Monitoring Places of Detention

Annual report of activities under the Optional Protocol to the Convention against Torture (OPCAT)

1 July 2014 to 30 June 2015

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Foreword

During the current reporting period the safety and wellbeing of detained individuals has been the subject of significant public discussion and debate. Media reports have highlighted allegations of violence and mismanagement at the privately managed Mt Eden Correctional Facility. These allegations include complaints about serious physical and sexual violence. Concerns about the welfare of children in the care of the State have been raised by the Children's Commissioner, as has the general inability of many of these children to fulfil their potential when they leave State care.

Complaints and claims from those who were mistreated in government-run health, education and care institutions during the latter part of last century have also left an enduring impression on many of us.[1] It is clear from the information provided by these victims of historical abuse that inadequate and abusive detention settings can cause life-long damage that has a severe impact, not just on detainees but on those around them.

These examples illustrate why the agencies charged with monitoring detention facilities in New Zealand cannot be complacent. Although many of the more extreme examples of torture and abuse that occur overseas are not generally seen in New Zealand, significant issues still arise and need to be addressed if we are to comply with international standards and the general expectations of a humane society.

Five agencies are tasked with monitoring New Zealand's compliance with the United Nation's Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).[2] Four agencies are designated National Preventive Mechanisms (NPMs) with a monitoring mandate: The Independent Police Conduct Authority, the Inspector of Service Penal Establishments, the Office of the Children's Commissioner, and the Office of the Ombudsman. The Human Rights Commission is the Central NPM (CNPM) with coordinating responsibilities. Collectively the four NPMs and CNPM are referred to in this report as the National Preventive Mechanism.

Since 2007 the National Preventive Mechanism has provided a system of independent monitoring. The National Preventive Mechanism and the individual agencies that comprise it make recommendations to detaining agencies to strengthen human rights protections and improve conditions of detention and sector capability according to international human rights standards. Further to its preventive monitoring work, the National Preventive Mechanism seeks to contribute to developing a culture where the rights of all persons deprived of their liberty are protected and respected.

1 See Human Rights Commission, 2015, New Zealand's 6th periodic review under the Convention Against Torture: Submission of the New Zealand Human Rights Commission, p.57ff.

2 This report uses the generic term 'ill-treatment' to refer to any form of cruel, inhuman or degrading treatment or punishment.

During their monitoring activities in the reporting period NPMs have not identified any incidents of torture. However, as in previous years, NPMs have observed certain circumstances and systemic shortcomings that potentially can and occasionally do subject detained persons to practices that according to international standards can be considered tantamount to ill-treatment.

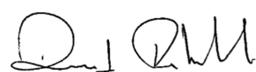
NPMs continue to identify gaps and put forward recommendations to implement progressive improvements in New Zealand's detention facilities. This work is informed by cross-sector dialogue with detaining agencies, civil society and international partners.

The United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) visited New Zealand in April 2013 and the Government published the SPT's findings in 2014. The United Nations Working Group on Arbitrary Detention, and United Nations Treaty Bodies such as the Committee against Torture and the Committee on the Rights of Persons with Disabilities, also continue to provide invaluable guidance on improving the conditions of some of New Zealand's most vulnerable population groups.

These international monitoring bodies have confirmed the National Preventive Mechanism's observation that managing people with high and complex mental health and addiction needs is a key area of concern in New Zealand's detention context. A disproportionate number of people with high and complex needs continue to be subjected to detention practices that can amount to ill-treatment.

The National Preventive Mechanism has therefore decided to focus the second part of its 2014/15 annual report on mental health in detention and the implications of inadequate or unsuitable management of people with high and complex needs for those detained. Although some of these issues cannot be addressed in the short term, an ongoing and more strategic cross-sector approach is needed along with joined-up service delivery to progressively improve conditions and prevent ill-treatment.

This thematic focus will continue to guide the National Preventive Mechanism's public reporting in the future. A number of priority areas require focussed attention and resources to bring about substantive change. Action is required to ensure that all detainees are afforded basic protections to keep them safe and to provide them with the best possible opportunities once they leave the detention setting. It is in the interests of all members of our community that this occurs.



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Chair, Independent Police Conduct Authority

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Inspector of Service Penal Establishments, Office of the Judge Advocate General

Dr Russell Wills
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Dame Beverly Wakem
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Section 1: Overview of NPM Activities

Human Rights Commission
Te Kāhui Tika Tangata

The Crimes of Torture Act 1989 designates the Human Rights Commission (HRC) as the Central National Preventive Mechanism (CNPM).

The HRC is an independent Crown Entity under the Crown Entities Act 2004, with a wide range of functions under the Human Rights Act 1993. One of the HRC's primary functions is to advocate and promote respect for, and an understanding and appreciation of, human rights in New Zealand society. The HRC's Central National Preventive Mechanism (CNPM) role entails coordinating with National Preventive Mechanisms (NPMs), identifying systemic issues, and liaising with government and the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT).

The HRC's functions may be undertaken through a range of activities including advocacy, coordination of human rights programmes and projects, carrying out inquiries, making public statements, and reporting to the Prime Minister on any matter affecting human rights. This reporting includes the desirability of legislative, administrative or other action to better realise and protect human rights. The HRC also administers a dispute resolution process for complaints about unlawful discrimination.

Commissioners are appointed by the Governor-General, on the advice of the Minister of Justice, for a term of up to five years.

Overview

The fundamental premise of OPCAT is based on international evidence highlighting the deterrent and preventive effect of independent monitoring and oversight.

The HRC's role as CNPM is established under sections 31–32 of the Crimes of Torture Act 1989 (COTA). COTA outlines, in general terms, the coordination role played by the CNPM. Following the definition of the HRC's job description in 2012/13, the HRC and NPMs further specified the scope and nature of the CNPM's functions in accordance with its statutory obligations. Accordingly, the CNPM's responsibilities include:

1. Consulting and liaising with NPMs and coordinating the activities of the National Preventive Mechanism, including:
   - facilitating meetings of the National Preventive Mechanism
   - meeting with international bodies
   - making joint submissions to international treaty bodies
   - providing communications and reporting/ advocacy opportunities
2. Providing human rights expert advice
3. Maintaining effective liaison with the SPT
4. Coordinating the submission of annual reports prepared by NPMs to the SPT
5. Reviewing annual reports prepared by NPMs to advise them of any systemic issues arising from those reports and, in consultation with NPMs, making recommendations to government on systemic issues arising from NPMs' reports through media releases and thematic reports or briefing papers
6. Coordinating and facilitating engagements with international human rights bodies and civil society consistent with the HRC's broader mandate under the Human Rights Act 1993 s5(1) to "promote respect for, and an understanding and appreciation of, human rights in New Zealand society"
7. Assisting with monitoring when and where requested by NPMs.

Summary of Activities

Two international monitoring bodies visited New Zealand in the two previous reporting periods (2012/13 and 2013/14). The findings and recommendations of the SPT, which visited New Zealand in April/May 2013, and those of the United Nations Working Group on Arbitrary Detention (WGAD), which visited New Zealand in March/April 2014, strongly informed strategic planning throughout the reporting period and will continue to do so. These findings and recommendations confirm many of the concerns identified by the National Preventive Mechanism to date. In particular, they have reiterated the need to make progress on some of the key issues that the National Preventive Mechanism has repeatedly raised since taking up OPCAT responsibilities in 2007, such as the detention of people with mental illness and the disproportionately high rate of Māori in detention.

Facilitating NPM meetings

The HRC convened four roundtable meetings of the National Preventive Mechanism during the reporting period to share information and discuss key issues. Two meetings focused on strategic questions about the role of the CNPM and the communications strategy of the National Preventive Mechanism. The thematic focus of this annual report is one outcome of an ongoing discussion to maximise the advocacy work of the National Preventive Mechanism and highlight key areas of concern.

One meeting provided an opportunity for the National Preventive Mechanism to explore perspectives, common concerns, and future opportunities for dialogue with several civil society organisations. Key issues raised included the status of volunteer support to detainees in Department of Corrections (Corrections) facilities and of independent research in the Corrections system. It was acknowledged that the lived experience of detained persons is as relevant in an OPCAT monitoring context as in other areas where the human rights of vulnerable groups are at risk.

The last meeting of the reporting period brought together the National Preventive Mechanism and all detaining agencies for the first time since the establishment of the mechanism in 2007. The purpose of the meeting was to consider key issues agencies and the National Preventive Mechanism could collaboratively address within the context of implementing recommendations made in the various United Nations processes to date.

Priorities for follow-up action include developing a coordinated approach to monitoring the government's implementation of recommendations by national and international monitoring bodies, to be led by the Ministry of Justice, and improving the way services are delivered to detained persons with high and complex needs, in particular children, young people, and people with psychosocial disabilities.

Joint submissions to international treaty bodies

In February 2015 the HRC coordinated a joint submission by the National Preventive Mechanism to New Zealand's 6th periodic review under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). The submission was based on the work that had been undertaken by the NPMs to date. It was presented according to thematic issues identified by individual NPMs, in keeping with their mandate and function, as well as the overarching issues that had been raised by the SPT and the WGAD

A strong foundation upon which to hold the government accountable and realise and protect the human rights of New Zealand's most vulnerable population groups can be built by having a more integrated approach to international treaty body reporting. Such reporting can identify common concerns across relevant international human rights treaties such as CAT, the Convention on the Rights of Persons with Disabilities (CRPD), the International Covenant for Civil and Political Rights (ICCPR), as well as the Universal Periodic Review (UPR).

Briefing to the Incoming Minister of Justice

In October 2014 the HRC facilitated a joint Briefing by the National Preventive Mechanism to the Incoming Minister of Justice. The two priorities highlighted for the next three-year period were resourcing of NPMs, raised previously on several occasions both by NPMs

and by international monitoring bodies, and the gap in monitoring aged care and dementia facilities, which was also noted in the 2013/14 annual report and is discussed below.

Torture Prevention Ambassador Project

This project, facilitated by the Association for the Prevention of Torture (APT) and funded by the European Union, addresses the gap in preventive monitoring identified in the 2013/14 annual report. The project seeks to analyse the range of service standards, auditing requirements, and complaints mechanisms of locked aged care facilities and community based care residences and homes for older people. Based on the premise that inadequate independent oversight can result in ill-treatment for people living in these situations, the project's goal is to develop a better understanding of the benefits of preventive monitoring so potential risks are identified effectively and responded to in a manner appropriate to the needs of the person concerned. The project is underway, and is scheduled to be completed by 30 June 2016.

Engagements with international human rights bodies

Following a request from the APT the HRC facilitated feedback by the National Preventive Mechanism in preparation for the Jean-Jacques Gautier NPM Symposium on "Addressing vulnerabilities of LGBT persons in detention", held in Geneva, Switzerland, in June 2015 and organised by the APT. The outcome report can be accessed on the APT's website (www.apt.ch). In March/April an HRC staff member participated in a pilot regional blended-learning course on "Investigating and Documenting Allegations of Torture", organised by the Asia Pacific Forum and the APT.

In response to a request from the Netherlands Institute for Human Rights, which is developing a monitoring mechanism under the OPCAT, the HRC shared the New Zealand experience of operating within a multi-body NPM model. In December 2014 the HRC presented on New Zealand's OPCAT experience and lessons learned at the conference "Human Rights in the Pacific: Priorities, Practice and Sustainability", held at Massey University, Auckland. The HRC further presented on New Zealand's OPCAT experience at the International Conference for National Human Rights Institutions in Turkey in June 2015, in a session shared with Germany's National Agency for the Prevention of Torture, an NPM separate from Germany's National Human Rights Institute, and Poland's NPM, the Office of the Human Rights Defender.

