instance, an Indigenous Australian is 20 times more likely to be in prison than a non-indigenous person.[240] This reflects on mental health rates, interventions and potential treatment options.

The concept of equivalence of care has not been formally adopted nationally as the provision of both prison services and the respective approaches to health care is the responsibility of the states and territories, rather than the federal government. Consequently, variations across state lines occur and no national oversight and monitoring body exists.[241] Dean notes a further challenge to the concept of equivalency lies in the fact that the needs of those who come into contact with the criminal justice system necessitate "more than" an equivalent standard.

Forensicare (the Victorian Institute of Forensic Mental Health) is responsible for the provision of specialist forensic mental health services at 12 of the 14 Victorian prisons. It handles reception screening assessments, outpatient care, and dedicated units for prisoners with mental health needs. It is not a part of the state's correctional apparatus. It describes its "primary focus" [as] the provision of clinical services within a recovery framework."[242] Corrections Victoria is, in its words, dedicated to "achieving the appropriate balance between a high level of community safety and the humane treatment of prisoners".[243] Any philosophical objection to the concept that these two objectives are either inversely related or, worse, mutually exclusive is a topic outside this paper but it is clear the primary purpose of Forensicare aligns more with a *treatment* model than a *containment and management* model.

3 England

The Prison Medical Service was responsible for the commissioning of prison health care until 2006, at which point the Department of Health took over – until the passing of the Health and Social Care Act 2012, which shifted responsibility to the National Health Service (NHS) from

[240] Dean, above n 143, at 15.

[241] At 11.

[242] Forensicare "About us" (accessed 12 September 2022) Forensicare <forensicare.vic.gov.au>.

[243] Corrections Victoria "Prison sites" <corrections.vic.gov.au>.

2013 onwards. These moves were, in part, to promote the equivalence of care.[244] Although directly responsible for the provision of services, the importance of a collaborative working relationship between the NHS, Public Health England and His Majesty's Prison and Probation Service could not be overstated.[245]

Public Health England undertook a service provision review in 2016 to investigate and report back on the move from the Prison Medical Service. The consensus was there had been "significant improvements" in the quality of the care.[246] A further report in 2020 concluded that, overall, health care in prison was "working well" although improvements to screening and assessment procedures were needed and provision differed prison to prison.[247] It was recommended prisons move towards becoming trauma-informed environments.[248] By no means a perfected system,[249] the goal of equivalence of care is closer in England than Aotearoa.

At a strategic level, the principle of equivalence in England can be defined as ensuring:[250]

> that people detained in prisons in England are afforded provision of and access to appropriate services or treatment (based on assessed population need and in line with current national or evidence-based guidelines) and that this is considered to be *at least* consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community, *in order to achieve equitable health outcomes* and to reduce health inequalities between people in prison and in the wider community.

[244] National Audit Office *Mental health in prisons* (29 June 2017).

[245] National Health Service *National Partnership Agreement for Prison Healthcare in England 2018 – 2021* HM Goverment (2018) at 5.

[246] Rachel Hutchings and Miranda Davies "How Prison Health Care in England Works" (20 October 2021) Nuffield Trust <nuffieldtrust.org.uk>.

[247] Durcan, above n 222, at 3.

[248] At 35. Trauma-informed care is understanding and acknowledging that trauma can negatively impact individuals (and communities), influencing behaviours that may be in response to such trauma.

[249] National Audit Office, above n 244, at 16; and House of Commons Justice Committee *Mental Health in Prison* (Fifth Report of Session 2021-22) at 8.

[250] National Health Service *National Prison Healthcare Board Principle of Equivalence of Care for Prison Healthcare in England* <www.nuffieldtrust.org.uk>.

Although it is a policy ambition to address inequalities and, as emphasised above, "achieve equitable health outcomes",[251] there are barriers to these ideals. These include the same issues as in Aotearoa – staff recruitment and retention, training, and an "old fashioned environment". The general view when defining equivalence of care is that there exists "equivalent health policy, equivalent standards and equivalent delivery of care".[252]

4 Europe

The European Prison Rules (the Rules) were developed by the Council of Europe and apply across all 47 countries within the Council. Rule 5 states "[l]ife in prison shall approximate as closely as possible the positive aspects of life in the community."[253] The principle of normalisation refers to, generally speaking, the shaping of the prison environment to resemble life outside prison. This does, however, allow for differences in application across member States however. For example, the Dutch self-sufficiency model[254] is similar to the arrangement in Aotearoa, in that all prisoners receive the same level of care – care provided by the Prison Service itself. In Norway, the role of the Correctional Service is to provide access for external social services to deliver health care to prisoners. Known as the import model, dilemmas still exist in terms of attempting to provide equivalent care evenly across the prison network. Additionally, resource allocation for social service providers can become strained when trying to meet the needs of complex and difficult prisoners over and above the need within the general community.[255]

In relation to the treatment of prisoners with mental health problems, the European Court of Human Rights (the ECHR) has consistently held that Article 3 of the European Convention on Human Rights (the Convention) requires States to ensure that the health and well-being of prisoners are met. The ECHR has ruled a prisoner's condition of detention must not cause "fear, anguish, [a sense of] inferiority capable of humiliating and debasing him and possibly breaking

[251] See Part V in which I will argue for a pursuit of equivalence of outcomes over standards.

