THINKING OUTSIDE THE BOX: The Treatment of Sentenced Offenders At-Risk of Self Harm[*]

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A dissertation submitted in partial fulfilment of the degree of Bachelor of Laws (Honours) University of Otago

October 2017

[*] This title has been adapted from Sharon Shalev *Thinking Outside the Box? A Review of Seclusion and Restraint Practices in New Zealand* (Human Rights Commission, April 2017).

ACKNOWLEDGMENTS

To Professor Geoff Hall, for introducing me to such an interesting and important topic. Your expertise in Criminal Justice and Corrections has been invaluable.

To Dr Mary Foley, for your guidance and constructive criticism. I have thoroughly enjoyed our extended meetings over the past year.

It has been a pleasure to get to know you both. Thank you for your supervision and support.

INTRODUCTION

"It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones."[1]

Prisoners are a marginalised sector of society who are vulnerable to abuse and neglect. Within the prison walls there are groups more vulnerable than others.[2] One such group is prisoners who are at risk of self-harm or suicide. These prisoners are known as 'at-risk prisoners'.[3] Mental health issues, substance and drug abuse, poverty and childhood trauma often underlie their behaviour. They are complicated individuals who present complicated problems for the Department of Corrections and, more generally, for the Criminal Justice system. For many, prison has a disastrous effect on their psychological and physical well-being. What then is the appropriate way to care for these individuals? This dissertation attempts to answer this difficult question.

In March 2017, the Chief Ombudsman Judge Peter Boshier produced a scathing report on the care and management of at-risk prisoners.[4] The Optional Protocol to the Convention Against Torture (OPCAT) Findings Report found that Corrections had breached the Convention against Torture and Other Cruel and Degrading Treatment or Punishment Act (CAT) and Corrections Act 2004. The severe treatment of one prisoner in particular resulted in substantial media attention.[5] The prisoner spent 37 consecutive nights secured on a tie-down bed for approximately 16 hours a day.[6] This OPCAT Findings Report demonstrated that there are substantial shortcomings in the treatment of at-risk prisoners.

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[1] Nelson Mandela "Long Walk to Freedom: The Autobiography of Nelson Mandela" (Little Brown and Co, London 1994) at 201.
[2] Māori prisoners are another vulnerable group in New Zealand's criminal justice system. However, the specific issues faced by Māori in the criminal justice system are beyond the purview of this dissertation. For discussion on the issues faced by Māori see: Charlotte Williams "The Too-hard Basket: Māori and criminal justice since 1980" (Victoria University Press, Wellington, 2001).
[3] 'At-Risk prisoners' is a term used to describe prisoners who are at risk, or potentially at risk of self-harm or suicide. This terminology is used synonymously in Australia. See: Corrective Services ACT and others *Standard Guidelines for Corrections in Australia* (2012).
[4] Peter Boshier *OPCAT Findings Report: A Question of Restraint: Care and Management of Prisoners Considered to be At-risk of Self-Harm: Observations and Findings from OPCAT Inspectors* (Office of the Ombudsman, March 2017) (Hereafter, OPCAT Findings Report).
[5] Issac Davidson "Prisoner At-risk of Self-harm Tied Down For 37 Consecutive Nights, Investigation Finds" *The New Zealand Herald* (online ed, 1 March 2017).
[6] OPCAT Findings Report, above n 4, at 29.

Before appraising what is being done, or suggesting what should be done to address this problem the prevalence of psychiatric disorders amongst New Zealand prisoners should be assessed. In 2016, the Department of Corrections (DOC) produced a report that found 91% of prisoners suffer from a lifetime diagnosis of "any mental disorder", 62% of whom had received such a diagnosis within the past 12 months.[7] This is substantially higher than the general population.[8] In particular, the following conditions are significantly more prevalent amongst prisoners:[9]

- major depressive disorder;
- bipolar disorder, especially current episode of mania;
- schizophrenia and related conditions;
- substance abuse and dependence, especially in women;
- post-traumatic stress disorder;
- obsessive compulsive disorder; and
- personality disorder.

Personality disorders are very difficult to diagnose. A 2010 report by the National Health Committee suggested that 60% of prisoners had at least one personality disorder. [10] This figure was consistent with a report in 1999.[11] However, a 2016 report recorded than one in three prisoners suffers from a personality disorder.[12] The same report also documented that approximately one in five prisoners had attempted suicide and one in three had thought about suicide.[13] These statistics make for poignant reading. New Zealand's prison population is largely mentally unwell and vulnerable to suicide. This fact must be considered when addressing the treatment of at-risk prisoners.

This dissertation discusses the treatment of sentenced offenders exclusively. As such the legal issues concerning fitness to stand trial and insanity are beyond its scope.[14] Similarly, the

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[7] Devon Indig, Craig Gear and Kay Wilhelm *Comorbid substance use disorders and mental health disorders among New Zealand prisoners* (2016) at 9.
[8] At 9.
[9] At 5-7.
[10] National Health Committee *Health in Justice: Kia Piki te Ora, Kia Tika! – Improving the Health of Prisoners and Their Families and Whanau: He whakapiki i te ora o ngā mauhere me ō rātou whānau* (July 2010) at 3.
[11] Alan Simpson and others *The National Study of Psychiatric Morbidity in New Zealand Prisons* (Department of Corrections and Ministry of Health, 1999).
[12] Indig, Gear and Wilhelm, above n 9, at 6.
[13] At 7.
[14] This determination occurs prior to sentencing. For detailed discussion of these legal avenues see: W Brookbanks and A Simpson (eds) *Psychiatry and the Law* (LexisNexis, Wellington, 2007) and W Brookbanks *Competencies of Trial: Fitness to Plead in New Zealand* (LexisNexis, Wellington, 2011).

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 is also beyond the current scope as discussion focusses on those with mental health issues and not intellectual disability.[15]

The law that governs compulsory psychiatric treatment in New Zealand is addressed in Chapter 1. The definition of 'mental disorder' in the Mental Health (Compulsory Assessment and Treatment Act) 1992 serves as the gatekeeper to entry and exit from compulsory psychiatric treatment.[16] The Mental Health Review Tribunal (MHRT) and Court have adopted intricate, interpretive strategies that are applied to the definition of 'mental disorder'. It is very difficult for personality disorders to fall within the ambit of the Act. The implications of this definition for at-risk prisoners are examined.

Chapter 2 describes the manner in which at-risk prisoners are currently treated. The law regarding segregation and restraint is examined. At-risk units (ARUs), where at-risk prisoners are managed, employ a situational or environmental approach to minimising risk by eliminating opportunities for self-harm. ARUs are a form of solitary confinement.[17] ARUs may fulfil their primary objective of eliminating the opportunity for self-harm but this comes at the cost of long-term psychological damage. These consequences are profound when segregation is prolonged or those subject to it are mentally unwell.

The various human rights obligations that relate to the treatment of at-risk prisoners are discussed in Chapter 3. There are a number of relevant international treaties that relate to the use of solitary confinement, restraints and treatment of prisoners generally. In 2015, the UN amended the Standard Minimum Rules for the Treatment (what are now known as 'The Mandela Rules') which represents unanimous agreement from the international community. The consistency of New Zealand's current approach to the treatment of at-risk prisoners is evaluated.

Therapeutic jurisprudence (TJ) is an approach to legal issues that seeks to maximise therapeutic

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[15] Despite the fact there is many instances in which mental health and intellectual disability may overlap. For discussion surrounding the structure of the ID(CCR)A and definition of 'intellectual disability' see A Duncan "The Intellectual Disability (Compulsory Care and Rehabilitation) Act", from J Dawson and K Glendhill (eds), New Zealand's Mental Health Act in Practice, Victoria UP, Wellington, 2013

[16] *Waitemata Health v A-G* [2001] 21 FRNZ 216; [2001] NZFLR 1122 [CA].

[17] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), r 44.

benefits whilst minimising anti-therapeutic effects. This requires solutions that will obviate the need for the treatment of at-risk prisoners. Chapter 4 proposes ways in which this can be achieved. Legislative reform to the definition of 'mental disorder' is necessary in order to produce more therapeutic outcomes for at-risk prisoners. This reform targets personality disordered offenders whose mental health needs are inadequately treated at present. Legislative reform itself will be ineffective unless appropriate therapeutic communities (TC) are developed.

The harmful effects of solitary confinement, or "the box" as it is sometimes referred, are well-established.[18] Why then do we subject some of our most vulnerable prisoners to it? The short answer is that it is necessary to prevent self-harm and suicide. However, the use must be minimised as far as possible. This requires practical solutions and political courage. This objective requires us to think outside of the box.