Going forward

In the 2015/16 reporting period the HRC will work on making progress with NPMs on the priority area of mental health in detention. It will also put further focus on high and complex needs for people with other forms of disability. As part of these efforts the HRC will facilitate a joint project with the NPMs to assess the current use of seclusion and restraint in detention. These practices can disproportionately affect detained persons with mental disorders and psychosocial disabilities and can have a detrimental impact on people who are already vulnerable.

The HRC will further seek to improve the monitoring of progress towards implementing OPCAT-relevant recommendations made by national and international monitoring bodies. The National Plan of Action for Human Rights, facilitated by the HRC and launched in June 2015, already provides a platform for monitoring the government's progress on a wide range of human rights-relevant government programmes.[3] This platform will eventually be expanded to include, among others, the monitoring of government actions designed to improve the management of New Zealand's detention facilities.

3 See http://npa.hrc.co.nz/#.

Independent Police Conduct Authority

Whaia te pono, kia puawai ko te tika

The Independent Police Conduct Authority (IPCA) is the designated National Preventive Mechanism (NPM) for people held in police cells and otherwise in the custody of the police. The IPCA is an independent Crown entity, which exists to ensure and maintain public confidence in the New Zealand Police (Police).

The IPCA does this by considering and, if it deems necessary, investigating public complaints against police of alleged misconduct or neglect of duty. It also assesses police compliance with relevant policies, procedures, and practices in these instances.

The Commissioner of Police also notifies the IPCA of all incidents involving police where death or serious bodily harm has occurred. The IPCA may investigate those incidents and other matters involving police policy, practice, and procedure where it is satisfied that it is in the public interest to do so.

In addition, the IPCA has entered into a Memorandum of Understanding with Police under which the Commissioner of Police may notify the IPCA of incidents involving offending or serious misconduct by a police employee, where that matter is of such significance or public interest that it places or is likely to place the police reputation at risk. The IPCA may act on these notifications in the same manner as a complaint.

Judge Sir David Carruthers is the Chair of the IPCA, having been appointed for a five-year term in April 2012.

Overview

In all of its work the IPCA is intent on shifting its general focus from one of blame to one of prevention. This philosophical shift has informed the way in which the IPCA has fulfilled its OPCAT function in this reporting year and it will continue to do so.

The IPCA's OPCAT-related work has two aspects. The first involves considering the quality and nature of police custodial facilities. The second concerns operating and managing those facilities and also other places in which custodial management is the responsibility of the police.

Police operate 437 custodial management facilities nationwide. The majority of these are cell blocks at police stations. In addition, however, police have responsibility for prisoners in District Courts. Although Police is not responsible for building Court cells, which are the responsibility of the Ministry of Justice, it is clear that the IPCA acting under its OPCAT jurisdiction has responsibility for monitoring the quality and nature of these cells.

Summary of activities

Development of National Standards

Last year the IPCA reported that it had been working closely with Police to develop National Standards for police custodial management. Those Standards are designed to cover both the physical infrastructure and the daily management and care of detainees.

This work continued during this reporting period, albeit more slowly than had been expected. There were two reasons for the IPCA's failure to complete this work within the expected time frames. First, developing National Standards was a large and complex project, involving examining a wide range of custodial management issues and models, and requiring regular lengthy meetings over a period of almost six months. Secondly, the IPCA's limited resources and the competing demands of complaints and investigations affected the extent to which staff time could be devoted to the project.

However, the IPCA is pleased to report that by year ended 30 June 2015 the Standards governing the

management and care of prisoners were completed in draft form, and have subsequently been adopted by the Police Executive as a new "People in Police Detention" policy. It is expected that during the 2015/16 financial year the Standards governing cell design and detail will also be completed.

The intention is that police will report on their own compliance with these Standards on both a national and District-by-District basis, and report to the IPCA annually. The IPCA also intends to periodically undertake an audit of those reports. The nature of, and process for, undertaking these reports and audits are being worked on and will be agreed with the Police by 31 December 2015.

The reporting and auditing process will enable areas where capital expenditure is required to be identified and prioritised. It will also enable the systematic identification of custodial facilities where management and care is falling below the required standard, and of policies and procedures that require refinement or change.

Site visits

Where possible during the reporting year, the IPCA has visited police custodial facilities in the course of its ordinary work. Where an incident requiring investigation comes to the attention of the IPCA, staff often visit the facility to discuss the issues with custodial staff. In addition, the IPCA takes the opportunity to make unannounced visits at custodial facilities when it is visiting a Police District for other reasons. This has occurred in a number of places throughout the year, notably Christchurch, Rotorua, Manukau, Auckland, Waitakere, and Nelson.

Issues

Oversight of police custodial management

Through the fulfilment of its statutory role in investigating complaints against the police and incidents involving death or serious injury that arise from police action, the IPCA is able to identify and address both individual instances where police officers have failed to perform their duty of care and broader systemic issues with police custodial management.

During the reporting year the IPCA received 2515 complaints and referrals, compared to 2193 complaints and referrals in the previous year. This increase put added pressure on the IPCA's operational resources. Over the past 12 months it has been difficult to achieve outcomes within the time-frames that have been set in the Statement of Performance Expectations. The IPCA is working with Police to develop a process that will enable more effective and timely outcomes and this work will continue.

Of the 2515 complaints and referrals, 165 were identified as having OPCAT-related issues. Many of these cases, and others that had come to the notice of the IPCA in earlier years, exposed systemic issues that needed to be addressed by changes in policy or procedure in custodial facilities. The IPCA also applies an OPCAT perspective to its independent investigations and reviews. Although independent investigations and reviews are a separate statutory function of the IPCA, the human rights principles and standards applied in the OPCAT context are equally relevant to the IPCA's general oversight role.

As a result, and as is discussed in more detail in Section 2 of this report, in March 2015 the IPCA issued a report on police custodial management.[4] The report brought together 31 different complaints about police conduct and the way in which police cells are managed throughout the country. That report set out in some detail the difficulties experienced by police custodial staff in assessing the risk that prisoners may harm themselves and in taking appropriate steps to mitigate that risk. It also drew attention to their lack of expertise and training in dealing with many of those who are brought into police custody, particularly those who are intoxicated or experience mental distress.

At about the same time, the IPCA published a report on the death of Sentry Taitoko exposing many deficiencies in police custodial practice that resulted in a failure to take effective action to prevent his death.[5]

4 IPCA 2015, Review of Police Custodial Management.

5 IPCA, 2015, Death in Police custody of Sentry Taitoko.

Both these reports have prompted significant changes to practice, both at the District level and nationally. A number of these were incorporated into the "People in Police Detention" policy. Others are still under development, including developing a structured risk assessment tool for custodial staff.

The IPCA also undertook two other significant pieces of work.

The first of these arose from an increase in the number of remand prisoners being held in police custody because the Department of Corrections (Corrections) system was under pressure, particularly in the upper North Island. The IPCA visited the relevant Police Districts to observe the problem and discuss the issues first hand. It then met with police and others to ensure that police established and adhered to strict limits on the number of remand prisoners being held in each facility and the maximum length of their detention, so that the safety of prisoners and their right to be detained in humane conditions was maintained.

The IPCA expresses its appreciation to police for their immediate response to the IPCA's concerns and for their cooperation in setting and maintaining proper safety standards.

From time to time remand numbers exceed those planned for by the Corrections (prison) system and police facilities are viewed as an emergency way of dealing with them. However, the IPCA is firmly of the view that safety levels have to be observed at all times and police ought not to be custodians of last resort when such emergencies arise.

The second issue arose from the death of a prisoner in the Papakura Court cells, which highlighted the substandard physical conditions of many court cells throughout the country. It became clear to the IPCA that this was posing an ongoing risk to the safety and wellbeing of prisoners and needed to be urgently addressed.

As a result, the IPCA initiated discussions with the Ministry of Justice, which has audited all cells according to criteria agreed with the IPCA. Work is continuing on developing a prioritised programme of work to address the deficiencies identified through this audit.

Going forward

As noted above, the IPCA has three priorities over the coming months. First, it will be working with the Police to finalise the review of the Accommodation Code, and to develop a systematic programme to monitor and audit compliance with the "People in Police Detention" policy. The monitoring and audit programme will involve extracting data from the police computer system to enable a District-by-District analysis of statistical trends – periodic audit of electronic custody documentation in individual cases – and periodic visits to District custodial facilities.

Secondly, it will be continuing to maintain close oversight of the audit of all Court cells by the Ministry of Justice, and will work with the Ministry to ensure a programme of work to address the manifest deficiencies in current facilities is urgently progressed.

Thirdly, it will continue to have discussions with the Police and the Ministry of Health, so that it is the exception rather than the rule that those who come to police attention because they are experiencing a mental health crisis are detained in police cells awaiting assessment. The present position is neither humane nor caring, and the IPCA is committed to facilitating necessary changes to policy and practice.

Inspector of Service Penal Establishments

The Inspector of Service Penal Establishments (ISPE) is the National Preventive Mechanism (NPM) charged with monitoring New Zealand Defence Force (NZDF) detention facilities.

The appointment of the ISPE is tied to the appointment of the Registrar of the Court Martial of New Zealand, an official appointed independently by the Chief Judge of that jurisdiction by the provisions of sections 79(1) and 80 of the Court Martial Act 2007.

Overview

The Services Corrective Establishment (SCE) is located in Burnham Military Camp, Christchurch. SCE is currently the only place where the formal punishment of service detention is carried out for members of the Armed Forces, as prescribed in the Armed Forces Discipline Act 1971. The punishment can only be used for naval ratings of able rank, Army privates, and Royal New Zealand Air Force leading aircraftmen, that is Private soldier equivalents.

In addition, each of the more significant NZDF base or camp facilities has a limited number of holding cells, used to briefly confine any members of the Armed Forces for their own protection or for the maintenance of good order and military discipline.

Although no detention facilities off-shore are currently available to the NZDF on New Zealand Navy Ships, they can be arranged relatively readily when required as the Armed Forces Discipline Act section 175(1) permits the Chief of Defence Force from time to time to:

- set aside any building or part of a building as a service prison or a detention quarter; or
- declare any place or ship, or part of any place or ship, to be a service prison or detention quarter.

The ISPE has no staff, but is able to second assistance if required in order to meet the OPCAT objectives of ensuring that all members of the Armed Forces deprived of their liberty are treated with humanity and respect, and not subjected to torture or ill-treatment.

SCE is a fairly modern but small detention facility that can cater for up to eight male and two female detainees at any one time. It has a professional full-time staff of Non Commissioned Officer wardens drawn from all three Armed Services. They are supported by the Commanding Officer of the Southern Regional Support Centre (SRSC) in Burnham Camp, who holds a dual appointment that includes the position of Commandant SCE in their job description. The SRSC has a medical officer on call to SCE and on the rare occasions when detainees require specialist treatment, referral to relevant health professionals in Christchurch is readily arranged.

ISPE arrives unannounced at the reception office of SCE and meets with the Chief Warden before reviewing the documentation and inspecting the facilities. Each detainee is interviewed individually and in private. Feedback is provided routinely at the conclusion of the inspection to the Commandant of SCE and to the Chief Warden. Any significant concern identified is reported in writing, without delay, directly to the Chief of Defence Force.

Summary of activities

Just two of the eight permitted inspections were conducted by the ISPE in the reporting period. Thirty-one detainees served sentences at SCE during the reporting period, which is one of the lowest occupancy rates in 15 years. One member of the Armed Forces was sentenced to three months' detention by the Court Martial of New Zealand during this period. The other 30 detainees were sentenced by their commanders at Summary Proceedings hearings, where the power of punishment is limited to a maximum of 28 days detention. The average length of detention at SCE over this reporting period was 18 days.