[252] Royal College of General Practitioners *Equivalence of care in Secure Environments in the UK* (Position Statement, July 2018) at 8.

[253] Jill van de Rijt, Esther van Ginneken, and Miranda Boone "Lost in translation: The principle of normalisation in prison policy in Norway and the Netherlands" (2022) 0(0) Punishment & Society 1.

[254] At 11.

[255] At 11.

his physical and moral resistance."[256] Recognising that prisoners with mental illnesses are more vulnerable than ordinary detainees, and certain situations within prison necessarily cause stress and anxiety, increased vigilance is needed in assuring compliance with the Convention.[257] The scope of treatment provided must go beyond basic care – however, the ECHR does not enter into analysing the *content* of the treatment offered.[258] The focus instead is on whether an individualised programme has been put in place, and consideration of the specific details of the prisoner's mental health with a view to preparing him or her for possible future reintegration into society.[259] Because of this overarching principle, the ECHR allows the authorities latitude with regard both to the form and the content of the care in question, although it was reinforced in *Rooman* that any detention of someone with a mental illness must have a therapeutic purpose.[260] The absence of such a purpose may amount to a "therapeutic abandonment" in breach of Article 3.[261]

This section opened by noting that comparative analysis carries certain inherent risks. Aotearoa is a unique and dynamic population and, although there are international reflections hinting at ideas that could be introduced here, some claims cannot be fully established based solely on studies abroad. Corrections has been criticised in the past for being too quick to adopt international penal policies and practices – in particular, United States-style prison architecture. Mental health treatment of prisoners is an international concern and the issues other jurisdictions have faced and reacted to are the same as we are facing now. Our responses should be measured on the reduction in self-harm incidents, suicides, and distress incidents within prisons.

Part IV How are the Obligations Applied in Practice?

This section will brief and critique the responses Corrections offer in Aotearoa. Some initiatives suggest promise … one of these is a mental health unit in Waikeria Prison in the Waikato.

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[256] European Court of Human Rights *Guide on the case-law of the European Convention of Human Rights: Prisoner's Rights* (30 April 2022) at 36.

[257] *Rooman v. Belgium* [GC], 2019, § 145.

[258] European Court of Human Rights, above n 256, at 38.

[259] *Murray v. The Netherlands* [GC], 206 at [101].

[260] *Rooman*, above n 257, at [208]-[211].

[261] *Strazimiri v. Albania*, 2020, [108]-[112].

A The Waikeria Prison Unit

Announced in 2018, a major rebuild of Waikeria Prison was expected to be completed by early 2022.[262] It was to include a 100-bed mental health and addiction service unit, *Hikitia* – the first of its kind in Aotearoa – and was described as the "antithesis to an 'American-style' mega prison."[263] The Minister of Corrections touted it as an initiative that will be "delivering real rehabilitation and mental health support to reduce reoffending", that would provide "wraparound services to those in prison who need the most help."[264] Corrections acknowledged the capacity of the Forensic Mental Health Services was not sufficient to meet demand[265] as (despite falls in recent years) the prison population across the last 20 years has risen at a far greater pace than that of hospital beds in psychiatric units. These constraints were identified in *He Ara Oranga*,[266] but until that time had not been noted in any of Corrections' Annual Reports or Statements of Intent.

There does appear to be collaboration with local iwi (Raukawa and Ngāti Maniapoto) which is positive, although reports that "over 2000 men a year"[267] will benefit from admission to the unit seems an exaggeration. A 100 bed unit (even assuming for complete occupancy, which in reality never occurs as prison transfers and cell swaps take time) would mean each cell had a new prisoner in it every two and a half weeks. That is not enough time to even induct someone into a new unit, let alone provide any level of treatment.

As Mills and Kendall pointed out, whether a prison can *ever* be mentally healthy for prisoners is a valid question.[268] Although not arguing *Hikitia* is an ill-conceived project, it must be

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[262] Shaun Sullivan and Maxine Mallinson "A mental health service for people in central North Island prisons" (2019) 7(1) Practice: The New Zealand Corrections Journal 78.