[18] D Polizzi *Solitary Confinement: Lived Experiences and Ethical Implications* (University of Bristol, Bristol, 2017).

CHAPTER 1: The Legal Criteria for Compulsory Psychiatric Treatment

"In albeit simplistic terms, there is a lack of clarity as to at what point people on the mad/bad continuum are cared for in hospital or controlled in prison."[19]

This chapter considers New Zealand's legal threshold for compulsory psychiatric treatment. It examines the complex structure and meaning of 'mental disorder' under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT Act)) and contrasts it with approaches in other jurisdictions. The interpretive approaches used by the Mental Health Review Tribunal (MHRT) and Courts when applying this definition are discussed.[20] This is relevant because prisoners that are deemed 'mentally disordered' under the MH(CAT) Act 1992 are transferred from prison to a forensic psychiatric ward. Those prisoners that do not meet the criteria are cared for within the prison system and are the subject of this dissertation.

What is the Relevance of Being 'Mentally Disordered' under the MH(CAT) Act 1992?

The MH(CAT) Act 1992 defines the circumstances where compulsory psychiatric treatment or assessment may occur. The Act attempts to ensure both vulnerable individuals and the public are protected from harm. Establishing that a prisoner is 'mentally disordered' governs entry and exit from compulsory treatment. Should a prisoner fall within the definition of 'mentally disordered' they will be placed in compulsory psychiatric treatment as a 'special patient'.[21] Special patient status provides for compulsory treatment in a secure environment. Special patients:[22]

> are placed in a quasi-criminal status that reflects their route of entry – via the criminal justice process - even after they enter treatment or care. Concerns about security, or risk of harm to others, tend to dominate their management

[19] Report of Mel Smith, Ombudsman Following a Reference by the Prime Minister Under Section 13(5) of the Ombudsmen Act 1975 for an Investing into Issues Involving the Criminal Justice Sector at (November 2007) at 95.
[20] The Mental Health Review Tribunal (MHRT) is an independent body appointed by the Minister of Health under the MH(CAT) Act. Mental Health (Compulsory Assessment and Treatment) Act 1992, s 101.
[21] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.
[22] John Dawson "The Legal Framework for Forensic Care" in P Skegg and R Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 2 at 6.

> and control.

Should the MHRT or responsible clinician[23] consider the person "fit to be released from compulsory status" they must be released.[24] Section 2 defines 'fit to be released from compulsory status' as: "no longer mentally disordered *and* fit to be released from the requirement of assessment or treatment under this Act" [emphasis added].

In *Waitemata Heallth v A-G* it was held that "and" is merely used to explain the natural consequence of being released from compulsory status that occurs when someone is no longer 'mentally disordered'.[25] That is a separate determination concerning their fitness to be released is not required. Chief Justice Elias stated that discharge from compulsory status should not depend on "any consideration other than whether the patient continues to suffer from mental disorder."[26] Accordingly, once someone is no longer 'mentally disordered' under the Act they must be released from compulsory status. They will either be transferred back to prison to complete their sentence or, if their sentence has ended, they will be released.

A. The Definition of 'Mental Disorder'

The meaning of 'mental disorder' for the purposes of the MH(CAT)A is complex. The Statute is split into what is commonly referred to as the "two limbs."[27] The first limb refers to the 'abnormal state of mind' which must be characterised by a list of delusions or disorders of mental function. This list is known as the phenomenological consequences.[28] The second limb refers to the consequences of this 'abnormal state of mind'. This second limb is sometimes referred to as the severity or consequential test.[29] Section 2 of the MH(CAT)A states:

> mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—
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> (a) poses a serious danger to the health or safety of that person or of others; or

[23] The responsible clinician is the psychiatrist in charge patient's treatment Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.
[24] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 35(1), 76(5) and 79(8).
[25] *Waitemata Health v A-G* [2001] 21 FRNZ 216; [2001] NZFLR 1122 [CA].
[26] At [90].
[27] As is advocated in Ministry of Health *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (November 2012) at 4.
[28] *Waitemata Health v A-G*, per Elias CJ, at [71].
[29] John Dawson "The Complex Meaning of "Mental Disorder"' in J Dawson and K Glendhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 29 at 31.

> (b) seriously diminishes the capacity of that person to take care of himself or herself;—
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> and mentally disordered, in relation to any such person, has a corresponding meaning.

A person is only considered 'mentally disordered' if both limbs of this definition are satisfied. The 'abnormal state of mind' must be 'of such a degree that' at least one of the specified consequences is apparent. This creates a requirement that there be a sufficient nexus between the two limbs. Someone who suffers bouts of depression and has a history of violent, unprovoked assaults may satisfy each limb independently. However, they will not be deemed 'mentally disordered' unless a sufficient connection between the 'disorder of mood' (depression) and serious danger that they pose to the health and safety of others is established.[30]

The First Limb: 'Abnormal State of Mind'

The first limb defines 'abnormal state of mind' through an exhaustive list of disorders of mental function. They are left undefined in the Act. The Act provides no specific reference to "mental illness, or disease, or brain, or personality … nevertheless the major manifestations of most serious mental disorders … are included on the list."[31] This limb consists primarily of clinical, psychiatric content and should be capable of clear meaning. However, in practice the various undefined terms create substantial ambiguity. This will be discussed when addressing the interpretive strategies adopted by the Courts and MHRT.

This approach is mirrored in many jurisdictions in Australia.[32] For example, New South Wales defines 'mental illness' as:[33]

> a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence of any one or more of the following symptoms: delusions; hallucinations; serious disorders of thought form; a severe disturbance of mood and sustained or repeated irrational behaviour indicating the presence of any one or more of

[30] For discussion concerning the required nexus Sylvia Bell and Warren Brookbanks *Mental Health Law in New Zealand* (3rd ed, Wellington, 2017) at 25.
[31] Dawson, above n 29, at 32.
[32] Comparative provisions are virtually identical in; Victoria, Australian Capital Territory and Queensland. See: Mental Health Act 1986 (Vic), s 8(1A); Mental Health (Treatment and Care) Act 1994 s 3 and Queensland Mental Health Act 2000 Sch 3.
[33] Mental Health Act 2007 (NSW) s 4.

> the [aforementioned] symptoms.

However, a prescribed list "leaves open the possibility that some relatively severe conditions, that might be thought to need compulsory treatment are not covered."[34] In particular, this limb makes it very difficult for people with personality disorders to fall within the ambit of the Act.[35] Many prisoners that suffer from personality disorders engage in self-harming behaviour.[36] For these at-risk prisoners compulsory treatment will rarely result. This fact was acknowledged by Ombudsman Mel Smith:[37]

> There remains, nevertheless, one significant group – that is people with severe personality disorders – who … are usually not considered appropriate for compulsory treatment, and who cannot be safely and effectively managed in the prison environment.

A list of features of mental disorder is not always replicated in other jurisdictions. Many jurisdictions have moved towards a broader definition for compulsory psychiatric treatment.[38] For example, in the United Kingdom mental disorder means "any disorder or disability of the mind."[39] However, an overly broad definition is open to potential abuse. It risks socially inconvenient people being subject to compulsory treatment for which there is no appropriate treatment. In this case, indefinite confinement may result. In order to understand why New Zealand's compulsory treatment law is formulated the way it is the historical context must be considered.

Although the MH(CAT) Act was not enacted until 1992 it has its nascence in the 1970's. It has been argued that Aubrey Lewis is "perhaps the person most responsible for this formulation."[40] In the 1970's Lewis and other prominent psychiatrists argued that for mental illness to be present there must be evident disturbance in the functions of the mind. Lewis argued that disturbed social functioning alone is not sufficient. He argued "deviant, maladapted, non-

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[34] Dawson, above n 29, at 32.
[35] Bell and Brookbanks, above n 30, at 23-53.
[36] Report of Mel Smith Report, above n 19.
[37] Report of Mel Smith, above n 19, at 96.
[38] This has occurred since the 1980's by economically developed countries. See: Elizabeth Fistein and others "A Comparison of Mental Health Legislation From Diverse Commonwealth Jurisdictions" (2009) 32 *Int J Law Psychiatry* 147.
[39] Mental Health Act 1983 (UK) s 1(2). Despite this broad definition the English provision has not resulted in many personality disordered individuals being committed.
[40] See Dawson, above n 29, at 34.

conformist behaviour is pathological *if* it is accompanied by a manifest disturbance of some such functions."[41] A clear definition was deemed necessary to prevent abuses of psychiatry. This is because abuses of psychiatry were rife during the 1970s in NZ and internationally.[42] Preventing the arbitrary use of state power was a clear priority. During the 1970s approximately one third of the Soviet Union's political prisoners were in psychiatric hospitals.[43] Intense debate also surrounded whether homosexuality should be removed from the Diagnostic and Statistical Manual (DSM).[44]

The Severity or Consequential Limb

The severity or consequential limb lists various consequences. Assessment is difficult since it requires the prediction of an individual's future behaviour. Establishing whether the requisite 'serious danger' requirement is met is "ultimately a matter of judgment, having regard to a multiplicity of considerations and the unique circumstances of each case."[45]

The MHRT has proposed the following framework on which to base an evaluation:[46]

(i) the magnitude or gravity of the behaviour concerned
(ii) the likelihood of the behaviour occurring
(iii) the proximity or imminence of the behaviour, in other words, how soon or quickly it might occur, and
(iv) the frequency of the behaviour, that is to say how often it might occur.