SCE was independently inspected in March 2014 by the United Nations Working Group on Arbitrary Detention (WGAD) as part of a wider inspection of New Zealand's detention facilities. Although this inspection by WGAD occurred outside the current reporting period, its report has only recently been circulated. Other than acknowledging the inspection of SCE took place, no further mention is made of SCE in the fairly comprehensive report, and there is certainly no criticism of the way it was run. This may reflect that this specialist UN monitoring team had no issues with SCE and supported the favourable comments made about the facility and its management by the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) about 12 months earlier.

Issues

It is important that places of detention in the New Zealand Armed Forces continue to be monitored, as OPCAT is based on the premise that regular independent visits to places of detention are an effective means of preventing torture and ill-treatment.

That said, it is equally important to put detention as a punishment in the New Zealand Armed Forces into some context in relation to the detention monitored in New Zealand by the other NPMs It is a markedly different environment.

An Armed Forces detainee who undergoes the military punishment of detention at SCE is still a soldier, sailor, or airman and on half pay while serving the sentence. He or she had been a trained and disciplined member of the Armed Forces before being convicted, so the role of SCE, apart from a custodial punishment, is to retrain and return those under punishment to their unit as better members of the Armed Forces.

Retraining is fairly fundamental, immediate, and not optional. Corrective training centres on maintaining discipline through physical training, drill on the parade ground, work details, and equipment husbandry. While detainees have no freedom of movement, are locked down at night, and closely supervised at all times, they are gainfully employed outside their cell environment for most of the day.

SCE is not a place members of the Armed Forces want to return to. Recidivism is not an issue, with just one detainee during this reporting period serving a second committal.

Every detainee is inspected by a Medical Officer on arrival in Burnham Military Camp and before undergoing any punishment at SCE. It is then that any temporary or permanent physical limitations might be imposed on the detainee and that any mental health issues are identified and acted upon. Inspection certificates have a review period, unless the nature of the illness of injury is unlikely to change for the complete time of the sentence. As part of induction each detainee is also interviewed by the Commandant of SCE in the first 24 hours of arrival and a "Visiting Officer" regularly calls at the facility and speaks privately with detainees.

SCE is staffed to cope with up to 10 detainees at any one time on a 24-hour basis although the reality, especially in recent years, is an occupancy rate far lower than this. Consequently, there is a close and regular interaction between all detainees and Burnham Camp medical staff, SCE leadership, and wardens. Any issues a detainee may be having on arrival at SCE or might be developing while undergoing punishment are quickly identified and acted upon.

In considering the thematic focus in the second part of this annual report, there is no doubt that mental health issues are recognised in the Armed Forces generally as a serious concern, and steps to support management of these issues were widely circulated recently by the Chief of Defence Force. This includes an after-hours 0800 telephone number linking Defence Force personnel and their families to a free and confidential external health service provider to discuss any concerns, including mental illnesses and substance abuse problems

There is no evidence to suggest that SCE has particular concerns with mental health issues. Indeed, given the level of support available to detainees, that group is arguably in a better place to have

their mental health needs met than a serviceman or servicewoman living in the community without the same close support at hand.

Going forward

Occasionally, for their own protection or the safety of others, members of the Armed Forces are arrested and confined briefly in Camp, Base, or Ship cell facilities and then released when those responsible for ordering the confinement are satisfied that it is safe to do so. Such confinements are usually under 12 hours' duration but infrequently can extend to two or three days. These people are "detained" by definition, but not serving a punishment of "detention" per se. Many of the cell facilities used for this purpose are substandard and the quality of care provided to the members of the Armed Forces confined under these circumstances is mixed. This category of cell facility is a potential vulnerability for the NZDF and is something the ISPE intends to address during the next reporting period.

The NZDF has recently reviewed the command and management of SCE and announced that in December 2015 it will transfer its management from the Southern Regional Support Centre in Burnham Military Camp to the NZDF Military Police. As a matter of international best practice, detention and corrective establishments are almost never run by police forces. This is because it is important to keep those responsible for detecting crime and enforcing the law quite separate from those responsible for dealing with offenders. That said, among many states similar to our own, SCEs seem to be an exception to this rule. In reaching this decision, the NZDF is following the lead of the USA, UK, Canada and Australia.

At the time of reporting insufficient detail is available about the new management structure at SCE to confirm whether or not the changes will generate any OPCAT concerns. The ISPE will continue to monitor this facility closely to ensure ongoing compliance with the OPCAT.

Office of the Children's Commissioner
Manaakitia A Tātou Tamariki

The Children's Commissioner is a designated National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989.

In this role, the Office of the Children's Commissioner (OCC) has responsibility for monitoring places of detention for children and young people to ensure compliance with OPCAT. The OCC has a range of statutory powers to promote the rights and wellbeing of children and young people up to 18 years of age.

The OCC also has a broader monitoring function. The OCC is an independent Crown entity appointed by the Governor-General and operating under the Children's Commissioner Act 2003. In this role, the OCC monitors activities under the Children, Young Persons and Their Families Act 1989 (CYPFA), including the policies and practices of Child, Youth and Family (CYF); undertakes systemic advocacy functions; and investigates particular issues with potential to threaten the health, safety, or wellbeing of children and young people.

Overview

The Children's Commissioner's OPCAT role under the Crimes of Torture Act overlaps with his general monitoring function under the Children's Commissioner Act, both of which involve regularly monitoring CYF residences.

The OCC currently monitors four care and protection residences and four youth justice residences managed by CYF, and one care and protection residence for young people with harmful sexual behaviour, managed by a non-government organisation, Barnardos. The OCC also monitors three Mothers with Babies Units (MBUs) within prisons, operated by the Department of Corrections (Corrections). The Office of the Ombudsman (the Ombudsmen) has responsibility for monitoring youth units within prisons and mental health facilities for children and young people. The Independent Police Conduct Authority (IPCA) has responsibility for monitoring police cells where young people may be held.

The OCC's monitoring visits to MBUs are conducted jointly with the Ombudsmen. The OCC focuses on the wellbeing and treatment of babies in the MBU, while the Ombudsmen monitor the wider prison environment from the perspective of the wellbeing and treatment of prisoners.

Summary of activities

Monitoring approach

Over the past year, the OCC has continued to use an organisational development and system performance approach to its OPCAT monitoring, in line with its general monitoring function. This has involved assessing residences' compliance with OPCAT conditions within a wider evaluation of factors such as their leadership, culture, operational management, quality of social work practice (including staff capability), and strength of partnerships and networks. Consideration of these broader domains enables the OCC to better understand the environment, conditions, and care for children and young people and the extent to which the treatment of children and young people is focused on enhancing their wellbeing and rights.

A significant achievement in the past year was the production of the OCC's first public aggregated report. The report summarised the key findings from both its OPCAT and general monitoring work, and was published at a time when CYF was undergoing a major review of its operating model. The aggregated report informed the public and key stakeholders about CYF's strengths and identified areas for development.

The OCC has also completed a substantial revision of the evaluative rubric that underpins its general monitoring approach. The rubric is an evaluation tool that defines standards of practice across the general domains the OCC monitors using a five-point scale. The points on the scale are 'transformational', 'well placed', 'developing', 'minimally effective', and 'detrimental' (see Table 1). Use of the rubric and its associated rating scale enables OCC to be transparent in its monitoring of CYF's performance, and provides CYF with clear information about what it needs to do to improve its ratings. The revised rubric includes more content about best practice in residences and prioritises both the voices of children and young people and responsiveness to Māori, to assess how well CYF is improving outcomes for children and young people.[6]

To enhance the OCC's OPCAT monitoring and better align it with our general monitoring approach, the OCC moved from rating OPCAT domains on a three-point scale to using the five-point scale used for our general monitoring. This has enabled the OCC to provide a more nuanced, finely graded assessment of facilities' achievements in each OPCAT domain. To understand whether a facility has met its basic OPCAT obligations, ratings of 'transformational', 'well placed' and 'developing' indicate a facility is compliant with the standard required for the relevant OPCAT domain, while ratings of 'minimally effective' or 'detrimental' indicate a facility is non-compliant with an OPCAT domain.

Table 1: Guide to the ratings provided for each domain

Rating	Assessment	What it means	Compliant with OPCAT
	Transformational/ outstanding	Exceptional, outstanding, innovative, out of the norm	Yes
	Well placed	Strong performance, strong capability, consistent practice	Yes
	Developing	Some awareness of areas needing improvement; some actions to address weaknesses, but inconsistent practice; pockets of good practice	Yes
	Minimally effective/weak	Low awareness of areas needing improvement; lack of action to address weaknesses; significant concerns exist	No
	Detrimental	Actively causing harm, negligent, ignoring, rejecting, undervaluing, undermining practice	No

6 The rubric is available on the Children's Commission's website at: http://www.occ.org.nz/assets/Publications/Living-evaluative-rubric.pdf.

NPM monitoring visits

Between July 2014 and June 2015 the OCC assessed seven facilities: four youth justice residences, two care and protection residences, and one MBU. Four of these visits were unannounced, as shown in Table 2.

Table 2: Facilities visited by the OCC in 2014-15

Name of facility	Type of facility
Korowai Manaaki	Youth Justice residence
Te Maioha o Parekarangi	Youth Justice residence
Te Poutama Ārahi Rangatahi	Care and Protection residence
Puketai (unannounced)	Care and Protection residence
Te Puna Wai o Tuhinapo (unannounced)	Youth Justice residence
Te Au Rere a te Tonga (unannounced)	Youth Justice residence
Christchurch Women's Prison (unannounced)	Mother with Baby Unit

Issues

Key OPCAT findings

Facilities compliant with OPCAT

The OCC's ratings for all facilities visited in 2014–15 are shown in Table 3. Five of the seven facilities monitored by the OCC received an overall OPCAT rating of well placed (two with developing elements and one with transformational elements), and the other two received a rating of developing, indicating that residences and MBUs in New Zealand are compliant with OPCAT conditions. The OCC found no evidence of intentional cruelty and no incidents of torture in any of the facilities. In general, children and young people in New Zealand residences have their rights upheld. They are usually treated well, understand the complaints system, eat well, participate in a range of sporting, leisure, and cultural activities, have reasonable access to family and whānau, and have good access to medical services and care.

Despite the positive findings described above, in the visits to CYF residences the OCC found room for improvement across several domains.

Table 3: Summary of the OCC's OPCAT ratings for facilities visited in 2014–15

OPCAT domain	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7
Treatment							
Protection system							
Material conditions							
Activities & contact with others							
Medical services & care							
Personnel							
Overall OPCAT rating							

Note: To protect the anonymity of each facility, they are listed in a different order in Table 3 compared with Table 2.

Inconsistent treatment of children and young people

One residence (Facility 6 in Table 3) received a rating of 'developing with detrimental elements' for the treatment domain. This was because of a few incidents where young people had been hurt by staff when staff used excessive force, either in self-defence or to restrain a young person. Subsequent investigations confirmed that staff had not acted intentionally to hurt the young people, and in all cases the residence manager had acted quickly to ensure that staff members involved were stood down while Human Resources investigations were completed. Nevertheless, whether intentional or not, such incidents can be detrimental to young people and staff. It is important that staff are skilled in preventing such incidents whenever possible.