[263] Katie Doyle "New Waikeria Prison facility delayed to 2023 due to Covid-19 disruptions" (24 March 2022) Stuff <stuff.co.nz>

[264] Department of Corrections "Excellent progress at new Waikeria prison build" (press release, 3 April 2021).

[265] Sullivan, above n 262.

[266] *He Ara Oranga*, above n 124, at 69.

[267] Jo-Lines MacKenzie "A multi-million dollar new build at Waikeria prison on track for August 2022 finish" (4 April 2021) Stuff <stuff.co.nz>, quoting the Minister of Corrections.

[268] Alice Mills and Kathleen Kendall *Challenges in the Provision of Mental Healthcare* University of Auckland Public Policy Institute (Policy Briefing, 2019).

acknowledged it is an experiment. It also signals an intention on the part of Corrections that it considers the answers lie within its skillsets. Moving mental health problems into a prison where they are no longer visible to the general public runs the risk of perpetuating the illusion of having solved them.

B Multi-Disciplinary Mental Health In-Reach Teams (MHIRTs)

The early 2000s saw the development and roll-out of MHIRTs across prisons in England and Wales. Intended to provide equivalence of care, they nevertheless failed to consider fully the nature of the prison environment and culture. Security and control take precedence over therapeutic idealisms. Although leading to improvements in treatment processes, MHIRTs continue to operate within prisons whose role is to "confine, control and punish".[269] Mills and Kendall argue any goal of equivalence of care is unrealistic given the "capacity of the prison to dehumanise, deprive and degrade." They suggest community change is the appropriate path forward – rather than pursuing treatment programmes within prisons. As previously pointed out in this paper, they state they would be "hard pressed to design anything worse than prisons for people who are emotionally distressed and vulnerable".[270]

Professor Brian McKenna, of the School of Clinical Sciences at Auckland University of Technology, wrote that prison in-reach teams offer multi-disciplinary specialist secondary services that provide "wrap-around, holistic services from initial screening through to reintegration to the community."[271] The STAIR model of care used in such teams is made up of five elements: Screening; Triage; Assessment; Intervention; and Reintegration. Developed in Aotearoa in 2011, it does present positive potential, although some development is still required. As an example, the integration of a recovery model into STAIR would "empower prisoners self-determination",[272] and a review of how culturally responsive the model is to Māori needs is needed.

C Centralised Database and Screening

[269] Mills.

[270] Mills.

[271] McKenna, above n 10, at 775.

[272] At 781.

Legal practitioners offer anecdotal evidence suggesting Corrections, in general, fails to provide complete mental health screenings upon entry to prison.[273] Upon reception at a prison Receiving Office, prisoners (both remand and custodial) are given a health screening by a nurse. This is not a full mental health assessment – it is simply to ascertain risk of immediate self-harm. Often Receiving Offices are extremely busy, chaotic places as new prisoners are processed.[274] This necessarily involves identification, processing of sentencing papers from the courts, allocation of cells and any SACRA analysis and paperwork,[275] provision of clothing and bedding, searches and physical health screening. Psychologists are not contracted to offer reception screening tests so it is, inevitably, left to untrained staff who work in the prison units to notice and refer prisoners in need of assistance. This "cumulative effect"[276] of inadequate screening[277] and the discretion open to untrained officers leads to prisoners falling through ever-widening cracks.

Corrections claim it has, and uses, a comprehensive induction process (including handbooks and interviews) has been challenged. Former prisoners have consistently reported not being inducted[278] … "they were useless in the R/O"; "there's no please or thank you … its who can kick the door the loudest"; and prisoners commenting they needed to be "putting on a mask, putting on a front" in order to be processed efficiently.[279]

Prisoners and the nature of prisons offer numerous reasons why reception screening can be difficult. Besides the fact being sent to prison is a stressful time that may mask issues,[280] substance misuse may also contribute to hiding what would normally be identifiable needs. Any withdrawal symptoms a prisoner displays may also colour how nurses assess them. The

[273] Susan Gray and Samantha Noakes "How to improve mental health care in prisons" (4 September 2020) Auckland District Law Society <adls.org.nz>.

[274] Graham Durcan *From the Inside: Experiences of prison mental health care* (Sainsbury Centre for Mental Health, London, 2008) at 27; and JustSpeak "True Justice: Episode One" (podcast, 2022).

[275] SACRA is an acronym for Shared Accommodation Cell Risk Assessment which, in the circumstance prisoners are required to share a cell (double bunk), is required to assess compatibility between potential cellmates.

[276] Gray, above n 273.

[277] Durcan, above n 222, at 7.

[278] JustSpeak, above n 274.

[279] JustSpeak "True Justice: Episode Two" (podcast, 2022).