The Tribunal went on to state that "a risk of, say, homicide is likely to constitute serious danger to others in the mental disorder definition despite the likelihood, proximity and frequency being relatively low."[47] This demonstrates that not all questions need to result in an answer that would independently suggest a 'serious danger' is present. The strength of one factor can be essentially determinative. For at-risk prisoners, the severity test will be easily established

[41] A Lewis *Health as a Social Concept* (4th Ed, Wiley, London, 1953) at 118.
[42] See Robert van Voren "Political Abuse of Psychiatry – An Historical Overview (2010) 36 The Journal of Psychoses and Related Disorders 33.
[43] Van Voren, above n 42, at 33.
[44] For discussion surrounding the history of homosexuality's inclusion in DSM see: William Turner "The Diagnostic Status of Homosexuality in DSM-III: a Reformulation of the Issues" (2006) 138 *The American Journal of Psychiatry* 210.
[45] *Re Mental Health [Serious Danger]* [2012] NZFLR 1 (MHRT).
[46] The following four questions were suggested to ascertain whether a 'serious danger' is satisfied in *Re Mental Health [Serious Danger]* [2012] NZFLR 1 (MHRT) at [57].
[47] *Re Mental Health [Serious Danger]* [2012] NZFLR 1 (MHRT) 1 at [58].

considering the imminent harm they pose to themselves. Whether at-risk prisoners are considered 'mentally disordered' will be contingent on the presence of an 'abnormal state of mind'.

Treatability, Necessity and Exclusionary Criteria

Section 66 of the MH(CAT) Act 1992 ensures every patient the right to "medical treatment and other health care appropriate to his or her condition." This cautions against classifying someone as 'mentally disordered' for which there is no effective medical treatment.[48] This is particularly important given once someone is committed under the Act they cannot be released until they are no longer mentally disordered. If treatment does not exist for the condition, then their confinement may be indefinite. Treatability is not, however, determinative. Instead it acts as an interpretive principle when assessing whether or not 'mental disorder' is present.[49] This principle is another reason why those people with personality disorders rarely fall within the ambit of the Act.

Section 27(3) requires that the order be deemed "necessary" having regard to the circumstances of the case. This provides the opportunity for a prisoner with an 'abnormal state of mind' to be dealt with as a voluntary patient. Importantly, this "necessity" requirement only applies to 'entry' into compulsory treatment and not 'exit'.[50] As previously discussed, *Waitemata* held that exit depends entirely on whether the patient is still 'mentally disordered'.[51]

The MH(CAT) Act 1992 contains exclusionary criteria. No one may be committed by reason only of: [52]

(a) that person's political, religious, or cultural beliefs; or

(b) that person's sexual preferences; or

(c) that person's criminal or delinquent behaviour; or

(d) substance abuse; or

(e) intellectual disability.

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[48] See Dawson, above n 29.
[49] N Dunlop, "Compulsory Psychiatric Treatment and 'mental disorder'" (2006) 225 *NZLJ* 229.
[50] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 27(3).
[51] However, this same process occurs through the process dynamic interpretation of dynamic interpretation. This will be discussed later in this Chapter.
[52] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 4.

It is common practice to use exclusionary criteria in order to prevent arbitrary detention and abuses of psychiatry.[53] However, the presence of one or more of the exclusionary criteria may exacerbate delusions and/or disorders a person experiences or make them more dangerous. This may increase the likelihood that they will be deemed 'mentally disordered'.[54] The exclusion only applies when behaviour is caused solely by one of the phenomena expressed in s 4 of the MH(CAT) 1992 Act.

B. The Interpretation of 'mental disorder'

Defining 'mental disorder' is a difficult interpretive task since it comprises psychiatric and non-psychiatric terms, all of which are left undefined. Furthermore, this task is undertaken by the Tribunal, by Courts as well as by psychiatrists. The parallel nature[55] of the decision-making process was outlined by Chief Justice Elias stating:[56]

> If at any time the responsible clinician *or* a judge is of the opinion that the patient is fit to be released from compulsory status, he or she *must* direct the patient's release [emphasis added].

In recent years, the Courts and Tribunal have developed three concurrent interpretive approaches.[57] These three approaches are broadly categorised as; the 'legal' approach, 'psychiatric' approach and 'dynamic' approach.[58] However, these approaches are all subject to an overriding principle based on justification for and against compulsory treatment.[59]

The 'Legal' Approach

The starting point when interpreting the definition of 'mental disorder' is the 'legal' approach. The definition is found in a statute and thus the definition must be considered from a 'legal'

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[53] Fistein and others, above n 38. It was found that 15 out of the 25 jurisdictions analysed incorporated exclusionary criteria. The use of ethnic, political, religious or cultural status as an exclusion is noticeable in the legislation of South Africa and Australia, all of which have an unfortunate history of oppression of indigenous peoples.
[54] Refer to Ministry of Health, above n 27.
[55] The 'parallel nature' refers to the fact that both the responsible clinician and the judge have the power (and duty) to release a person from compulsory status if they no longer consider them 'mentally disordered'.
[56] *Waitemata Health v A-G* at [68].
[57] As discussed in Dawson, above n 29.
[58] As proposed in Dawson, above 29.
[59] For detailed explanation of this justification principle N Dunlop, "Compulsory Psychiatric Treatment and 'mental disorder'" (2006) 225 NZLJ 229.

perspective. Acts of Parliament are intended to be read and comprehended by a range of people, not just those with specific expertise. Section 5 of the Interpretation Act requires that the meaning of an Act be "ascertained from its text and in the light of its purpose." The purpose of 'mental disorder' is to be the exit and entry 'gatekeeper' to compulsory psychiatric treatment. Substantial rights are denied as a result and so the interpretation must be consistent with whether the rights' infringements are justified.

The MHRT explained that in some instances there is a "distinction between the legal and clinical imperative."[60] In other words, a definition that sits consistently with the purpose of the Act may not necessarily be consistent with how the psychiatric profession defines a term.

The 'Psychiatric' Approach

A purposive reading of the statute also suggests terms be given a meaning consistent with the psychiatric profession. There are many indications that Parliament intended terms to be considered from a psychiatric perspective. At various stages psychiatrists are charged with assessing whether the person is 'mentally disordered'. A psychiatrist must also sit as a member of the Tribunal. Parliament did not intend the expertise of the psychiatric profession to be entirely overlooked.

A compromise must be forged between the 'legal' and 'psychiatric' approach to interpretation. This need for compromise is demonstrated by Chief Justice Elias stating "the words used in the definition of mental disorder are words in their ordinary use, although their application is heavily dependent upon the assessment of clinicians."[61] Both psychiatric professionals and legal actors must apply the definition at various stages. Therefore, principles from both disciplines must be applied concurrently.

However, there are certain parts of the definition that suggest they should have a stricter psychiatric meaning than others. The tribunal stated that the definition is "clinically descriptive, particularly the first limb."[62] Accordingly, the Tribunal has held that clinical terms such as

[60] *Re KMD* [2004] MHRT 04/139.
[61] *Waitemata Health v A-G* at [1].
[62] *Re KMD* at 22.

'delusions', 'mood' and 'perceptions' be given "a specialised meaning."[63] Despite the predominantly clinical content of the first limb, both 'cognition' and 'volition' are given a more ordinary meaning.[64] This is because these terms are not usually associated with psychiatry but rather more general philosophical terms.