A broader, related issue for residences is staff's inconsistent treatment of children and young people, particularly in managing challenging behavioural, emotional, and mental health problems. Table 3 shows the three residences that received a predominant rating of 'developing' for the treatment domain also received a predominant rating of 'developing' for the personnel domain. These findings reflect the close association between the way children and young people are treated and the knowledge, skills, and behaviour of staff who are employed to care for them. The OCC has observed a negative cycle in some residences whereby inconsistent management of young people results in young people acting out, sometimes aggressively, putting themselves and staff at risk. This increases staff's anxiety about managing challenging behaviours, sometimes resulting in a reluctance to intervene when such behaviours occur or alternatively responding more heavy-handedly. In turn, this fuels young people's behavioural, emotional, and mental health problems, leading to more frequent use of restraints and secure care, and creating an environment where limits are unclear and young people do not feel safe.

Each residence develops an action plan that responds to the recommendations in our monitoring reports. The OCC expects the plans in place at the three residences that received developing ratings for the domains 'treatment' and 'personnel' will help address the issues identified. In addition, CYF has developed a training plan to strengthen staff capability in preventing and safely managing young people's challenging behaviours. This plan involves giving staff additional training in strengthening their engagement with young people and in structuring an effective day for young people. Over the next year the OCC will continue to monitor progress in implementing residence plans and staff training.

Lack of access to specialist mental health treatment

Residences have onsite health teams who ensure young people can easily ask to see a nurse (or doctor) to discuss any physical or mental health problem. Also supporting young people's access to mental health care are the residences' clinical teams. Clinical teams consist of qualified professionals, such as social workers, psychologists, and counsellors, who are typically well trained and usually receive regular supervision from their Team Leader of Clinical Practice. The clinical teams undertake assessments and associated intervention planning. This generally works well to ensure that young people's clinical needs are identified early in their stay in residence. The clinical teams also deliver a range of group and individual therapeutic interventions for children and young people. This helps to meet children and young people's mental health needs.

However, CYF staff across several care and protection and youth justice residences have told the OCC the residences now have more children and young with complex mental health issues. Residences' ability to successfully treat the young people with the most serious mental health issues (eg, suicide or self-harming) often depends on their relationship with local specialist Child and Adolescent Mental Health Services (CAMHS), managed by district health boards. The quality of relationships between CYF and CAMHS is variable around the country. Relevant to the mental health theme of this annual report, it can be a real challenge for some residences to get young people access to ongoing specialist mental health treatment.

Material conditions at some residences not upholding young people's wellbeing

Table 3 also shows some minimally effective ratings associated with two of the residences' material conditions. Although the OCC was satisfied that all residences passed a basic test for the quality of material conditions, we felt that parts of these two residences did not uphold young people's dignity or sense of wellbeing. The interiors were stark, badly defaced, and needed upgrading. There was also clear room for improvement at a third residence that received a predominant rating of 'developing' for material conditions. CYF national office is working with the Ministry of Social Development's property section to ensure that all residences are on a schedule to be upgraded. The OCC will continue to monitor progress in this area.

Protection system not sufficiently child-centred

Four of the six residences received a predominant rating of 'well placed' for their protection system, reflecting that most residences have a clear grievance process that is relatively easy for young people to access. A more youth-friendly grievance system, known as Te Whaea Maramatanga, has recently been rolled out to residences. The new approach enables young people to submit feedback, suggestions or complaints to residence staff. Residences continue to have a fair back-up system in place when children or young people are not happy with how their grievances are dealt with. The majority of young people know they can ask an independent Grievance Panel to review the outcomes of investigations.

Despite residences' consistent efforts to ensure that children and young people know about and can access the grievance system, the OCC still hears frequent comments from young people that they have little confidence that their grievances make a difference to the way the residence operates. There are many reasons for this. When a young person makes a complaint, residence staff have 14 days to investigate and get back to the young person. This feels like a long time to many young people. The OCC administers a youth survey to young people in residences during announced visits only. The survey has revealed that about half of all young people surveyed are unsure about whether it is safe to make a complaint against some staff or other young people. For young people who reported wanting to lodge a grievance but deciding not to, the most common reason given was that they did not think it would be taken seriously. Other young people are reluctant to lodge a grievance because of a strong youth culture against 'narcing' or 'snitching'.

The grievance system should be only one of many methods for enabling children and young people's voices to be heard. Two of the six residences monitored did not have any formal mechanism in place for young people to provide feedback or input directly to residence management. Although it is positive that four residences have established such forums, young people at these residences do not typically know if their input is being used to inform service delivery priorities and direction.

Broader systemic themes

Underpinning many of the key OPCAT findings described above are several broader systemic issues that impact on the ability of residences to deliver the preventative care and services that children and young people require. These are outlined below.

Lack of clear purpose and direction

A clear purpose and direction is lacking, particularly for youth justice residences. The OCC frequently observed that staff in youth justice residences did not have a clear and consistent vision of what they were there to achieve, resulting in tension about the primary purpose of the residence. There is no consistent understanding across the whole of CYF about the relative weight that should be given to the related purposes of containing young people and holding them to account for problem behaviours, and providing therapeutic support to help them improve their outcomes. The physical environment in many of the residences suggests an organisation geared towards containment and accountability, but in the OCC's view a child-centred organisation should prioritise treatment and improving outcomes. The time a young person spends in a youth justice residence is an opportunity to place support around them that can help them improve their outcomes when they leave, even for those young people who

are only in residence for a short time (eg, on remand). Staff in each residence need to know how they can contribute to the realisation of a shared purpose in their daily work.

Lack of workforce capacity

Some residences told the OCC that they struggle to fill vacancies and have issues with staff retention. The stressful nature of the work means that many get burnt out and leave. Others are seconded into more senior roles. While secondments can present valuable professional development opportunities for the individuals involved, it contributes to significant staff turn-over and many staff working in acting roles, leading to uncertainty and instability. Being chronically short-staffed puts additional pressure on existing staff and affects morale.

Lack of workforce capability

A key challenge for CYF is building and maintaining a workforce with sufficient capability to undertake the work required for young people with increasingly complex needs. While CYF has a well-considered learning and development programme, existing staff do not always have the skills they need to deliver effective services to children with high and complex needs and their families/whānau. Day-to-day care of young people is in the hands of care staff. Unlike the clinical teams, the majority of care staff are youth workers who are inexperienced and unqualified, and lack confidence to manage young people's serious behavioural, emotional, and mental health problems.

Care staff also do not have the support they need to do their jobs well. Team Leaders Operations (TLOs) are responsible for supervising care staff, but the high ratio of care staff to TLOs means that care workers have insufficient access to professional supervision. The situation is further exacerbated by residences employing many care workers on a casual basis. Casual staff often do not receive any formal supervision.

Lack of cultural capability

There is ample evidence, both nationally and internationally, that access to culture and culturally appropriate social work practice are strong protective factors for children and young people who come into contact with the care and protection and youth justice systems. Positioning indigenous cultural identity as a strength can provide a foundation from which young people can build resilience. Nearly 70 per cent of young people in CYF residences are mokopuna Māori. Therefore, it is of utmost importance that residences ensure their staff are well equipped to deliver culturally responsive services to mokopuna Māori.

While CYF has given considerable attention to building Māori cultural capability in recent years, and some residences do an exceptional job of this, the OCC's overall finding is that at most residences cultural capability is still not given sufficient priority. The OCC has come across only a couple of residences that are well set up to attract and support Māori staff. Māori practitioners are often called on to support their colleagues to engage with mokopuna Māori and their whānau, without being allocated any extra time or resources or being acknowledged by management for doing so. Formal cultural supervision is limited at the residences and dedicated training opportunities for staff to develop expertise in culturally appropriate practice are rare.

The current implementation of a newly developed indigenous and bicultural framework is promising but will need a high degree of sustained commitment and leadership from CYF national office. It will also need dedicated investment in building Māori cultural capability across the whole organisation, to make a positive difference for mokopuna Māori.

Transformational practice at one residence

One residence received transformational elements for two domains – material conditions, and activities and contact with others. This residence had transformed care and containment rooms into therapeutic spaces for children and young people. Rooms that had previously been used as time-out spaces for punishment had been transformed into tranquil spaces for quiet relaxation by

repainting the walls in child-friendly colours and using soft furnishings. The change means that children and young people have a soothing space they can use to calm down. Young people perceive the use of this space as supporting their wellbeing rather than as a place of punishment.

This same residence also did an outstanding job of enabling children and young people to maintain their connection with safe whānau and caregivers. A family flat is attached to the residence building so that children and young people can spend time with their visiting family and whānau without going off-site. The accommodation also enables staff to work intensively with the young person and their family while the family is resident onsite, and it means that caregivers can have a number of contacts with young people before their transition from the residence back into the community.

The OCC's reports, recommendations and engagement with CYF aim to support CYF to learn from and draw on best practice examples like this to lift performance at other residences.

In summary, three factors together have a large impact on the residential environment for children, young people and staff:

- complex and challenging behavioural, emotional, and/or mental health problems
- a relatively unskilled care workforce
- insufficient clinical and cultural supervision

To improve the consistency of staff management of challenging behavioural, emotional, and mental health problems, increase the safety and effectiveness of residence environments, and better uphold children's and young people's wellbeing, it is clear that further work is required to:

- build the capacity and capability of care staff
- increase the frequency and quality of supervision for care staff
- upgrade the material conditions at several residences
- increase opportunities for young people to have their feedback heard by residence management and to have input into residences' service delivery priorities and direction
- clarify at the national level the purpose and direction of residences
- build cultural capability

The OCC acknowledges that CYF is currently focused on making these large strategic shifts both through the significant external review of CYF that is underway and CYF's internal modernisation programme.

Going forward

Over the next year, the OCC will continue to monitor the recommendations and plans already identified. Evaluating facilities' progress with OPCAT recommendations within the broader context of their leadership, social work practice, and partnerships, as well as their own plans for improvement, strengthens our ability to fulfil a preventive role, as is desirable for a NPM.

The OCC will also undertake a thematic review relevant to youth justice residences on how well CYF sites partner with these residences to meet the needs of young people in the youth justice system. This thematic review will provide further information about the wider organisational systems that are relevant to residences' ability to not only meet their OPCAT obligations, but exceed them. The OCC will continue to monitor the OPCAT domains during these visits.

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

The Office of the Ombudsman has been designated as the National Preventive Mechanism (NPM) for prisons, immigration detention facilities, health and disability places of detention, and child and youth residences.

The Office of the Ombudsman (the Ombudsmen) has wide statutory powers to investigate complaints against central and local government agencies. The functions and powers of the Ombudsmen are set out in several pieces of legislation, including the Ombudsmen Act 1975.

The Ombudsmen's role includes providing an external and independent review process for individual detainees' grievances, as well as the ability to conduct investigations on their own motion.

The Ombudsmen are responsible to Parliament but are independent of the government of the day. Ombudsmen are appointed by the Governor-General on the recommendation of the House of Representatives for a period of five years.

Overview

Under the Crimes of Torture Act (COTA), the Ombudsmen are the designated NPM responsible for monitoring and making recommendations to improve the conditions and treatment of detainees, and to prevent torture and ill-treatment in:

- eighteen prisons[7]
- seventy-nine health and disability places of detention[8]
- one immigration detention facility
- four child care and protection residences
- five youth justice residences.[9]

The designation for child care and protection and youth justice residences is jointly shared with the Office of the Children's Commissioner. This year we undertook our second joint visit to the Mother and Baby Unit (MBU) at Christchurch Women's Prison.