[280] Durcan, above n 274, at 28.

nature of prison can also contribute to prisoners not being willing to share information relating to their mental health. Whether it is due to a distrust of authorities or a fear of future repercussions, prisoners often withhold any known mental illnesses. Of course, there are also prisoners who are not even aware of their vulnerabilities or, at the time of reception, such problems are not apparent and only emerge later.[281] It has been estimated 75% of mental health needs are missed at reception screening.[282] Although a British study, with a similar screening tool, it is not inconceivable the Aotearoa experience is much different.

This paper previously noted that a prison Receiving Office is often not the first contact with a mental health service such prisoners have experienced – evidenced by lifetime diagnosis rates of upwards of 90%. Presently there is no centralised database with this information available to Corrections staff (either the nurses at entry, or officers "on the floor"). This disconnect between Corrections, the Ministry of Health and Forensic Mental Health Services has, arguably, cost lives.[283]

According to Corrections, only a fraction of prisoners are mentally ill enough to be transferred to a psychiatric hospital.[284] This raises some glaring questions. Firstly, since untrained Corrections officers are responsible for such identification, what about the people who *are* serious enough to be admitted but are not noticed? Secondly, what happens to those that are mentally ill, but not mentally ill *enough*? The answer to the first question is systemic in nature and can only be solved through an enormous investment in training and screening programmes that utilise intervention teams and a co-ordination effort far in excess of current realities. The answer to the second question is the wider ranging one, impacting the most people – thousands of prisoners at any one time.

Corrections provides its response by reminding everyone it is only obligated to offer primary health care to a standard reasonably equivalent to that received by the general public. Thus far, this paper has demonstrated how Corrections is failing at even that yardstick, but for some

[281] At 28.

[282] House of Commons Committee of Public Accounts *Mental health in prisons: Eighth Report of Session 2017–19* (2019).

[283] Ethan Griffiths *Corrections ordered to review mental health services after suicide of Whanganui prisoner* New Zealand Herald (online ed, Auckland, 28 October 2021).

[284] Gray, above n 273.

isolated programmes. It is submitted a substantial part of the reason for this failure is the conflation of the terms "rehabilitation" and "treatment".

D Conflation of treatment and rehabilitation

Prison programmes are designed to reduce reoffending by addressing criminogenic factors identified as drivers of crime. These include substance abuse, criminal associates, lifestyle imbalance, a propensity for violence, gambling, risk taking and poor relationships[285] … all factors which are addressed through *rehabilitative* programmes.[286] Prisoners are allocated rehabilitative programmes on a discretionary basis as per s 52 of the Act. Psychiatric disorders are included in the Criminogenic Needs Inventory[287] but in order to address these, *treatment* is required – an entitlement conferred by s 75 of the Act.

Corrections' psychologists make it clear to prisoners that "treatment in prison" is "offending-focussed rather than mental health focussed".[288] The Psychological Service's dual roles are to (a) reduce recidivism and (b) contribute to the safe and humane containment of offenders. Its success or failure is measured primarily by its impact on recidivism rates, an index related only to the first role.[289] Lowering the rate of recidivism across either an offence group or an individual patient should be a by-product of a successful treatment programme rather than a primary goal for a psychologist.

Evidence of the blending of the terms is the following comments from within a three-paragraph excerpt by a Corrections' psychologist in the New Zealand Journal of Psychology:[290]

[285] Department of Corrections "Criminogenic Needs" <corrections.govt.nz>.

[286] Consider my discussion of the s 52 discretion in Part II.

[287] Department of Corrections, above n 285. The Criminogenic Needs Inventory (CNI) is a risk analysis model designed for Aotearoa that assesses an individual's criminogenic needs and attempts to answer the question of "why do people offend?" and, in particular, re-offend.

[288] Parole Board decision of John Harold La Roche (31 August 2017).

[289] Brendan Anstiss "Just How Effective is Correctional Treatment at Reducing Re-Offending" (2003) 32(2) New Zealand Journal of Psychology 84 at 86.

[290] At 89. Italics added.

> Yet we have by no means reached the pinnacle of *treatment* effectiveness, even for our so-called most effective programmes … Firstly, the majority of the specialist *treatments* appear to only reduce the reoffending rate of the behaviour under intense focus …However, given the above discussion on the specificity of *treatment* results (ie *treatment* appears to only impact …)

Rehabilitative programming is not *treatment* of mental illness. It is this confusion of terms over several years that has led to Corrections making comments such as treatment is "offending focussed rather than mental health focussed" and being slow to introduce trauma-informed care into male prisons as there is no "causal connection between childhood trauma and offending". The (unproven) fact such a connection may not be able to be directly made should not be an excuse to fail to treat trauma victims while they are in prison. Surely, that is actually the *best* time to do so. Within the context of a correctional setting that has the operational mandate to run prisons as "safely" as possible, it is understandable Corrections tends towards empirical analysis of recidivism rates when assessing its treatment of prisoners. This is compounded when parole is considered … the Parole Board obliged to only release prisoners when it is satisfied on reasonable grounds they no longer pose an undue risk to the safety of the community.[291] The Parole Board regularly use the terms "untreated" or "treated" when referring to whether prisoners have undertaken rehabilitative programmes.[292] However, there are some phrasings noted with optimism. "Risk-based rehabilitative work" and even "risk-based rehabilitative treatment"[293] are becoming more common in Parole Board decisions – helping drive greater clarity for both prisoners, counsel, and hopefully, Corrections.