The 'Dynamic' Approach

The final approach that must be considered when interpreting the definition focuses on the dynamic of the interaction between the two limbs. It allows for the precise scope of certain terms within the definition to widen (or narrow) depending on the overall justification of compulsory treatment.

If one limb is easily satisfied then the scope of the other limb may widen.[65] If, for example, someone poses a serious and imminent danger to an identifiable third person then the requisite 'abnormal state of mind' for example disorder of cognition may be more easily established than in other circumstances. This is because the rights of the third party, who may be detrimentally affected, justify the compulsory treatment. Conversely, someone with a severe, long-term 'abnormal state of mind' may require a lower consequential threshold in terms of serious danger. The same logic can be applied to the undefined 'intermittent nature'. If someone poses a particularly serious danger, then the definition of 'intermittent' will be stretched further to maintain the compulsory status.[66]

The entire scope of the definition may widen based on the overall strength of justifications for or against compulsory treatment. This allows for the broader context to be brought to the fore to aid interpretation. For example, where treatment is invasive and has proved futile there may be sufficient justification to end compulsory treatment. The person will therefore no longer be considered 'mentally disordered'. This is an example of a rights-driven interpretation where conflicting rights of the patient and any third parties is balanced to assess whether there is sufficient, overall justification for compulsory treatment.

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[63] *Re IM* [2002] NZMHRT 57/00 at [68]
[64] These terms do not have a particular psychiatric meaning. As a result they have generated considerable controversy as to their ambit. See for example: *Re K* DC Rotorua FAM-2009-063-732, 5 November 2009.
[65] The serious danger posed by RCH justified 'stretching' disorder of cognition *Waitemata Health v A-G.*
[66] Dawson, above n 29.

As previously mentioned, s 27(3) MH(CAT) Act 1992 requires that compulsory treatment be "necessary" given the circumstances, it is not applicable when considering whether someone is *still* 'mentally disordered'.[67] The necessity of the compulsory treatment is a valid consideration when considering the overall justification for compulsion.[68] If someone can be appropriately treated voluntarily, this will reduce the overall justification for compulsory treatment. The 'exit' criteria also takes into account the rationale in s 27(3). But it does this via an interpretive tool as opposed to constituting a separate test.

This interaction between the two limbs and the justification for compulsory treatment, creates a degree of discretion for those assessing whether a 'mental disorder' is present. The interpretive strategies provide some flexibility. However, the discretion is not unbridled and both limbs do need to be independently established.

All interpretive approaches are complementary and must be considered concurrently in order to reach a reasoned and justifiable decision. In its most simple form "the issue is not so much whether patients are mentally disordered but whether they should be regarded as such for the Act."[69] The overall justification for compulsory treatment must be considered when ascribing meaning to the definition of 'mental disorder'.

The Interpretation of Personality Disorders under the MH(CAT) Act 1992

Personality disorders are not usually considered appropriate for compulsory treatment. The cases of *RCH* and *Waitemata Health* exemplifies the difficulty in establishing that someone with a personality disorder exhibits the requisite characteristics to be able to establish an 'abnormal state of mind'.[70]

The Case of RCH and Waitemata Health

RCH was a particularly disturbed individual, subject to extensive sexual and physical abuse as

[67] *Waitemata Health v A-G.*
[68] Dunlop, above n 49.
[69] Dunlop, above n 49.
[70] The following cases all concern the same individual. *In the Matter of RCH* (2000)*; In the Matter of RCH*, MHRT No 12/039, 24/5/2012 and *Waitemata Health v A-G.* However, *Waitemata Health v A-G* also considered the meaning of 'fit to be released from compulsory status' as discussed earlier.

a child.[71] RCH had a mix of borderline and narcissistic personality disorder.[72] He had an extensive criminal history and expressed constant ruminations about harming former counsellors who he felt had wronged him.[73] He was considered to be extremely dangerous given the nature of his criminal offending and the threat he posed to identifiable woman.[74]

This invited a broader interpretation of 'abnormal state of mind'. Throughout the extensive judicial proceedings, the MHRT (and COA) have stretched the terms listed within the 'abnormal state of mind' definition in order for RCH to remain in a secure environment. Even though, at times, the expert evidence of psychiatrists contended there was no requisite 'abnormal state of mind', the Tribunal (and COA) held that the term 'disorder of cognition' is broad enough to apply to abhorrent thought content and not just deficient thought processes as understood by the psychiatric profession.[75]

Prior to compulsory treatment RCH spent 13 consecutive years in prison as a result of violence against woman and threats made to counsellors. Throughout this period, he was not considered 'mentally disordered'. This is because the secure environment of prison meant he was not a serious danger to others. *RCH* illustrates that it is very difficult for those with personality disorders to be considered 'mentally disordered'. His personality disorder was severe and the threat he posed overwhelming.

Conclusion

The definition of 'mental disorder' dictates those that receive compulsory treatment. The consequential limb is capable of broad application and will be easily established for at-risk prisoners. However, the phenomological consequences are stated in specific terms. This creates the potential for some people, who may benefit from compulsion, slipping through the cracks. The manner in which the Tribunal and Courts have interpreted the definition has partially remedied this problem. The dynamic, purposeful application centred around the primacy of justification ensures that many of those who would benefit from compulsory treatment will

[71] *In the Matter of RCH* (2000) at 4.
[72] At 4.
[73] At 7.
[74] *In the Matter of RCH* (2000).
[75] *Waitemata Health v A-G.*

receive it.[76] In saying this, when assessing whether the 'abnormal state of mind' is evident, psychiatric "meanings cannot be cast aside because it might be inconvenient due to the circumstances of the case."[77] Widening the scope of the phenomological consequences is not necessarily appealing. There must sufficient provisions to ensure that socially inconvenient people who pose risks are not committed merely to mitigate the risk they pose. Where there is no treatment available it may amount to arbitrary, potentially indefinite detention. Accordingly, suitable treatment must be provided for those that are subject to compulsory psychiatric treatment.

At-risk prisoners that do not satisfy the 'abnormal state of mind' limb must be cared for within the prison environment. They should be managed in a humane, therapeutic manner and their mental health needs addressed. However, New Zealand currently fails to achieve this desired outcome. The treatment of at-risk prisoners often exacerbates mental health problems and is thus inconsistent with principle of therapeutic jurisdiction (TJ).

[76] The same can be said if society would benefit from individuals being subject to the Act.
[77] Re IM [2002]NZMHRT 57/00 at [68]

CHAPTER 2: What is New Zealand's Current Approach to Dealing with At-Risk Prisoners?

"Once in prison, of course, matters get only worse: prisons make sane people mad, and mad people madder"[78]

Prisoners who are considered at-risk, but are not deemed 'mentally disordered' under the MH(CAT) Act 1992, create a dilemma for the criminal justice system, especially the Department of Corrections (DOC). A prisoner's fundamental human rights must not be breached, yet all efforts must be made to minimise the risk they pose to themselves. There is an inherent conflict between these two imperatives.

There are two courses of action open to Corrections staff when a prisoner is considered at-risk. The first option is segregation via the use of At-Risk Units (ARUs). These are special cells designed to limit the risk of self-harm. ARUs have limited fixtures and fittings, with special bedding and clothing to prevent self-harm. In more extreme cases, where ARUs are ineffective in sufficiently minimising the risk posed by self-harm, different methods of restraint may be used. In New Zealand, the legal framework for these two options is set out in the Corrections Act 2004, Corrections Regulations 2005 and the Prisoner Operations Manual (POM). The use of ARUs and restraints generate harmful psychological and physiological effects.

What is Segregation and Restraint?