Two Inspectors help us carry out our OPCAT functions under COTA. In 2014/15 we committed to carrying out 32 visits to places of detention. We exceeded this commitment and carried out a total of 40 visits, including 22 formal inspections. Twenty-nine (72.5 per cent) were unannounced. This year we obtained funding for a third Inspector and specialist advisors as and when required.

Each place of detention visited contains a wide variety of people, often with complex and competing needs. Some detainees are difficult to deal with – demanding and vulnerable – others are more engaging and constructive. All have to be managed within a framework that is consistent and fair to all. While the Ombudsmen appreciate the complexity of running such facilities and caring for detainees, our obligation is to ensure that appropriate standards are maintained in the facilities, and to prevent torture and ill-treatment. In line with the power to make recommendations aimed at improving the treatment and conditions of people deprived of their liberty, the Ombudsmen also comment on proposed policy changes and legislative reforms.

The 22 formal inspections were at the sites set out in the table on the facing page.

7 The new South Auckland Corrections Facility increased the number of prisons we visit from 17 to 18.

8 This year, an additional eight secure community care homes and the new national intellectual disability unit for youth have increased the number of health and disability facilities we visit from 70 to 79.

9 Child care and protection residences as well as youth justice residences are being monitored by the Office of the Children's Commissioner (OCC). OCC's NPM designation was originally set up as a joint responsibility with the Office of the Ombudsman. In practice, and with the agreement of the Chief Ombudsman, OCC now carries out its NPM role independently.

Name of facility	Type of facility	Recommendations made
Child, Adolescent and Family (CAF) Unit, Princess Margaret Hospital, Canterbury District Health Board (DHB)	Mental Health	1
Te Whare Manaaki, Hillmorton Hospital, Canterbury DHB	Forensics	1
Assessment, Treatment & Rehabilitation (AT&R) Unit, Hillmorton Hospital, Canterbury DHB	Intellectual Disability	0
Puna Maatai Unit, Henry Bennett Centre, Waikato DHB	Forensics	2
Puna Awhi-rua, Henry Bennett Centre, Waikato DHB	Forensics	2
Southland Inpatient Mental Health Unit, Southern DHB	Adult Mental Health	4
Ward 9A, Wakari Hospital, Southern DHB	Forensics	3
Ward 10A, Wakari Hospital, Southern DHB	Intellectual Disability	3
Kingsley Mortimer Unit, North Shore Hospital, Waitemata DHB	Mental Health – Older Adults	0
Rata Unit, Mason Clinic, Waitemata DHB	Forensics	6
Tane Whakapiripiri Unit, Mason Clinic, Waitemata DHB	Forensics	1
Kahikatea Unit, Mason Clinic, Waitemata DHB	Forensics	4
Fraser McDonald Unit, Auckland DHB	Mental Health – Older Adults	1
Te Whare Oranga Tangata O Whakaue, Rotorua, Lakes DHB	Adult Mental Health	2
Hikitia Te Wairua Unit, Capital and Coast DHB	National Forensic Youth, Intellectual Disability	0
Te Whare Ra Uta	Mental Health – Older Adults	1
Tumanako Unit, Whangarei, Northland DHB	Mental Health – mixed	4
Kensington Centre, Timaru, South Canterbury DHB	Adult Mental Health	0
Otago Corrections Facility (Health Services)	Prison	8
Mount Eden Corrections Facility (Follow-up)	Prison	8
Christchurch Women's Prison	Prison	7
Tongariro Working Prison	Prison	5

The Ombudsmen reported back to 22 places of detention (100 per cent) within three months of conducting an inspection and made 63 recommendations, of which 52 were accepted or partially accepted (as set out in the table below).

Recommendations	Accepted	Not accepted
Prisons	18	10
Health and disability places of detention	34	1

Of the 10 recommendations not accepted by the Department of Corrections (Corrections), 7 concerned two common matters that were repeated across several sites, namely:

- the use of cameras and prisoners' right to privacy (three recommendations)
- segregated prisoners being placed in non-compliant cells (four recommendations).

This brings the total number of visits conducted over the eight-year period of our operation as an NPM to 339, including 137 formal inspections.

Prisons

In last year's annual report the Ombudsmen identified four key areas that raised concerns following inspections:

- segregation facilities
- prisoner meal times
- young persons
- privacy issues

All of these matters continued to be of particular concern in the 2014/15 reporting year.

Segregation facilities

Management cells, separates cells, or punishment cells are some of the terms used to describe a form of confinement where prisoners are held alone in a cell for up to 24 hours a day, and are only allowed to leave it for outdoor exercise (generally an hour's duration). Segregation may be imposed on prisoners as short-term punishment for prison offences (misconducts), or indefinitely for a prisoner's own protection, either at their request or at the discretion of the prison director. At other times prisoners may be isolated from others as a long-term strategy for managing challenging and disruptive behaviour, where prisoners are deemed to be a threat to security, or to assess a prisoner's physical health. It is the most extreme form of custody and one where purported containment needs can infringe prisoner rights.

Because of the differences between prisons in the physical environment of segregation units and cells, segregation remains a cause for significant concern. Evidence is ongoing of variances in the way directed segregation is being applied to prisoners pursuant to sections 58, 59 and 60 (1)(a) of the Corrections Act 2004 (the Act) across the prison estate.

Although the new management cells at Auckland Prison are bigger, brighter, and less oppressive than the old ones; their design is intended to increase surveillance, enable prolonged solitary confinement, and minimise contact between prisoners and staff. Cells are self-contained with a toilet and shower. Other measures, such as a small barren exercise yard and feeding-slots built into cell doors, serve to reduce prisoner movement in and out of the unit.

Tongariro/Rangipo Prison has no management unit; therefore, prisoners on directed segregation are located in the separates units (in a punishment cell). As previously reported, separates facilities are designed for prisoners undertaking a period of cell confinement and do not have some of the design features legally required for prisoners subject to a segregation directive under the Act. Furthermore, cells are monitored on camera, including the toilet and shower facilities.

Meal times

For the last three years the Ombudsmen reported that the 8am to 5pm unlock regime has condensed the working day for many prisoners, including meal times, with some dinners being routinely served as early as 3.30pm, leaving prisoners without meals for lengthy periods. Last year, Corrections advised that it would begin a review of the national prisoner menu. The Ombudsmen are unaware of any such review having taken place and still saw lunch being served at 11.10am in Christchurch Women's Prison and the evening meal being served as early as 3.15pm at Mount Eden Corrections Facility (MECF) during this reporting period.

Young persons

In last year's report the Ombudsmen highlighted the inadequate facilities available for young people at Waikeria Youth Unit and made a total of 12 recommendations to improve conditions for young people. While some remedial work was undertaken to improve the environment for youth, the unit eventually closed in early 2015 with prisoners transferred to either Hawke's Bay or Christchurch Youth Unit. Remand prisoners were sent to MECF.

As previously reported MECF has no youth unit and is not set up to manage young people long term.

Following an unannounced inspection in April 2014 we found the average period of unlock for young people was five hours a day. The Ombudsmen made two recommendations: that Corrections considers developing a dedicated youth unit, and reviews the unlock hours and facilities available for young people. Corrections responded:

> *As the young prisoner population is projected to decrease, we are not considering the development of a dedicated Youth Unit at MECF at this time. However, as a result of the projected decrease we are currently considering a more intensive and coordinated approach to managing these individuals in our prison system. This includes considering our options for expanding available placements for under 20 year olds in the Auckland Region.*

A follow-up visit in October and November 2014 and January 2015 found the time spent out of cells for youth had reduced considerably to between one and two hours a day, with minimal access to programmes and facilities. Youth were housed in various units around the prison, including the management unit (not on segregation).

The number of young people in MECF over the past two years has fluctuated (as set out in the table below).

	Sept 13	April 14	Oct 14	Jan 15	Jun 15	Jul 15	Aug 15
Under 18	5	7	5	19	18	15	10
18–19 yrs	N/A	N/A	N/A	N/A[10]	53	64	51

Young people in detention are extremely vulnerable – by virtue of their age and capacity; separation from families and friends at a formative time; and, in many cases, characteristics such as a mental illness. Monotony, reduced environmental stimulation and social isolation can be extremely distressing and potentially fatal.

10 N/A – Information not available at the time.

Privacy issues

This year the Ombudsmen found continued examples where perceived needs for order and security prevailed over treating prisoners with dignity and fairness, resulting in serious privacy breaches for prisoners.

As well as being monitored on camera, women in the separates cells at Christchurch Women's Prison can be observed using the toilet by staff through the cell door. In the at-risk unit, cells are monitored by cameras, including the unscreened toilet area. Footage from cameras in both units are visible to staff in the office and in master control, including officers of the opposite sex in the course of their work when female staff are unavailable, as well as to visitors to the office. Eleven per cent of officers at Christchurch Women's Prison are male.

The Ombudsmen are pleased that privacy screening around the toilets has now been completed in wings one, two, and three of Christchurch Women's Prison in response to our recommendations.

Similarly, in the separates cells at Tongariro/Rangipo Prison and Otago Corrections Facility prisoners are monitored, including the toilet and shower area, on camera, and by staff in the corridor. The Ombudsmen made several recommendations that camera surveillance should not cover toilets and shower areas. The Ombudsmen are concerned that these recommendations were not accepted by Corrections and this situation continues, in spite of our advice that this practice amounts to degrading treatment or punishment for the purposes of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), Art. 16(1).

Follow-up to previous recommendations

Last year the Ombudsmen reported on the less-than-satisfactory conditions in the Separates Unit at Northland Prison and recommended that they be upgraded. Corrections responded:

> *The Department acknowledges that the use of indoor shower facilities is best practice and thus the use of the showers in the Separates Unit is not ideal. The Separates Unit will undergo significant remedial work in 2014 to be upgraded to the Departmentís Management Unit standard. This remedial work will address the issue with the current shower facilities as it is intended that it will include both covered yard and indoor shower blocks, replacing the individual cell yards and current showers.*

A follow-up with the Department found that some remedial work to upgrade the separates cells in Northland was completed in late 2014. However, the covered yard and internal shower block was not completed, resulting in prisoners continuing to have to shower in external yards and being monitored on camera.

In 2011 and 2014 the Ombudsmen reported on the living conditions in Waikeria Separates Unit, describing them as deplorable and recommending that they be urgently upgraded and brought in line with international standards. In May 2015 the Department announced the closure of the top jail (which houses the Separates Unit) at Waikeria Prison as part of the Department's *Lifting Productivity and Performance in New Zealandís Prisons strategy*.

Good practices at the prisons visited

- Over three-quarters of prisoners at Christchurch Women's Prison are unlocked for more than 12 hours a day.
- All prisoners at Tongariro/Rangipo Prison are unlocked for more than 12 hours a day.
- Meals at Tongariro/Rangipo Prison are served within normal times – 7am, 12pm, and 5pm.

Health and disability places of detention

Mental Health (Compulsory Assessment and Treatment) Act

Generally, the Ombudsmen found good areas of practice and many positive findings across the adult acute, older, and forensic inpatient services around New Zealand. Service users[11] held staff in high regard and felt they could approach them if they had a problem.

Kingsley Mortimer (Waitemata DHB), Fraser McDonald (Auckland DHB) and Te Whare Ra Uta Unit (Capital & Coast DHB) provide assessment and treatment for older people with mental health needs. The Ombudsmen observed service users experiencing compassionate person-centred care and support. Potential risks associated with aging, such as falls, were well managed and meant health was promoted.

Improvements need to be made in three main areas. These relate to bed occupancy rates, restraint training for staff, and seclusion rooms being used as long-term bedrooms.