Part V Critique

Part V will outline three recommendations that this research suggests will improve the current state of care:

(i) Adoption of a principle coined "Equivalence of Outcome" to replace the current target of "reasonable equivalence of care"; and

[291] Parole Act 2002, s 28(2).

[292] Parole Board decision of Hori Irimana Tenaku Winiata Kemp Gemmell (10 October 2022); and Parole Board decision of Scott Watson (30 November 2021).

[293] Parole Board decision of Justin Ames Johnston (10 May 2022); and Parole Board decision of Pasilika Naufahu (12 September 2022).

(ii) Transferring responsibility for primary health care, including mental health treatment, to the Ministry of Health; and

(iii) Clarification of the delineation between the terms "rehabilitation" and "treatment" within the legislation, and a further commitment to work towards using correct terminology in future cases, Parole Board decisions and programme development. This will be aided somewhat by the Ministry of Health managing prison health care.

A Equivalence of Outcome

International evidence clearly shows that mental health needs of prisoners are far from being adequately met. As the criminal justice system and the prison experience itself disproportionately impacts those who are socially or economically disadvantaged, mental health pressures are concentrated on those already at most risk. Societal disconnection is not a treatment tool used by psychiatrists in the community, yet prisoners who live with mental health issues face precisely that as a routine part of their human condition.

As argued in this paper, the adequacy and efficacy of prison mental health services cannot be isolated from the concerns of the wider community simply by dint of "out of sight, out of mind". Although improved from the panic of the 1980s, the caricature of the mentally disturbed individual is still often considered "dangerous" in the eyes of the general population.[294] It is undeniable that untreated mental illness does result in a higher risk of serious violent crime. Extreme health needs provide fertile soil for dangerous behaviour. Given this, providing mentally ill prisoners a standard of health care equivalent to that found outside prison will inevitably fall short of achieving any level of social wellness. It may be that a particular level of intervention and investment is sufficient to meet the needs of a general population (a level Aotearoa is arguably still well short of). However, that same level of intervention is, by definitional logic, simply not adequate to meet the needs of those in prison if the same level of social wellness is desired.

[294] Lauren Callaghan "The inaccurate science of assessing 'dangerousness' under the Mental Health (Compulsory Assessments and Treatment Act) 1992" [2003] CanterLawRw 7.

In light of the scope of the problem and the urgency inherent in the issues, the Government has a moral and legal obligation to provide prisoners with a level of mental health care greater than that available in the community. Reasonable equivalence is not enough. It is not an adequate target. This paper therefore proposes an adoption of the goal of "*Equivalence of Outcome*".

This section will make that argument. It is founded on three principles:

(i) Prisons are closely linked to communities. Healthy prisoners become healthy ex-prisoners which benefits society; and

(ii) There is a moral imperative because of the custodial relationship between prisoners and the State; and

(iii) There are already legal tools in place that recognise such a concept, meaning the adoption of Equivalence of Outcome will not be too dramatic.

Simply providing a reasonably equivalent standard of care that someone from the general population would receive misses the point that prisoners present with more extreme, complex and wide-ranging problems than a "normal person".

1 Historical Foundations

The claim that health standards within prison should exceed those without is not a new construct. In 1774, the colourfully named "Act for Preserving the Health of Prisoners in Gaol, and preventing the Gaol Distemper" was passed by the British Parliament. The first piece of legislation in Great Britain to address prisoner health, it was likely one of the earliest anywhere. The great prison reformer, John Howard (namesake of the Howard League for Penal Reform) wrote of the statute demanding:[295]

> … an experienced Surgeon or Apothecary be appointed to every gaol: a man of repute in his profession. His business is, in the first place, to order the immediate removal of the sick, to the infirmary; and see that they have proper bedding and attendance. Their irons should be taken off; and they should have, not only medicines, but also diet suitable to their condition. He must diligently and daily visit them himself; not leaving them to journeymen and apprentices. He should constantly inculcate the necessity of

[295] Howard *Prisons and Lazerettos* (Patterson Smith, Reprint 4th ed, New Jersey, 1973) quoting John Howard in 1777.