Segregation is defined as "the physical isolation of individuals in a place of confinement for twenty-two to twenty-four hours a day."[79] The use of segregation in prison first emerged in the 19th Century.[80] At this point, the rationale behind segregation was to rehabilitate criminals.[81] Segregation is no longer regarded as a rehabilitative tool. It is now primarily used as a means of: punishment; to manage specific groups of prisoners (such as those that present a risk of

[78] Jock Young "Crime and the Dialetics of Inclusion/Exclusion (2004) 44 *Brit J Criminol* 550 at 552.
[79] As defined in the International Psychological Trauma Symposium "Istanbul Statement on the Use and Effect of Solitary Confinement" (9 December 2007) Solitary Confinement <http://www.solitaryconfinement.org/istanbul>.
[80] N Morris and D Rothman (eds) *Oxford History of the Prison: The Practice of Punishment in Western Society* (Oxford University Press, Oxford, 1998).
[81] Morris and Rothman, above n 80. Solitary confinement was also justified as criminality was seen as a disease.

self-harm or need protective custody); to isolate detainees who are a part of an ongoing criminal investigation; and as a sentencing option.[82] The incidence of segregation in New Zealand is considered very high by international standards.[83] This dissertation focuses on the use of segregation to enable medical oversight for prisoners who pose a risk, or potential risk, of self-harm. Isolation, segregation and solitary confinement[84] have different meanings in different jurisdictions.[85] However, for the purposes of this dissertation these terms will be used interchangeably.[86]

Restraints are used to restrict bodily movement. In general, there are two types; mechanical or physical restraints and chemical restraints. Mechanical restraints refer to "a physical appliance that inhibits free physical movement."[87] Chemical restraints are "pharmaceutical[s] given with the specific and sole purpose of inhibiting specific behaviour or movement."[88] New Zealand law does not provide for the use of involuntary chemical restraints in prison. As such, the use of 'restraint' throughout this dissertation refers to mechanical restraints. Restraints are commonly used for many reasons. These include to prevent escape, for the safety of third parties and the safety of the person themselves. This dissertation deals with restraints that are used for the purpose of restricting opportunities for self-harm.[89]

[82] See Istanbul Statement on the Use and Effect of Solitary Confinement (2007) Accessed at <http://solitaryconfinement.org/uploads/Istanbul_expert_statement_on_sc.pdf>

[83] A report into New Zealand's segregation practices found that on average New Zealand used segregation four times as often as England/Wales. England/Wales usage was considered high by international standards. However, there are no available statistics concerning the level of segregation for self-harming prisoners specifically. Therefore, it is impossible to tell whether New Zealand's rate of segregation for at-risk prisoners is high by international standards. See: Sharon Shalev *Thinking Outside the Box? A Review of Seclusion and Restraint Practices in New Zealand* (Human Rights Commission, April 2017).

[84] 'Solitary confinement' has been given a specific meaning in international human rights law which will be discussed in Chapter 3. However, New Zealand's 'segregation' practices are consistent with this definition and as such the terms can be treated synonymously.

[85] The conditions in ARU's, which the department of corrections also refers to as segregation or isolation units, are equivalent to solitary confinement. Accordingly, in the context of ARU's these words can be used interchangeably.

[86] The interchangeability of these words is prescribed in Sharon Shalev "A Sourcebook on Solitary Confinement" (October 2008) <www.solitaryconfinement.org> at 2.

[87] Istanbul Statement on the Use and Effect of Solitary Confinement, above n 82.

[88] AB Covert, T Rodrigues, K Solomon, "The Use of Mechanical and Chemical Restraints in Nursing Homes" (1977) 25 Journal of American Geriatrics Society 85.

[89] Protection of third parties may include using restraints such as handcuffs to protect other inmates, officers, other staff or the general public.

A. Legal Framework for the Segregation of At-Risk Prisoners

The use of segregation is administered by the DOC. It must be administered in a manner that is consistent with the Corrections Act, Corrections Regulations and the POM. Under New Zealand law segregation is defined as denying or restricting the ability of a prisoner to associate with other prisoners.[90] Segregation may be imposed for the purposes of: protective custody (s 59); security; good order and safety (s 58); and for medical oversight (s 60). Segregation for the purposes of medical oversight is the only relevant justification for segregation of prisoners at-risk of self-harm.[91]

When prisoners first arrive at prison they must be promptly assessed by a registered nurse to identify any "immediate physical or mental health, safety, or security needs" (s 49(a)).[92] These needs must then be addressed. Addressing these needs may require segregation pursuant to s 60.

How does the Corrections Act relate to Segregation?

New Zealand's legal framework for the use of segregation is found in ss 57-61 of the Corrections Act 2005. Section 60(1)(b) of the Corrections Act stipulates that the prison manager may direct segregation if the health centre manager recommends segregation for the purposes of medical oversight. This oversight includes assessing and ensuring the prisoners mental health and assessing the risk of self-harm.[93] The health centre manager is a nurse or medical practitioner whom the prison manager is statutorily required to appoint.[94] However, if the situation is beyond the health centre manager's usual scope of practice, a medical practitioner with appropriate expertise must be consulted.[95] Section 60(2) requires that if a direction for segregation is given, then the prisoner and the chief executive of the Department of Corrections must be informed of the reasons for the direction. While a direction is in force

[90] Corrections Act 2004, s 57.
[91] Although a prisoner with mental health issues may be segregated for protective custody or good order and safety this is beyond the scope of this dissertation.
[92] Pursuant to Corrections Act 2004, s 49 the prison chief executive must ensure this risk assessment occurs upon initial reception into custody and after returning from bail or parole.
[93] Corrections Act 2004, s 60(1)(b).
[94] Corrections Act 2004, ss 19A, 3.
[95] Corrections Act 2004, s 60(1)(a).

under s 60, a registered health professional must visit the prisoner at least once a day.[96] This will be the case when segregation for medical oversight of physical health and not due to risk of self-harm. If the prisoner has been assessed by the health centre manager as at risk of self-harm then a registered health professional must visit twice a day.[97]

Section 60(3) provides for the revocation of a segregation order. Only the prison manager or chief executive of the DOC may revoke a direction under s 60. Revocation of the direction may only be given where the health centre manager is satisfied there is no longer justification for continued segregation. This determination is based on the health centre manager's professional expertise.

Section 61 requires that the accommodation, in this case ARUs, meet the 'prescribed standards' outlined in the Corrections Regulations. These 'prescribed standards' differ depending on the reasons the direction was ordered.[98] In the case of those deemed at-risk of self-harm these 'prescribed standards' are stringent and focus solely on ensuring the standard of accommodation does not provide the prisoner an opportunity to self-harm. These standards are set out below.

How do the Corrections Regulations 2005, Prisoner Operations Manual (POM) relate to Segregation?

The Correction Regulations 2005 stipulate the way in which segregation must operate. Regulation 57 requires that all segregation units, regardless of why the direction was ordered, have artificial light, a fire detector, fresh or conditioned air and heating as appropriate. Additional requirements apply to at-risk prisoners.[99] For at-risk prisoners, the 'prescribed standards' sole focus is risk minimisation. Part C of Sch 2 must be adhered to.[100] Part C contains a myriad of features that prevents a prisoner from self-harming. At-risk prisoners are subject to more stringent conditions than other segregated prisoners. For example, the requirement that "no privacy screening … prevents a full view of the cell" from the door window.[101] Regulation

[96] Corrections Act 2004, s 60(5)(a).
[97] Corrections Act 2004, s 60(5)(b).
[98] Corrections Act 2004, s 61.
[99] In addition to the requirements that apply to all segregation orders Corrections Regulations 2005, Pt C, Sch 2 must also be adhered to. Refer to Appendix for Sch C and D.
[100] Corrections Regulations 2005, reg 60(1)(a).
[101] Corrections Regulations 2005, Sch 2, Pt C.

60 also requires the cell be as close to the health centre manager as practicable. ARUs differ marginally throughout New Zealand but all have limited fixtures and fittings, special clothing and bedding and are under 24-hour surveillance. [102] There is usually no access to reading or writing material or televisions.[103] Consequently, the prisoner has no means to gainfully occupy themselves. All these factors create an austere environment.

The length of stay in ARUs is uncertain and depends on the assessment of the health centre manager and approval of the prison manager or chief executive. Empirical evidence shows that the duration of stays in ARUs is often prolonged.[104] Over the last 5 years, 16% of admissions to ARU lasted 8-20 days, while 9% of admissions were for longer than 20 days.[105]

The POM provides further guidance for the management of at-risk prisoners. The POM requires that if a prisoner is deemed at-risk when assessed upon reception they must be placed in an ARU.[106] Often this will coincide with an order under s 60 of the Corrections Act. However, this is not always the case. For example, people will be automatically deemed at-risk if they cannot engage in Reception Risk Assessment. This may occur if they do not speak sufficient English or are intoxicated. The POM also provides for the review of risk assessment.[107]

Once a prisoner is deemed at-risk they must have an individualised management plan.[108] The content of this management plan is outlined in the POM as well as s 51 of the Corrections Act. The POM outlines that the purpose of observing and managing at-risk prisoners is to "ensure that they are managed through accurate recording of information, frequent observation [and] following a management plan."[109] The management plan must be created in consultation with appropriate support personnel, including medical staff, cultural advisors and whanau.[110]

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[102] See OPCAT Findings Report, above n 4.
[103] The OPCAT Findings Report, above n 4, at 13. Prisoners in ARU's are almost always preventing from having access to reading/writing material a
[104] Solitary confinement in excess of 15 days is considered prolonged. See Nelson Mandela Rules, above n 17, r 44.
[105] At-risk Unit Duration Statistics (Obtained under Official Information Act 1982 Request to the Corporate Services, Department of Corrections).
[106] Prisoner Operations Manual (2017) Department of Corrections <www.corrections.govt.nz/Prison-Operations-Manual> M 05.01.
[107] Prisoner Operations Manual, above n 106, M 05.02.
[108] Prisoner Operations Manual, above n 106, M 05.03.04.
[109] Prisoner Operations Manual, above n 106, M 05.03.
[110] Prisoner Operations Manual, above n 106, M.05.03.04.