A visit to Tumanako Unit (Northland DHB) and Southland Inpatient Mental Health Unit (Southern DHB) noted bed occupancy rates above 100 per cent. Both facilities have converted offices and day rooms into makeshift bedrooms in order to accommodate extra service users. These makeshift bedrooms lack adequate privacy, reduce the communal space available for service users (and their family and other visitors), and place extra pressure on the workforce.

Nine of the eighteen health and disability sites visited this year had staff who were not up to date with their restraint training updates. This appears to be a problem across most DHBs. With the exception of Tumanako Unit (Northland DHB), the use of seclusion and restraint appears to be reducing.

As previously highlighted, seclusion rooms continue to be used as bedrooms for difficult-to-manage and disruptive service users at some sites. For the last two years the Ombudsmen have reported on a patient in Tawhirimatea Unit (Capital & Coast DHB) who was being managed in seclusion/de-escalation on a semi-permanent basis. Although progress remains slow, the Ombudsmen are encouraged by recent developments for an independent external review of the service user.

The Ombudsmen will continue to work with the DHB and the Ministry of Health on this issue.

Follow-up to previous recommendations

In our 2012/13 annual report the Ombudsmen reported on the practice of using outdated "night safety procedures" in Totara Unit in the Mason Clinic (Waitemata DHB) to justify locking service users in their bedrooms overnight. Despite their assurance that the "blanket" policy had been replaced with individualised night safety plans, the Ombudsmen discovered in March 2015 that all of the service users in Rata Unit (the Mason Clinic) were on a night safety plan with no evidence that they were regularly reviewed. The oldest plan was dated September 2011.

The Ombudsmen raised the issue with the Director of Mental Health who confirmed that guidance was being developed for DHBs on restrictive practices within the mental health arena. Night safety orders will be included in this guidance.

Intellectual Disability (Compulsory Care and Rehabilitation) Act

Overall, service users in the Assessment, Treatment & Rehabilitation Unit (Canterbury DHB), Ward 10 (Southern DHB), and Hikitia Te Wairua Unit (Capital & Coast DHB) gave positive feedback about staff in the unit. Interactions between staff and service users were observed and considered appropriate and caring.

Hikitia Te Wairua Unit, the new national youth facility for people with an intellectual disability, was clean and bright with plenty of open space and fresh air. Youth had access to a variety of activities both on and off the unit as well as education and training opportunities. Ward 10 (Wakari hospital) was less than satisfactory and requires significant investment to bring it up to an acceptable standard. Activities in the unit were limited because of a lack of adequate space.

11 The term 'service user' encompasses patients, clients, and care recipients.

This year the Ombudsmen revisited Haumietikitiki Unit (Capital & Coast DHB) to follow up on two service users identified in our 2013/14 Report who were subject to restrictive regimes. While it was encouraging that one of the service users had moved to a more suitable facility, it was disappointing that the second service user was still subject to a permanent seclusion order – although they had been, until recently, spending considerable amounts of time outside the seclusion room. A third service user on long-term seclusion in Te Whare Manaaki Unit (Canterbury DHB) had been successfully managed out of seclusion back into the unit.

The Ombudsmen will continue to work with the Ministry of Health on all of the above issues.

Other activities

Detention centre inspections in Samoa

In January 2015, the Chief Inspector was invited to join the Samoan Ombudsman's office to undertake their first detention centre inspections. The inspections were conducted under the Samoan Office of the Ombudsman's new mandate as the National Human Rights Institution of Samoa. The visit was funded by the Asia Pacific Forum as part of an initiative to strengthen the capacity of National Human Rights Institutions in the Asia Pacific to prevent torture and other cruel, inhuman and degrading treatment and punishment.

Going forward

The NPM's ability to ensure its recommendations are implemented is central to its success. The different agencies that are monitored have no uniform approach in the way they respond to NPM recommendations. This is something the Ombudsmen intend to work on over the next 12 months, along with increasing uptake of recommendations in the Corrections area.

Section 2: Thematic Review

Mental Health in Detention: Duties of the State

Since its inception in 2007 New Zealand's National Preventive Mechanism has identified as a key priority the management of detained persons with high and complex needs. These are people who along with a mental disorder have one or more co-occurring problems that may include alcohol and drug abuse, physical health problems, and associated behavioural issues.[12] The management in detention of the whole range of disabilities continues to be an area of significant concern for the National Preventive Mechanism and will be the subject of further inquiry as we go forward.

This thematic review will focus on detained persons with mental disorders and associated behavioural issues. These issues can be difficult to manage appropriately if adequate and timely assessment procedures are not in place. Providing appropriate treatment for detainees with mental disorders or psychosocial disabilities continues to be a major challenge in a variety of detention settings. The key rationale for the Ministry of Health's 2012–2017 Mental Health Service and Addiction Development Plan was the identified need for a renewed focus on earlier and more effective responses, improved outcomes, better system integration and performance, increased access to services, effective use of resources, and stronger whole-of-government partnerships.[13] It is essential that these efforts are extended to the detention environments discussed in this review.

For the purposes of this discussion, the terms 'mental disorder' and 'psychosocial disability' are used in a very broad sense to include mental health conditions, intellectual/learning disability, neurodevelopmental disorders such as Asperger's spectrum disorder, and Alcohol and Other Drug (AOD) abuse and dependence along with associated behavioural disorders. Although these conditions differ in a number of practical respects, similar overall principles are relevant to the State's obligations towards detained persons who are affected by such disorders.

Inadequate provision of therapeutic care and support can have a devastating impact on individual physical and mental health and wellbeing. It can also have a much broader impact on the wider community with missed opportunities for diagnosis, treatment, and support potentially impacting on an individual's future ability to integrate successfully when they leave the detention setting.

12 See 'Monitoring Places of Detention', OPCAT Annual Reports 2008–2015, on the Human Rights Commission's website (www.hrc.co.nz/your-rights/human-rights/our-work/opcat). For an expanded definition of 'high and complex needs' see Acqumen Ltd, 2009, High and Complex Needs: Report for the Mental Health Commission. See also the High and Complex Needs Unit (HCN), a cross-agency initiative including Ministry of Health, the Ministry of Education, and the Ministry of Social Development.

13 Ministry of Health, 2012. Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017, p.iii.

The National Preventive Mechanism recommends:

- That the Ministry of Health ensures that mental health and addiction service planning comprehensively addresses the requirements of detained persons with high and complex needs and identifies ways to obtain more effective outcomes for this group
- That NPMs more formally engage with detaining agencies on strategic planning and developments, in order to provide an independent and preventive perspective on mental health and addiction services in detention
- That detaining agencies and responsible Ministries give priority to the implementation of mental health-related recommendations made by National Preventive Mechanisms (NPMs) and other national and international monitoring agencies, including United Nations bodies.

General background

The 2006 New Zealand Mental Health Survey found that mental disorders are common in New Zealand, with 46.6 per cent of the population (16 years and over) predicted to meet the criteria for a disorder at some time in their lives.[14] The 2012/13 New Zealand Health Survey found that 16.3 per cent, or approximately one in six New Zealand adults (15 years and over) had been diagnosed with a common mental disorder, such as depression, bipolar disorder, and/or anxiety disorder at some time in their lives.[15] The Ministry of Health observed that in the general population service quality and the level of access to services remain variable for people with mental health and addiction issues.[16] As outlined in more detail below, mental disorders are much more prevalent among people in detention compared to the general population. Variations in the level of access pose significant challenges to managing the wellbeing of what is already a highly vulnerable population group.

Alongside observations by New Zealand's National Preventive Mechanism, international monitoring bodies have expressed concern over the management of people with mental disorders in detention. The United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), which made its first visit to New Zealand in 2013, noted that there did not appear to be any national strategy for providing mental health care in places of detention.[17] The United Nations Working Group on Arbitrary Detention (WGAD), which visited New Zealand in 2014, was concerned that there may be an underestimated number of cases of arbitrary detention of people with mental illness.

Factors that can exacerbate mental disorders in a detention context include an unsuitable physical environment, a workforce that is inadequately trained or lacking skills, insufficient clinical and cultural supervision, and the lack or infrequent access to specialist mental health services. The duty of the State is to eliminate these risks in order to protect the rights of all people in detention.

14 Browne et al., 2006, Te Rau Hinengaro: The New Zealand Mental Health Survey, p.xix.

15 Ministry of Health, New Zealand Health Survey: Annual update of key findings 2012/13, p.6.

16 Ministry of Health, Rising to the Challenge, p.iii.

17 SPT, 2014, Report on the visit of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment to New Zealand, p.12.

The domestic and international legal framework

The State has a positive duty to ensure preventive measures are taken to protect the physical and mental health and wellbeing of detained persons. The rights of detained persons are protected under the Human Rights Act 1993,[18] the Bill of Rights Act (BoRA) 1990,[19] the Crimes of Torture Act 1989, the Corrections Act 2004,[20] the Mental Health (Compulsory Assessment and Treatment) Act 1992,[21] the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, and the Children, Young Persons and their Families Act 1989. There are also other relevant national and international obligations, including those arising under the Convention on the Rights of Persons with Disabilities (CRPD), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) and OPCAT.

Section 23(5) of BoRA protects the right of every person arrested or detained to be "treated with humanity and with respect for the inherent dignity of the person". This obligation incorporates into domestic law the obligation under Article 10(1) of the International Covenant on Civil and Political Rights (ICCPR), which states that "[a]ll persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person".

People in detention retain their fundamental right to enjoy good health, both physical and mental, and they retain their entitlement to a standard of medical care that is reasonably comparable to that provided to the wider community.[22] Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes:

> [t]he right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

This obligation is further expounded in the ICESCR Committee's General Comment (14), which states that:

> In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.[23]

18 Human Rights Act 1993. Section (21)(1)(h) on the prohibition of discrimination on the grounds of disability, which means (i) physical disability or impairment, (ii) physical illness, (iii) psychiatric illness, (iv) intellectual or psychological disability or impairment, (v) any other loss or abnormality of psychological, physiological, or anatomical structure or function, (vi) reliance on a guide dog, wheelchair, or other remedial means, and (vii) the presence in the body of organisms capable of causing illness.

19 Bill of Rights Act 1990. S(27)(1) on the right to natural justice (including fair procedure); s(9) on the right not to be subjected to torture or ill-treatment; s(21) on protections in relation to search and seizure; s(22), on the right not be arbitrarily arrested or detained; s(23), on the rights of those who are arrested or detained. In respect to detention, these rights include the right to be treated with humanity and with respect for the inherent dignity of the person.

20 Corrections Act 2004. Corrections Act 2004. S(49) on the right to be assessed on reception and have needs addressed; s(75) on medical treatment and standard of health care.

21 Mental Health (Compulsory Assessment and Treatment) Act 1992. The Act provides for clinical, judicial and tribunal review of the condition and status of persons detained for mental health reasons. Under s(16) patients can apply for a review of their conditions by a District Court judge when they are detained under the Act for assessment. S(64) to (76) define the rights of individuals detained under the Act, including rights to treatment, being informed, independent psychiatric advice, legal advice, company and seclusion, and the right to complain about breaches of these rights.

22 Corrections Act 2004, section 75(2).

23 Committee on Economic, Social and Cultural Rights, 2000, General Comment No. 14: The right to the highest attainable standard of health, p.10, emphasis in original.

Alongside the fundamental rights of all human beings, detainees have additional safeguards resulting from their status. When a state deprives people of their liberty it takes on a responsibility to look after their health in terms of both the conditions under which it detains them and the individual treatment that may be necessary as a result of those conditions.[24] This applies to all people in detention, but particular attention needs to be given to the needs of more vulnerable population groups, such as Māori, Pasifika, women, young persons, older persons, lesbian, gay, bisexual, transgender and intersex (LGBTI) persons, and persons with disabilities.