> cleanliness and fresh air; and the danger of crowding prisoners together: and he should recommend, what he cannot enforce. I need not add, that according to the act, he must report to the justices at each quarter-sessions, the state of health of the prisoners under his care.

Although in the context of communicable diseases, the 1774 Act for Preserving the Health of Prisoners placed responsibility on the State to provide both primary medical care *and* preventative health measures such as hygiene, cleanliness and ventilation.[296] Taxes were to be levied and if any "Gaoler or Keeper of any Prison shall, at any Time, neglect or disobey" the legislation, they were liable for fine and possible imprisonment.[297] Such services or preventative measures were not an entitlement to ordinary citizens who lived outside the prison walls. Lines suggests such a condition is a by-product of the "very nature of the relationship between the State and the detainee" and the level of control and consequent responsibility the State has over and for those in its penal system.[298] One may also argue legislators in the late eighteenth century understood that a prison is a prime candidate for a disease outbreak and greater precautions and interventions are necessary within its boundaries.

The United Nations Human Rights Committee has ruled "the State … by arresting and detaining individuals takes responsibility to care for their life."[299] In *Lantsova*, it was found the failure to provide a "properly functioning medical service" violated a prisoner's right to life (following the death of a prisoner due to poor conditions inside the prison) which is enshrined in Article 6(1) of the ICCPR. No such entitlement to a medical service exists for non-imprisoned people under the same treaty. Similarly, the right to life guaranteed in Article 2 of the European Convention on Human Rights (ECHR) was ruled to have been violated in the case of *Edwards and another v United Kingdom*.[300] In *Edwards*, one of the requirements the Court[301] specified as lacking was a mental health screening tool – something not available by right to non-prisoners.

[296] Lines, above n 212, at 274.

[297] At 274.

[298] At 274.

[299] *Lantsova v Russian Federation* (26 March 2002) UN Doc CCPR/C/74/763/1997.

[300] *Edwards and another v United Kingdom* (2002) 35 EHRR 417.

[301] European Court of Human Rights.

Case law considering the application of the ECHR is clear that failure to provide sufficient medical treatment to prisoners which unnecessarily exacerbates suffering can breach the Article 3 protection against torture.[302] Again, no such guarantee of a general right to health exists for European citizens.

2 Aotearoa Context

The National Health Committee (NHC) in 2010 argued the equivalence of care standard should be "based on needs",[303] reflecting the concept that the loss of liberty through imprisonment is the punishment itself; one is not sent to prison to be punished. It is "not a sentence to physical harm or poor health."[304] There is a nuanced difference between providing the same care to prisoners as they would receive in the community, and providing a level of care that responds to *needs*. One of the potentially positive recommendations of the NHC is the re-prioritising of existing health legislation to better reflect the needs of prisoners – allowing for the logical argument to be made that prisoners have greater needs and therefore require greater intervention.

A piece of legislation that should be at the forefront of discussions relating to health care for prisoners is the New Zealand Public Health and Disability Act 2000.

3 New Zealand Public Health and Disability Act 2000 (NZPHDA)

The NZPHDA encapsulates the objectives for the health and disability sector. My argument is these objectives should rightly prevail over s 75 of the Act. Prison health services should be required to meet the objectives of the NZPHDA, which include the "improvement, promotion, and protection" of the health of all New Zealanders and to provide "the best care or support for those in need of services."[305] Additionally, it is also an objective of the NZPHDA to "reduce heath disparities by improving health outcomes of Māori and other population groups."[306] There is a clear distinction between the NZPHDA wording of, in particular, the requirement to

[302] *Rohde v Denmark*, 2005; see also *Kudla v Poland*, 2000; *Melnik v Ukraine*, 2006 from Lines, above n 212.

[303] National Health Committee, above n 57, at 42.

[304] At 42.

[305] Section 3(1)(a).

[306] Section 3(1)(b).

target health *outcomes* as opposed to simply pursuing equivalent standards (as described in the Act).

Although these aspirations apply for all New Zealanders, including prisoners, it is unclear whether they are required of the Corrections' health service.[307]

B Increased Duty of Care for those in a Custodial Relationship

It would be accurate to describe the scope and nature of the duty of care owed to prisoners is a matter of some debate. Some hold true to notions of fundamental human rights that transcend the actions of offenders … while others demand that from the moment of conviction (if not sooner) all rights a person previously held are forfeit. Lord Atkin encapsulated the modern law of negligence[308] within the "neighbour principle" – people must take reasonable care not to harm others who could be foreseeably affected by their action or omission. As a result of their detention, prisoners are vulnerable members of society, therefore the accepted requirements for imposing a duty of care on Corrections exists.[309] The question is then "what is the scope of that duty?"