B. The Legal Framework for the Use of Restraints

As with segregation, the Corrections Act, Corrections Regulations and POM provide the legal framework for the use of restraints. In extreme circumstances, the use of ARUs alone may be insufficient to manage the risk of self-harm.[111] In such instances the use of force, via mechanical restraints may be the only appropriate course of action. Section 83 dictates when the use of force by an officer is permissible. Importantly, the use of force must be no more than is "reasonably necessary in the circumstances".[112] Furthermore, s 83(3) provides that should any force be applied, excluding the use of handcuffs, then a registered health professional must examine the prisoner as soon as practicable.

Section 87 relates to restraint of prisoners as a specific type of force. Mechanical restraints must be used in a manner that "minimise harm and discomfort to the prisoner".[113] Mechanical restraints may never be used for any disciplinary purpose.[114] Section 87 creates a restriction on the way in which the Regulations may operate. Section 87(3) provides that Regulations can only be made provided the Minister is satisfied the method of restraint is consistent with the humane treatment of prisoners and that the potential benefits of the kind of restraint outweighs the potential risks. A prison manager may authorise that restraints be used on a prisoner for more than 24 hours if in the opinion of a medical officer it is necessary to prevent self-harm (s 87(5)). Section 87 prohibits irons and chains being attached to the neck or torso.

The Corrections Regulations specify that a mechanical restraint can only be used if it is listed in Sch 5.[115] Schedule 5 also requires that each method of restraint be used in a specified manner. This differs depending on which method of restraint is being employed. Pursuant to Sch 5 the only restraints that can be used are various types of handcuffs, tie-down beds, wrist bed restraints, torso restraints, head protectors, spit hoods, and waist restraints used in conjunction with handcuffs. Tie-down beds, wrist bed restraints, torso restraints and head protectors "may

[111] This was the case with 'Prisoner A' in OPCAT Findings Report, above n 4, at 24-29. His self-harming was so persistent that DOC deemed a tie-down bed was the only appropriate way to prevent self-harm. This fact was reflected in his management plan.
[112] Corrections Act 2004, s 83(2).
[113] Corrections Act 2004, s 87(4)(b).
[114] Corrections Act 2004, s 87(4)(a).
[115] Corrections Regulations, s 124.

only be used on medical advice".[116]

The POM requires that restraints must follow the guidelines detailed in the Custodial Practice Manual.[117] Additionally, when using restraints on at-risk prisoners "all actions are designed to ensure that prisoners are only restrained for the least time necessary to safeguard their wellbeing."[118]

In practice, handcuffs are the most commonly used method of restraint. This is consistent with the requirement to minimise discomfort where possible as other forms of restraint are more restrictive. According to the DOC, in the 6 month period beginning May 2016 there were 423 incidents in which mechanical restraints were used.[119] Throughout this period there were 3 uses of head protectors, 5 uses of a restraint bed, 9 uses of spit hoods and 16 uses of waist restraints. This demonstrates that all methods of restraint are used, but the most restrictive methods of restraint (such as tie-down beds) are seldom employed.

C. The Provision of Healthcare for At-risk Prisoners

The Corrections Act stipulates some mandatory obligations in respect of the standard of health care in prison. Section 75(1) states that the prisoner is "entitled to receive medical treatment that is reasonably necessary." Furthermore, like many other jurisdictions New Zealand abides by the principle of equivalence. Section 75(2) necessitates the "health care that is available to prisoners … be reasonably equivalent to the standard of health care available to the public."

The OPCAT Findings Report identified some problematic aspects of mental health care provision. The inspection found that "primary mental health services were limited and generally focussed on crisis management."[120] The Regional Forensic Psychiatric Service is responsible for transferring 'mentally disordered' prisoners from the community, Courts or prison to forensic mental health facilities. However, admissions from the community and Courts are favoured over those from prison.[121] These prisoners are 'waitlisted' as the prison

[116] Corrections Regulations 2005, sch 5.
[117] Prisoner Operations Manual, above n 106, M 05.03.
[118] Prisoner Operations Manual, above n 106, M 05.03.
[119] Shalev, above n 83, at 26.
[120] At 37.
[121] At 37.

environment is considered secure. Some acutely unwell prisoners in ARUs were 'waitlisted' for several months until a forensic bed became available.[122] This reality is a reflection that the prison population has grown steadily throughout the 21st Century without a corresponding increase in forensic beds.[123]

New Zealand's current approach to the treatment of at-risk prisoners must be considered in the context of their health and well-being. At-risk prisoners are housed in ARUs which amount to solitary confinement. Whilst solitary confinement may represent a pragmatic and cost effective means for managing at-risk prisoners, research unequivocally shows that this approach is not without significant negative psychological and physiological effects on those who are subjected to it. Furthermore, the effects of solitary confinement are exacerbated when it is prolonged, used on those with pre-existing mental health issues or when used in conjunction with restraints. Understanding the detrimental effects of using solitary confinement for at-risk prisoners should inform ways in which the health and well-being of these prisoners can be enhanced.

D. What are the Health Effects of the Current Treatment of At-Risk Prisoners?

Three characteristics typify solitary confinement: social isolation; lack of control and autonomy over aspects of daily life; and a reduction in environmental stimulation.[124] These characteristics are inherent features of New Zealand's current use of ARUs.

The detrimental health effects of solitary confinement have been understood since the 19th Century.[125] Countless studies have reached the same conclusion that solitary confinement has harmful effects on the health and well-being of anyone subjected to it.[126] It has been argued

[122] At 37.
[123] Beverly Wakem and David McGee *Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prison Health Services* (Presented to the House of Representatives 2012) at 153.
[124] Sharen Shalev "Solitary Confinement as a Prison Health Issue" in Lars Møller and others (ed) *Health in prisons: a WHO guide to the essentials in prison health* (2nd ed, WHO Regional Office Europe, Copenhagen, 2014).
[125] Stuart Grassian and Nancy Friedman "Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement" (1986) 8 *International Journal of Law and Psychiatry* 49.
[126] Peter Schaff *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature* (2006) 34 *Crime and Justice* 441.

that the: [127]

> evidence overwhelmingly [demonstrates] that solitary confinement alone, even in the absence of physical brutality or unhygienic conditions, can produce emotional damage, decline in mental functioning and even the most extreme forms of psychopathology such as depersonalization, hallucinations and delusions.

Psychological effects include increased instances of: anxiety; depression; anger; cognitive disturbances; perceptual distortions (such as hallucinations); and paranoia or psychotic episodes.[128] The deleterious effects are not only psychological. Physiological effects include: headaches; profound fatigue; insomnia; weight loss; and the aggravation of pre-existing medical conditions.[129] The term "isolation psychosis" has been coined by Stuart Grassian to explain the cumulative phenomenon of the potential physiological and psychological effects.[130]

The potential health effects from the use of restraints is not as well-established in part due to the scant research.[131] However, the method and duration of restraint are important factors. It has been established that individuals who have been restrained felt a loss of dignity and sense of autonomy.[132] For those that have suffered trauma, restraint may result in them re-living their traumatic experience(s).[133] This suggests that solitary confinement will be damaging for personality disordered individuals given there is a strong link between childhood trauma and an adult diagnosis of personality disorder.[134] Physiological effects such as asphyxiation causing death, lesions, fractured bones and blood clots are well documented.[135]

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[127] Thomas Benjamin and Kenneth Lux "Solitary Confinement as Psychological Punishment" (1977) 13 *California Western Law Review* 265 at 265.
[128] For a summary of the research findings see: Stuart Grassian "Psychiatric Effects of Solitary Confinement" (2006) 22 *Journal of Law and Policy* 325; and Stuart Grassian and Nancy Friedman "Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement" (1986) 8 *International Journal of Law and Psychiatry* 49.
[129] See generally: Scharff , above n 126, at 488-490.
[130] Grassian, above n 128.
[131] As explained in Wanda Mohr, Theodore Petti and Brian Mohr "Adverse Effects Associated with Physical Restraint" (2003) 48 *Canadian Journal of Law and Psychiatry* 330.
[132] Richard Barnett, Chris Stirling and Anand Pandyan "A Review of the Scientific Literature Related to the Adverse Impact of Physical Restraint: Gaining a Clearer Understanding of the Physiological Factors Involved in Cases of Restraint-related Death" (2012) 52 *Medicine, Science and the Law* 137.
[133] S Smith "Restraints: Re-traumatization for rape victims? (2002) 33 *J Psychosoc Nurs* 23.
[134] Kelly Grover and others "The Relationship Between Childhood Abuse and Adult Personality Disorder Symptoms" (2007) 21 *J Pers Dis* 442.
[135] Mohr, above n 131.