The principle of 'reasonable accommodation' requires detaining agencies to appropriately modify the procedures and physical facilities of places of detention to ensure that persons with disabilities, including mental disorders and other psychosocial disabilities, can enjoy or exercise their human rights on an equal basis with others. Article 2 of the CRPD defines "reasonable accommodation" as:

> necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Providing appropriate support for detained people with high and complex needs who require therapeutic care poses significant challenges.

Mental health in New Zealand detention

Detention can exacerbate certain health conditions and can reinforce pre-existing disabilities. This can be particularly problematic when detainees with psychosocial disabilities are being managed in custodial settings instead of being professionally treated in a therapeutic environment, which is the approach recommended by various bodies and experts.[25] The inadequacy of caring for people with psychosocial disabilities in a custodial setting and the additional pressures this puts on custodial facilities and staff has been acknowledged in several reports. Most recently, these include the Independent Police Conduct Authority's (IPCA) 2015 review of police custodial management and the Office of the Children's Commissioner's (OCC) 2015 report on children and young people in the formal custody of the State.[26]

If someone is affected in such a way that they do not understand the consequences of their actions, and if their disability and their associated needs are not identified, recognised or responded to, custodial interventions and sentences are likely to further criminalise rather than offer support. Consequently, detainees with disabilities who do not receive adequate treatment are more likely to break rules and cause behavioural problems, which further affects both staff and co-detainees.

For some people their need for tailored treatment and rehabilitation might be better met within the community or in psychiatric hospitals rather than in detention. Early screening and identification of mental health conditions and psychosocial disabilities is important, along with early intervention where appropriate, and integration with services on their release from detention.

24 Coyle, 2009, A human rights approach to prison management, p.47ff.

25 See, eg, National Health Committee, 2010, Health in Justice: Improving the health of prisoners and their families and whānau, p.100; Stanley, 2011, Human Rights and Prisons. A Review to the Human Rights Commission, p.66; Coyle, p.52; UNDOC, 2010, Handbook for prison leaders, p.81.

26 IPCA 2015, Review of Police Custodial Management; OCC, 2015, State of Care.

Key challenges

The National Preventive Mechanism has identified numerous systemic issues that pose significant challenges to managing people with mental disorders and psychosocial disabilities consistent with domestic and international standards and best practice.

Realising the variety of detention facilities monitored under OPCAT, the National Preventive Mechanism can make some general observations that apply to most, although not all, detention contexts. As noted in section one of this report, the detention context monitored by the Inspector of Service Penal Establishments differs substantially from those monitored by the other NPMs. Also, detaining people under the Immigration Act (2009) has to date not presented challenges comparable to those in other contexts. This section focuses on detention facilities under the management of the Ministry of Health; Child, Youth and Family (CYF); the Department of Corrections (Corrections); and New Zealand Police.

Across these detention contexts, unsuitable physical environments, an inadequately trained or skilled workforce, insufficient clinical and cultural supervision, and the lack or infrequent access to specialist mental health services have been identified as key challenges that need to be prioritised in order to implement progressive improvements.

NPMs observed that the physical environment of many of New Zealand's detention facilities is more conducive towards a custodial approach to containment and accountability, rather than the therapeutic and client-centred approach that would allow for more adequate management and treatment of detainees. This is particularly the case for detainees with high and complex needs.

Police custodial facilities

In 2014/15 police responded to over 25,500 mental health-related calls for assistance, 4245 of which were repeat mental health calls. Over the past 20 years the number of incidents involving someone suffering from acute mental distress has increased by 350 per cent. At the same time, incidents involving threatened or attempted suicide increased by 800 percent. The needs of callers and the requirements put on staff dealing with callouts have also changed significantly, with callouts taking an average of five-and-a-half hours to resolve compared to two-and-a-half hours in 2013/14. On an average day police deal with over 100 people suffering from mental distress or who are suicidal.[27] All police employees involved in detaining or arresting people are required to participate in Custodial Management Suicide Awareness (CMSA) training. Yet the IPCA noted that CMSA training does not directly address the risk assessment or management of detainees who are mentally impaired or under the influence of AOD and/or solvents.[28]

In March 2015 the IPCA issued a report on police custodial management. The report considered 31 different complaints during the years 2012–2014 about the way in which police operate and police cells are managed throughout the country.[29] The report focused on problems with the way in which police respond to and deal with those in mental distress who end up in police custody. The IPCA review included many incidents of injury, self-harm, and suicide attempts. Many of those incidents were caused, or at least not prevented, because of recurring systemic problems in custodial management practices and procedures. The report made clear that the way in which police respond to those in mental distress often causes long-term trauma and avoidable harm. The IPCA noted that:

27 See New Zealand Police Annual Report 2015, p.8; See also IPCA, 2015, Review of Police Custodial Management.

28 IPCA 2015, p.13.

29 IPCA, 2015, p.83.

> "[t]he police custodial environment to which [mentally impaired persons] are taken is designed and constructed to facilitate the effective management of those who pose a risk to others and is an entirely inappropriate environment in which to hold a person in mental distress. It is high sensory, uninviting and frequently noisy. The problems arising from a lack of training and skills of custody officers in dealing with at-risk detainees are accentuated when people are mentally distressed. As a result, while officers strive to deal with such people patiently and professionally, their mental distress is often exacerbated".

The IPCA concluded that these problems are not of the police's own making. Police are often left to deal with those who are in mental distress, but have not committed any offence, because mental health professionals are not available to attend and no other suitable facility is available that they can be taken to. Rather than taking these people into police custody to await a mental health assessment the police need to work with the Ministry of Health and other agencies to identify options for reducing the number of mentally distressed people who are detained in police cells.

In April 2015, the IPCA hosted and facilitated a meeting involving selected senior police, mental health, and other associated professionals to identify possible solutions. It was agreed that the way people having a mental health crisis are currently managed is unacceptable and has to change. Encouragingly, there was also broad agreement on the nature of and reasons for the current situation and agreement on the way forward to effect change. The IPCA has been working with the Director-General of Health, the Director of Mental Health, and the Commissioner of Police to develop the action points agreed at the meeting, in the expectation that new policies and procedures will be developed consistently throughout the country.

Child, Youth and Family residences

Studies have shown that between 40 and 60 per cent of youth who have offended have mental health and/or AOD disorders, a proportion that is significantly higher than that in the overall population of young people.[30] The OCC has identified issues related to inexperienced and unqualified residential youth workers, or care staff, providing day-to-day care to vulnerable young people, many of whom have behavioural or emotional issues and may suffer from psychosocial disabilities. CYF staff across several care and protection and youth justice residences suggested that the children and young people in their care now present with more complex issues than previously. Many care staff are not adequately skilled to manage such complex young people. Nor do they have sufficient access to professional supervision, further exacerbating their ability to provide adequate care and services.[31]

The ability of residential clinical teams to successfully assess and treat those young people with the most serious mental health issues, such as suicide or self-harming, often depends on their relationship with local child and adolescent mental health services (CAMHS), managed by district health boards (DHBs). As noted in section one, the quality of the relationship between CYF and CAMHS is variable around the country, further detrimentally affecting overall service delivery.

Youth forensic services have recently been introduced into CYF youth justice residences around the country. This service provides in-reach teams to youth justice residences to help assess and treat young offenders who have serious mental disorders. Some of the youth forensic teams are co-located within youth justice residences. It is too early to assess the impact this service has made but the OCC thinks it is a promising development. There is no equivalent in-reach service providing mental health treatment for children and young people in care and protection

30 See Ministry of Health, 2011, Youth Forensic Services Development: Guidance for the health and disability sector on the development of specialist forensic mental health, alcohol and other drug, and intellectual disability services for young people involved in New Zealand's justice system, p.v.

31 OCC, 2015, p. 32.

residences. Ideally, an equivalent level of in-reach or co-located specialist mental health support would be provided in care and protection residences. The staff time required to deal with those young people with the highest needs reduces opportunities for quality time and access to off-site activities for other children and young people.

The lack of specialist mental health support for young people with high and complex needs in residences, coupled with care staff's inconsistent management of young people's behavioural, emotional, and mental health problems, contributes to young people's underlying issues not being adequately addressed on a day-to-day basis. This feeds into a negative cycle in residences where young people's ongoing challenging behaviour puts pressure on staff and results in either staff letting some behaviours go or alternatively using restraints and secure care more frequently. Under such conditions, the environment can become unsafe for both young people and staff.

Health and disability places of detention

One of the key challenges identified by the Office of the Ombudsman (the Ombudsmen) concerns the sometimes disproportionate use of seclusion and restraint in health and disability places of detention. While their purpose is to prevent behavourial problems, these practices can and do detrimentally impact on a person's condition. Staff from several health and disability places of detention were also not up to date with their restraint training.

The number of people in seclusion and the total number of hours spent in seclusion in psychiatric hospital inpatient units continues to decline.[32] Yet seclusion remains a cause for significant concern in health and disability places of detention. This has also been noted by several international monitoring bodies, including the Committee against Torture, the Committee on the Rights of Persons with Disabilities and the WGAD.[33]

The Ombudsmen have repeatedly reported on individuals who have been kept in secure care for lengthy periods.[34] In several circumstances identified by the Ombudsmen since 2007, secure care has been used for longer than necessary because of a shortage of suitable community-based accommodation or a shortage of staff. As noted in Section 1 and in the 2013/14 OPCAT Annual Report for the past two years, the Ombudsmen reported cases of care recipients who were kept in seclusion rooms permanently or semi-permanently. Although progress is being made on minimising and, where feasible, eliminating this practice, the Ombudsmen have urged the Ministry of Health to identify immediate, alternative accommodation for those individuals that remain in such positions.

Corrections facilities

The Corrections context presents an equally challenging environment for managing people with high and complex needs. The first national study of the prevalence of mental disorders among prison inmates found a significantly higher rate of mental disorder among inmates compared to the general population.[35] This is particularly so for schizophrenia, bipolar disorder, major depression, obsessive–compulsive disorder, and post-traumatic stress disorder. Mental illnesses with the highest lifetime occurrence among male, female, and remand prisoners were substance abuse or dependence (usually involving alcohol or cannabis), major depression, and post-traumatic stress disorder. Over 70 percent of prisoners experienced alcohol abuse or dependence issues. The lifetime occurrence of substance abuse or dependence was found to be occurring in over 85 percent of those with bipolar disorder, major depression, schizophrenia, obsessive–compulsive disorder, and post-traumatic stress disorder.[36]

32 Office of the Director of Mental Health Annual Report 2013, pp.26ff.

33 Committee against Torture, 2015, Concluding observations on the sixth periodic report of New Zealand, p.5; United Nations Working Group on Arbitrary Detention, 2015, p.17; Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of New Zealand, 2014, p.4;

34 See 'Monitoring Places of Detention', OPCAT Annual Reports 2008 – 2015, on the Human Rights Commission's website (https://www.hrc.co.nz/your-rights/human-rights/our-work/opcat).

35 Department of Corrections, 1999, National Study of Psychiatric Morbidity in NZ Prisons: An Investigation of the Prevalence of Psychiatric Disorders among New Zealand Inmates.