The duty of care any state owes to a prisoner is, arguably, a greater responsibility than it owes to a general citizen. The involuntariness of imprisonment, the degree of control by authorities over their lives (and their corresponding lack of personal autonomy) and the vulnerability of prisoners due simply to the inherent danger of the prison system gives rise to this special duty.[310]

Prisoners are, as mentioned, included in the category of vulnerable people.[311] The response, in general, by prison authorities[312] is provided it complies with the Act, the Corrections

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[307] National Health Committee, above n 57, at 43.

[308] *Donoghue v Stevenson* [1932] UKHL 100.

[309] *Dorset Yacht Co Ltd v Home Office* [1970] UKHL 2; [1970] AC 1004; and *Hill v Van Erp* (1997) 188 CLR 159, 216.

[310] Andrew Morrison, "The duty of care to prisoners" (2007) 81 Precedent 8.

[311] Nicola Peart "Chief Executive of the Deapartment of Corrections v All Means All" [2014] NZLJ 297 at 298; Crimes Act 1961, s 2.

[312] Both Corrections and private prison manager, Serco Limited.

Regulations 2005, the Mandela Rules (in accordance with s 5(1)(b) of the Act),[313] and s 23(5) of the BORA,[314] then no further duties exist. International courts have consistently ruled a duty of care does exist when one person is detained in the care of another, and a "special duty" can be formed in that scenario.[315] However, in Aotearoa there has been recent judicial sentiment suggesting a common law duty of care for prisoners does *not* exist. Lang J has ruled there is only one relevant reason for that assessment: prison authorities have a wide discretion in how they manage prisoners.[316] He continues by describing the imposition of a common law duty of care upon Corrections to take reasonable care of its prisoners as being a "major step"[317] as it is already encumbered by obligations under the Act.

With due respect to Lang J, he misses the point of the inherent power imbalance which exists, and places too much trust in the statutory arrangement to protect the rights of prisoners – all of whom have only one option when it comes to health care arrangements. This is the reasoning behind the United States decision of *Gregoire*[318] in which the Washington Supreme Court held prison authorities have a "special relationship" with the prisoners in their care … in fact, a "special affirmative" and nondelegable duty.[319] The case was one of first impression in which the Court was asked to determine whether a prisoner should be held partially responsible for their own suicide while incarcerated. That is, in the case of self-injurious behaviour, can a jailer be relieved of its duty of care given the special relationship between a jailer and a prisoner? The Court said logic would fail if jailers owed a duty of care but could then abrogate that duty when it failed (through either deliberate or negligent acts) to protect its prisoners from their own acts. The opinion states that suicides in prisons are reasonably foreseeable due simply to their frequency. It is this foreseeability that sheets home liability to the jailer for failing to protect a prisoner from that danger.

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[313] See discussion of compliance with the Nelson Mandela Rules in Part II of this paper and the use of ISUs in Part I.

[314] *Littleton v Serco* [2017] NZAR 1580 (HC) at [10].

[315] *New South Wales v Napier* [2002] NSWCA 402 at [75]; *Ellis v Home Office* [1953] 2 ALL ER 149 (CA) at 154; *Bujdoso v New South Wales* [2004] NSWCA 307 at [45].

[316] *Nicholas Paul Alfred Reekie v Attorney-general* [2019] NZHC 1679 at [86].

[317] At [89].

[318] *Gregoire v City of Oak Harbor*, 244 P.3d 924 (Wash. 2010) (SC Washington).

[319] Himani Ghoge and Melvin Guyer "Jailer's Special Duty of Care in Inmate's Suicide Negligence-Based Claims" (2012) 40(4) The Journal of the American Academy of Psychaitry and the Law 579 at 580.

Although the Court in *Gregoire* was faced with a penal environment that imposed considerable legislative obligations on the corrections authorities, it not only found a special duty sat comfortably alongside that, but the duty was armed with enough teeth as to impose a responsibility to protect mentally ill prisoners from their own actions. Complying with its duties under a statutory regime is simply a minimum standard. The same should apply in Aotearoa. When Ray Smith, the Chief Executive of Corrections at the time, said "our duty of care is as strong as our call to action"[320] it appears the "duty of care" is not really what it could or should be. In fact, given the opportunity in a courtroom, the response from Corrections as to whether a duty of care even exists is to turn to the legislatively imposed obligations and meet only the bare minimum.

Corrections holds the lives of thousands of people in its hands. Those people have no autonomy of choice or freedom to select health care provider or type of treatment. This imbalance cannot be mitigated effectively by the current legislative landscape alone.