Although there is a the lack of scientific literature examining the psychological effect of restraints their usage in combination with solitary confinement creates a potent mix of harmful health and well-being effects.

Solitary Confinement and the Individual

An individual's experience will vary depending on personal and environmental factors such as: the condition in which they are confined; personal histories; amount of human contact and whether confinement is involuntary.

When placed in an ARU the prisoner has no contact with other prisoners and very few meaningful human interactions.[136] Additionally, the austere environment provides few avenues in which the prisoner can occupy themselves. Furthermore, the rigid regime imposed upon prisoners in an ARU means they lack the exercise of personal autonomy. Time in an ARU is marked by boredom, lack of choice, loss of empowerment and loneliness. Some prisoners will be more vulnerable to the negative effects than others.

Those with pre-existing mental health problems are more likely to experience negative psychological and physiological effects of solitary confinement.[137] The longer the duration of solitary confinement the greater the risk of negative effects. [138] Additionally, when length of solitary confinement is uncertain, the risk of problematic psychological effects is increased.[139]

Conclusion

The use of segregation for at-risk prisoners takes an environmental or situational approach to minimising risk. The focus is on mitigating the risk as opposed to addressing underlying causes of that risk. New Zealand's current practices may achieve the primary short-term objective of reducing the possibility of a prisoner self-harming, but there may be longer-term psychological

[136] OPCAT Findings Report, above n 4. The report found that interactions between officers and at-risk prisoners were limited and did not amount to meaningful contact.
[137] T Kupers *Prison madness: the mental health crisis behind bars and what we must do about it* (Jossey Bass, San Francisco, 1999).
[138] One study found that all prisoners who were subject to involuntary solitary confinement for more than 10 days had negative psychological effects. Craig Haney "Mental Health Issues in Longterm Solitary and Supermax Confinement" (2003) 49 *J Res Crime Delinq* 124.
[139] H Toch *Mosaic of Despair: Human Breakdown in Prison* (American Psychological Association, Washington DC, 1992).

harm and/or exacerbation of pre-existing mental health issues.

Given all the reasons discussed, logic should suggest that at-risk prisoners are the most likely to suffer negative effects from solitary confinement whether or not this is combined with the use of restraints. The prolonged nature of many ARU is particularly concerning. At-risk prisoners often have existing mental health issues which are manifested in suicidal or self-harming behaviour.

A recent report commissioned by the Human Rights Commission and funded by the United Nations claims that ARUs are "the most concerning aspect of [NZ's] prison segregation practices."[140] This opinion was due to the fact that New Zealand's current practice does not ensure that the human rights of at-risk prisoners are upheld. These human rights are enshrined in international human rights treaties, the New Zealand Bill of Rights Act (1990) and internationally agreed minimum standards. New Zealand's current practice is inconsistent with a number of these human rights obligations.

[140] Shalev, above n 83, at 33.

CHAPTER 3: New Zealand's Human Rights Obligations

"I strongly believe that the way societies treat those who have been deprived of their liberty is a litmus test of commitment to human rights."[141]

The following chapter considers the various international human rights obligations that relate to the treatment of at-risk prisoners in New Zealand. The International Covenant on Civil and Political Rights[142] (ICCPR) and the Convention Against Torture[143] (CAT) are addressed. The precise scope and language of these treaties is interpreted through the expert bodies established under these treaties. New Zealand's 'dualist'[144] approach to international law means that these treaties are not enforceable unless incorporated directly into New Zealand legislation.[145] The human rights afforded by the New Zealand Bill of Rights Act (NZBORA) 1990 are also considered. In particular, the various international instruments that govern the use of solitary confinement and mechanical restraints are discussed. The focus is not just on the instruments enforceable under NZ law, but also the universally agreed minimum standards for the treatment of prisoners. Finally, it considers whether the current approach to treatment of at-risk prisoners is consistent with the various human rights obligations.

A. What are New Zealand's Human Rights Obligations?

The Universal Declaration of Human Rights expressly prohibits torture irrespective of the particular circumstances. This prohibition has been incorporated into various human rights instruments which New Zealand has ratified.[146] As such the prohibition on torture is well established in New Zealand law.[147]

New Zealand has ratified both the International Covenant on Civil and Political Rights

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[141] Andrew Coyle *A Human Rights Approach to Prison Management Handbook for prison staff* (International Centre for Prison, London, 2002) at 3.
[142] International Covenant on Civil and Political Rights (opened for signature 16 December 1966, entered into force 23 March 1976).
[143] Convention Against Torture and Other Cruel Inhumane or Degrading Treatment or Punishment (opened for signature 10 December 1984, entered into force 26 June 1987).
[144] A dualist system means that in order for legislation to be enforceable it must be incorporated into legislation. Whereas, monism allows domestic courts to enforce domestic and international law.
[145] For a detailed analysis of the standing international law has in New Zealand see Law Commission *A New Zealand Guide to International Law and its Sources* (NZLC R34, 1996).
[146] This ban on torture is in ICCPR, art 7; NZBORA s 9 and CAT art 2.
[147] This level of entrenchment is evidenced by the fact the ban on torture constitutes a customary law. See Anthony D'Amato "The Concept of Human Rights in International Law" (1982) 82 *Columbia Law Review* 111.

(ICCPR) and the Convention Against Torture and other Cruel, Inhumane or Degrading Treatment (CAT). The New Zealand Bill of Rights Act 1990 was enacted to promote fundamental rights and to "affirm New Zealand's commitment to the [ICCPR]."[148] The ICCPR is a cornerstone of New Zealand's human rights law. The NZBORA ensures "everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person."[149]

The ICCPR reinforces the prohibition on torture. Article 7 states that "No one shall be subjected to torture or to cruel, inhumane or degrading treatment or punishment."[150] This right is absolute in nature, a rarity in the ICCPR. Accordingly, no restrictions are permitted and there is no provision to derogate from that right irrespective of what the circumstances may be. The Human Rights Committee, the United Nations body charged with implementing the ICCPR, has claimed that prolonged use of solitary confinement may breach Art 7.[151] The ICCPR affords people deprived of their liberty with a positive right. They are to be "treated with humanity and with respect for their inherent dignity."[152] Article 16 of the CAT mirrors this prohibition on cruel, inhumane or degrading treatment. Article 10(1) of the ICCPR further mandates that the essential aim of the prison system is "reformation and social rehabilitation." The prohibition on torture or cruel, inhumane or degrading treatment or punishment is echoed by Section 9 of the New Zealand Bill of Rights Act "Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment."[153]

Article 1 of the CAT provides a working definition for torture. Torture is defined as:

> Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person.