36 Ministry of Health, 2005, Prisoner Health Survey, p.7.

All these conditions are associated with high levels of distress and disability, especially during the acute phases of these illnesses. The Corrections study revealed that nearly 60 percent of all inmates have at least one major personality disorder.[37] A 2006 study further found that 66 percent of women prisoners suffer from a mental disorder.[38] The Ministry of Health estimates that prisoners are three times more likely to require access to specialist mental health services compared to the general population.[39] The recent Corrections survey of prisoners' mental health and substance abuse disorders involving 1200 prisoners admitted to prison over the first half of 2015 will provide much-needed data on the proportion of the prison population suffering from mental disorders.[40]

Corrections continues to develop and implement improvements to managing prisoners with high and complex needs. These include an ongoing pilot of expanded primary mental health services, expanding the High Dependency Unit at Rimutaka Prison, and initiatives focusing on preventing self-harm, including tools to assess levels of risk and new processes for the transition of prisoners between At-Risk Units and the mainstream population.[41]

At the same time, the number of unnatural deaths of prisoners increased when compared to the previous year, reversing an overall downward trend since 2010/11. Of 18 deaths in custody (compared to 13 in 2013/14), 10 were assumed to have been caused by natural causes, seven were assumed to have been suicides (compared to three in 2013/14) and one was an assumed homicide.[42] Reports of self-harm incidents have decreased along with a decrease in the number of such incidents with a 'threat to life' level of seriousness.[43]

The systems for providing mental health services in a Corrections context are under significant pressure from increasing prison musters and a high demand for inpatient beds. This disproportionately affects some population groups, including those with mild to moderate mental disorders, women, those with personality disorders, and Māori.[44] Little is known specifically about the mental health situation of other minority groups in prisons, including Pacific Islanders and LGTBI persons.

The 2012 investigation into prison healthcare by the Ombudsmen further highlighted deficiencies in the care and management of mentally unwell prisoners. The investigation found that aspects of the management of prisoners at risk of self-harm could be detrimental to their long-term mental state and behaviour.[45] It was found that services were insufficiently responsive to the diverse needs of prisoners requiring mental health care. Prison staff need to be adequately trained in managing people with disabilities in detention. More trained health professionals are needed, as well as specific training for general staff on better identifying mental disorders and psychosocial disabilities, distinguishing between intellectual and mental disabilities, and acquiring de-escalation techniques to deal with detainees in decompensation.

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37 Department of Corrections, 1999, p.45.

38 Tye and Mullen, 2006, Mental disorders in female prisoners" Australian and New Zealand Journal of Psychiatry 40/3:266, cited in JustSpeak, 2014, Unlocking Prisons, p.56.

39 Office of the Auditor General, 2008, Mental health services for prisoners, p.5.

40 Corrections Annual Report 2014/15, p.44.

41 Corrections Annual Report 2014/15, p.44

42 Corrections Annual Report 2014/15, p.137.

43 Corrections Annual Report 2014/15, p.44.

44 See Office of the Auditor General, 2008.

45 Office of the Ombudsman, 2012, Investigation of the Department of Corrections in relation to the provision, access and availability of prisoner health services, p.90.

Going forward

The National Preventive Mechanism acknowledges the inherent challenges in managing people with high and complex needs, some of whom present difficult and challenging behaviour. This can be exacerbated when their needs are being managed in restrictive custodial environments. As noted above, some progress is being made, yet systemic gaps remain.

Detaining agencies agree on the need for improved capability across the sector for managing and reasonably accommodating people with high and complex needs. As NPMs have frequently observed, two of the key underlying factors are the continued dominance of a punitive over a therapeutic approach and the lack of an adequately trained and skilled workforce. These concerns, and possible ways of addressing them, are interrelated. The first annual OPCAT report for the 2007/08 reporting period noted the importance of including specialist competencies when recruiting and training staff to accommodate those clients with high and complex needs. Seven years on, this observation still stands.

An effective response to these systemic issues requires an inter-agency approach across the system that involves criminal justice, social and health sector agencies, and other relevant stakeholders, including people with lived experience, to inform the development and implementation of solutions. We strongly urge the government to extend planning for and development of national mental health and addiction services to include the detention environments discussed above as it is rising to the challenge of providing better system integration and performance. Stronger whole-of-government partnerships would also increase national consistency in access, service quality, and outcomes for detained people with high and complex needs who require mental health and addiction services. The National Preventive Mechanism will further engage with detaining agencies and other relevant stakeholders to make progress towards realising the rights of people in detention.

Appendix: OPCAT background

Introduction to OPCAT

The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to help States meet their obligations in preventing torture and ill-treatment in places where people are deprived of their liberty.

Unlike other human rights treaty processes that deal with violations of rights after the fact, OPCAT is primarily concerned with preventing violations. It is based on the premise, supported by practical experience, that regular visits to places of detention are an effective means of preventing torture and ill-treatment and improving conditions of detention. This preventive approach aims to ensure that sufficient safeguards are in place and that any problems or risks are identified and addressed.

OPCAT establishes a dual system of preventive monitoring, undertaken by international and national monitoring bodies. The international body, the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), will periodically visit each State Party to inspect places of detention and make recommendations to the State.

At the national level, independent monitoring bodies called National Preventive Mechanisms (NPMs) are empowered under OPCAT to regularly visit places of detention, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing torture and ill-treatment.

Preventive approach

The Association for the Prevention of Torture (APT) highlights the fact that "prevention is based on the premise that the risk of torture and cruel, inhuman or degrading treatment or punishment can exist or develop anywhere, including in countries that are considered to be free or almost free from torture at a given time".[46]

On the principle of prevention, the SPT noted that:

> Whether or not torture or other cruel, inhuman or degrading treatment or punishment occurs in practice, there is always a need for States to be vigilant in order to prevent ill-treatment. The scope of preventive work is large, encompassing any form of abuse of people deprived of their liberty which, if unchecked, could grow into torture or other cruel, inhuman or degrading treatment or punishment. Preventive visiting looks at legal and system features and current practice, including conditions, in order to identify where the gaps in protection exist and which safeguards require strengthening.[47]

46 APT (March 2011) *Questionnaire to member states, national human rights institutions, civil society and other relevant stakeholders on the role of prevention in the promotion and protection of human rights*, p. 10.

47 Subcommittee on Prevention of Torture (May 2008). *First Annual Report of the Subcommittee on Prevention of Torture*, CAT/C/40/2, para 12.

Prevention is a fundamental obligation under international law, and a critical element in combating torture and ill-treatment.[48] The preventive approach of OPCAT encompasses direct prevention (identifying and mitigating or eliminating risk factors before violations can occur) and indirect prevention (the deterrence that can be achieved through regular external scrutiny of what are, by nature, very closed environments).

The UN Special Rapporteur on Torture remarked that:

> The very fact that national or international experts have the power to inspect every place of detention at any time without prior announcement, have access to prison registers and other documents, [and] are entitled to speak with every detainee in private … has a strong deterrent effect. At the same time, such visits create the opportunity for independent experts to examine, at first hand, the treatment of prisoners and detainees and the general conditions of detention … Many problems stem from inadequate systems which can easily be improved through regular monitoring. By carrying out regular visits to places of detention, the visiting experts usually establish a constructive dialogue with the authorities concerned in order to help them resolve problems observed.[49]

Implementation in New Zealand

New Zealand ratified OPCAT in March 2007, following the enactment of amendments to the Crimes of Torture Act (COTA) 1989, to provide for visits by the SPT and the establishment of NPMs.

New Zealand's designated NPMs are:

1. the Independent Police Conduct Authority – in relation to people held in police cells and otherwise in the custody of the police;
2. the Inspector of Service Penal Establishments of the Office of the Judge Advocate General – in relation to Defence Force Service Custody and Service Corrective Establishments;
3. the Office of the Children's Commissioner – in relation to children and young persons in Child, Youth and Family residences;
4. the Office of the Ombudsman – in relation to prisons, immigration detention facilities, health and disability places of detention, and Child, Youth and Family residences; and
5. the Human Rights Commission has a coordination role as the designated Central National Preventive Mechanism (CNPM).

Functions and powers of National Preventive Mechanisms

By ratifying OPCAT, States agree to designate one or more NPMs for the prevention of torture and ill-treatment (Article 17) and to ensure that these mechanisms are independent, have the necessary capability and expertise, and are adequately resourced to fulfil their functions (Article 18).

The minimum powers NPMs must have are set out in Article 19. These include the power to regularly examine the treatment of people in detention, to make recommendations to relevant authorities and submit proposals or observations regarding existing or proposed legislation.

NPMs are entitled to access all relevant information on the treatment of detainees and the conditions of detention, to access all places of detention and conduct private interviews with people who are detained or who may have relevant information. NPMs have the right to choose the places they want to visit and the persons they want to interview (Article 20). NPMs must also be able to have contact with the SPT and publish annual reports (Articles 20, 23).

48 It sits alongside the obligations to criminalise torture, ensure impartial investigation and protection, and provide rehabilitation for victims.

49 UN Special Rapporteur on Torture, Report of the Special Rapporteur on torture to the 61st session of the UN General Assembly, A/61/259 (14 August, 2006), para 72.

The State authorities are obliged, under Article 22, to examine the recommendations made by the National Preventive Mechanism and discuss their implementation.

The amended COTA enables the Minister of Justice to designate one or more NPMs as well as a Central NPM and sets out the functions and powers of these bodies. Under section 27 of the Act, the functions of an NPM include examining the conditions of detention and treatment of detainees, and making recommendations to improve conditions and treatment and prevent torture or other forms of ill treatment. Sections 28-30 set out the powers of NPMs, ensuring they have all powers of access required under OPCAT.

Central National Preventive Mechanism

OPCAT envisions a system of regular visits to all places of detention.[50] The designation of a CNPM aims to ensure there is coordination and consistency among multiple NPMs so they operate as a cohesive system. Central coordination can also help to ensure any gaps in coverage are identified and that the monitoring system operates effectively across all places of detention.

The functions of the CNPM are set out in section 32 of the COTA, and are to coordinate the activities of the NPMs and maintain effective liaison with the SPT. In carrying out these functions, the CNPM is to:

- consult and liaise with NPMs
- review their reports and advise of any systemic issues
- coordinate the submission of reports to the SPT
- in consultation with NPMs, make recommendations on any matters concerning the prevention of torture and ill-treatment in places of detention

50 OPCAT, Article 1.

Monitoring process

While OPCAT sets out the requirements, functions and powers of NPMs, it does not prescribe in detail how preventive monitoring is to be carried out. New Zealand's NPMs have developed procedures applicable to each detention context.

The general approach to preventive visits, based on international guidelines, involves:

1. Preparatory work, including collecting information and identifying specific objectives, before a visit takes place;
2. The visit itself, during which the NPM monitoring team speaks with management and staff, inspects the institution's facilities and documentation, and speaks with people who are detained;
3. Upon completion of the visit, discussions with the relevant staff, summarising the NPM's findings and providing an opportunity for an initial response; and
4. A report to the relevant authorities of the NPM's findings and recommendations, which forms the basis of ongoing dialogue to address identified issues.

NPMs' assessment of the conditions and treatment of detention facilities takes account of international human rights standards, and involves looking at following **six domains:**

1. Treatment: any allegations of torture or ill-treatment; the use of isolation, force and restraint;
2. Protection measures: registers, provision of information, complaint and inspection procedures, disciplinary procedures;
3. Material conditions: accommodation, lighting and ventilation, personal hygiene, sanitary facilities, clothing and bedding, food;
4. Activities and access to others: contact with family and the outside world, outdoor exercise, education, leisure activities, religion;
5. Health services: access to medical and disability care; and
6. Staff: conduct and training.

NPM contacts

Independent Police Conduct Authority

0800 503 728 (toll free)
Language Line available
Telephone 04 499 2050
Email enquiries@ipca.govt.nz
Website www.ipca.govt.nz

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