C Transferring Responsibility for Primary Health Care

As noted in Part I, it appears Corrections intends to retain its role as the primary health care provider rather than transfer responsibility to the Ministry of Health. Its Director of Offender Health stated:[321]

> There is no empirical evidence or international example that demonstrates that a change in the service delivery model would significantly improve health outcomes for prisoners. In addition, there are substantial benefits that derive from health services being delivered by the department – all staff share a common goal of contributing to a goal of reducing reoffending by 25 per cent.

Firstly, why *significant* improvements in health outcomes are required before Corrections will consider change is a worthwhile question. Improvement in and of itself is surely a goal worth pursuing. Even a 10% improvement, although by no means "significant", would be a moral imperative if considered from a purely clinical point of view. The refusal to make any change,

[320] Department of Corrections, above n 6, at 4.

[321] Ratcliffe, above n 76.

unless significantly improved outcomes can be evidenced, is indicative of a custodial management approach rather than a medically informed one. Additionally, there is considerable evidence improvements are both real and measurable in terms of international practice.[322]

Secondly, there is no evidence of "substantial" benefits in Corrections retaining responsibility. There has not been any academic research supporting this claim and, in terms of grey literature, there is considerable commentary pointing out failings in the mental health system prisoners experience. The "substantial benefit" identified is that "all staff share a common goal of reducing reoffending by 25%." Expecting medical staff to consider anything more than the optimal treatment of the patients before them is a serious and worrying conflict of interest that should not be tolerated.

Aotearoa needs to follow the path of England and Wales and shift responsibility for primary health care from Corrections to the Ministry of Health. A funding model that reflects the needs and complexity of prisoners is required, but the benefits outweigh the costs. Continuity of care will improve, as will equivalence of treatment … until a progressive move to an Equivalence of Outcomes model moves mental health care into a brighter future.

D Delineate "Rehabilitation" and "Treatment"

As described earlier in this paper, the conflation of the terms *treatment* and *rehabilitation* muddies already murky water swirling around prisons. These terms need clarification and definition from the legislature itself. A more refined terminology would assist the courts which, in turn, would send a message to Corrections that obligations under s 75 of the Act are wide-ranging, non-discretionary and non-delegable. This paper asserts that, in general, Corrections tends towards a minimalist response in terms of mental health provision. If the Ministry of Health was the primary health provider for prisoners, this misunderstanding of terms would not occur – the Act itself would be changed by simply removing s 75 and an "equivalence of care" section added to the NZPHDA (and possibly the Health Act 1956). The discussion as to whether Aotearoa adopts an Equivalence of Outcome model over a "reasonable equivalence" of care schema would be worthwhile and needed.

[322] See Part III, in particular England and Wales.

E Conclusion

> "When deviation from the principle of equivalence occurs, the tendency must always be to exceed community standards, and never to fall short of them."[323]

It appears prisons cannot offer the same level of care as a hospital and, as David Scott said, the "quest for equivalence remains only a forlorn hope."[324] This dissertation attempted to answer the question of how, and to what extent, Corrections is upholding its legal obligations to provide equitable mental healthcare to prisoners in Aotearoa. Its conclusion is that, despite some valiant efforts, Corrections is a victim of its own existence. The requirement to ensure the secure containment of prisoners (and the consequent operational constraints that implies) means Corrections should step back from also attempting to be a primary health care provider. Its insistence that not only would improvements be unlikely if the Ministry of Health assumed responsibility, but that the status quo offers prisoners a substantial benefit, is indicative of misplaced hubris and a blinkered approach that has cost lives. The mental health system, although not perfect for those living in the community, is not improved for prisoners by being provided by Corrections.

The development and adoption of *Hōkai Rangi*, while laudable in terms of rhetoric, is yet to be reflected in the day-to-day realities of prison. Although a focus on whānau was promoted as a strategic priority, there is no evidence of that being any more than a mere consideration when operational decisions are being made. Connections with whānau are vital for mental health and yet, at the time of writing, thousands of prisoners in Aotearoa have not had contact visits for over 18 months – a direct result of operational objectives trumping *Hōkai Rangi*.

The "reasonable equivalence" model of care provision is failing prisoners, and ultimately falling short of both public health objectives and human rights duties. Unfortunately, this failing is not seen until after prisoners are released and too often the outcome is tragic. The call for a higher standard of health care may seem futile, however needed. In a context of political populism that sees prisoners regularly stigmatised and demonised, such moves may be difficult

[323] Niveau, above n 2100, at 612.

[324] David Scott and Helen Codd *Controversial issues in prisons* (Open University Press, Berkshire, England, 2010) at 33.

but the rights and needs of those imprisoned should not be abrogated or dictated to by apathy or hostility.

Moving to a needs-based “Equivalence of Outcome” model is a key to a reformation which is not only needed, but overdue.

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