This definition requires that the act in question have a dominant purpose to elicit information, punish, intimidate or coerce. As a result, New Zealand's current treatment of self-harming

[148] New Zealand Bill of Rights Act 1990, Title.
[149] New Zealand Bill of Rights Act 1990, s 23(5).
[150] ICCPR, Art 7.
[151] Shalev, above n 83, at 67.
[152] ICCPR, Art 10(1).
[153] New Zealand Bill of Rights Act, s 9.

prisoners will not fall within this definition.[154] However, the ICCPR prohibits torture *or* cruel, inhumane or degrading treatment. Potential violations of the CAT or ICCPR will relate to cruel, inhumane or degrading treatment of prisoners. The UN Committee Against Torture, the body responsible for monitoring the implementation Convention Against Torture, has asserted that the use of restraints in prisons and psychiatric hospitals should be regulated and minimised with the eventual aim of "abandoning its use in all non-medical settings."[155] Furthermore, the UN Committee Against Torture, when observing New Zealand's current practice, recommended a prohibition on solitary confinement for people with psychosocial disabilities.[156]

New Zealand is also party to the Optional Protocol to the Convention Against Torture (OPCAT). OPCAT attempts to strengthen the rights afforded to those deprived of liberty. However, OPCAT is a preventative mechanism as opposed to enforcing any human right breaches. Article 1 stipulates the objective of OPCAT: [157]

> is to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

It represents the unanimous agreement by the international community that people deprived of their liberty are particularly susceptible to ill-treatment. In summary, it operates by creating a framework that ensures regular, independent inspections and reviews of places of detention. OPCAT requires nations set up National-Prevention Mechanisms (NPM) to monitor places of detention.[158] New Zealand's OPCAT framework operates with the Human Rights Commission as the Central National Preventative Mechanism. OPCAT has also established the Sub-Committee on Prevention of Torture (SPT), an international body, that assists NPM's by conducting its own inspections and providing consultation. Section 32 of the Crimes Of Torture Act 1989 requires that the Human Rights commission "maintain effective liaison" with the SPT whilst also "co-ordinating the activities" of the NPMs. Section 27 of the COTA stipulates that the function of NPMs is to examine conditions of detention and the treatment of

[154] There is no provision in the Corrections Act, Corrections Regulations or Prisoners Operations Manual for any actions that would amount to torture.
[155] United Nations General Assembly *Report of the Committee against Torture* (A/67/44, June 2012) at 47.
[156] *UN Committee Against Torture* "6th periodic review" CAT/C/NZL/6 (2015).
[157] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), Art 1.
[158] This requirement has been incorporated into legislation. Crimes of Torture Act 1989, s 26(1).

detainees (s 27(a)(i)(ii)). It is also required to make recommendations to improve these conditions or treatment (s 27(b)). Pursuant to s 27(c) the NPMs must produce one report per year on the exercise of its functions.[159] The recommendations and reports of NPMs are non-binding and there is no legislative requirement that Parliament or the Department of Corrections address them.

The legislative functions and powers of NPMs are useful in providing information concerning our current (or previous) treatment of those deprived of liberty.[160] However, mistreatment of prisoners will not breach the OPCAT, given its preventative nature. Obligations under OPCAT have been incorporated into New Zealand law (s 26-32 of COTA). However, these obligations do not relate to the actual treatment of prisoners. Potential breaches would relate to a failure to establish the OPCAT framework as opposed to the actual treatment of detainees. Accordingly, adherence to the OPCAT will not be considered. Instead the substance of the OPCAT findings will be used as evidence of the treatment of prisoners.

The SPT has advised that prolonged solitary confinement may amount to torture or cruel, inhumane or degrading treatment or punishment. They have also recommended that solitary confinement be prohibited for those who are mentally disabled.

Additional Human Rights Standards

The ICCPR, CAT and NZBORA are fundamental to New Zealand's human rights obligations. They clearly mandate that New Zealand treat prisoners with inherent dignity and prohibit cruel or degrading treatment in any circumstance. Additional guidance can be found in what the international community views as minimum standards for the treatment of prisoners.

In 2015, the UN amended The Standard Minimum Rules for the Treatment of Prisoners and unanimously adopted a revised version known as the Nelson Mandela Rules ("The Mandela Rules"). The Mandela Rules cannot be applied uniformly to every legal context within which

[159] This report is either provided to the House of Representatives (if the NPM is an Officer of Parliament) or to the Minister (if the NPM is not an Officer of the Parliament) (Crimes of Torture Act 1989, s 27(c)(i)(ii)). However, discretion is used when deciding whether to undertake any of the recommendations.
[160] Crimes of Torture Act, ss 28-30 details special access to information and places of detention and wide ranging abilities to conduct interviews with detainees. Meaning good, regular, accurate and independent information.

they may operate. In this sense, they do not seek to bind parties to adhere to every rule in all circumstances. Rather they "set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management."[161] Despite the utopian nature of the Mandela Rules, the New Zealand Parliament has expressed a desire to remain consistent with them by making explicit reference to them in the Corrections Act 2004. Section 5 states that the purpose of the corrections system is to adhere to the rules in the Act that "are based, amongst other matters, on the United Nations Minimum Standard Rules for the Treatment of Prisoners."[162] Despite the direct reference to the Mandela Rules and the fact much of the Act mirrors the Mandela Rules there is no statutory requirement with the Act to adhere to them. Moreover, there is no right of redress should a Mandela Rule be breached unless the Mandela Rule is also expressly mentioned in the Corrections Act. However, given the Mandela Rules are the primary basis for the Corrections Act New Zealand should be consistent with the Rules where possible.

There are several Mandela Rules that are relevant to the treatment of at risk prisoners:

- Rule 14 requires the provision of fresh air regardless of whether there is artificial ventilation.
- Rule 15 stipulates that sanitary installations be adequate to enable use in a clean and decent manner.
- Rule 23 mandates that, at a minimum, prisoners should be afforded one hour of exercise daily in open air.

There are also Mandela Rules that specifically apply to the use of solitary confinement and restraints. Solitary confinement is defined as the "confinement of prisoners for 22 hours or more a day without meaningful human contact."[163] Based on this definition the prescribed conditions of ARU's detailed in the Corrections Act, Regs and POM amount to solitary confinement.[164] The Mandela Rules also stipulate that solitary confinement must only be used in exceptional cases for as short a period of time as possible.[165] There is also a prohibition on solitary confinement where the prisoner has "mental or physical disabilities when their

[161] Nelson Mandela Rules, above n 17, Preliminary Observation 1.
[162] Corrections Act 2004, s 5(1)(b).
[163] As defined in Nelson Mandela Rules, above n 17, r 44. OPCAT Findings Report, above n 4, reported that interactions with staff were minimal and could not be described as 'meaningful contact'.
[164] See Chapter 2 for discussion of ARU's.
[165] Rule 45(1).

conditions would be exacerbated by such measures."[166] Rule 43 also provides a prohibition on the use of prolonged or indefinite solitary confinement. Prolonged solitary confinement is defined as solitary confinement for a continuous period of 15 days or more.

The use of mechanical restraints is governed by Mandela r 47-49. Instruments of restraint that are inherently degrading or painful are prohibited. Various principles for the use of restraints are provided for in r 48:

(i) Instruments of restraint may only be imposed when no lesser form of control would be effective to control the specific risks.
(ii) The method of restraint shall be the least intrusive method that is necessary and reasonably available to control the prisoner.
(iii) Restraints shall be imposed only for the time-period required, and removed after risks of unrestricted movement are no longer present.

Rule 24 provides that "prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status."[167] Finally, Rule 49 provides that prison administration should provide training in the use of techniques that would obviate the need for instruments of restraint.

B. How Consistent is New Zealand's Current Approach with the Relevant Human Rights Obligations?

New Zealand's current approach to the treatment of at-risk prisoners will now be considered in light of the various human rights obligations. It is difficult to always remain consistent with human rights obligation, especially, the Mandela Rules when dealing with at-risk prisoners. This reflects the fact that at-risk prisoners are a substantial, immediate risk to themselves and as such precautions must be taken to ensure their immediate safety. These precautions will not always be consistent with human rights obligations. However, where possible the treatment of at-risk prisoners should be consistent with the international human rights obligations. As noted above, the NZBORA and Corrections Act explicitly refer to the ICCPR and Mandela Rules.

[166] Rule 45(2).
[167] Rule 24.

However, there are instances where our current practice falls short of this benchmark.

This dissertation, will not focus on instances where the domestic law has not been adhered to. In other words, the assumption is made that at-risk prisoners are treated consistently with the Corrections Act, Corrections Regulations and POM. A 2016 report found instances where domestic law was not followed, these findings are outside the purview of this dissertation.[168] However, findings that related to practice that was consistent with New Zealand law will be discussed in turn. Deliberation will now be given to specific inconsistencies between New Zealand's current practice and human rights obligations.

Mandela Rule 45(2) prohibits the use of solitary confinement on those with mental disabilities where such conditions would exacerbate their condition.[169] This Rule has two limbs; the requirement of a 'mental disability' and the requirement that solitary confinement would exacerbate this 'disability'. As discussed above, solitary confinement has a wide range of deleterious effects on those that suffer with mental illness.[170] As such, the second limb is easily established. However, given 'mental disability' is not defined in the Mandela Rules the scope of this limb is ambiguous. There are some at-risk prisoners who cannot be appropriately classed as having a 'mental disability'.[171] Self-harming can result from attention seeking behaviour which is not always accompanied by a 'mental disability'. Undoubtedly, a portion of at-risk prisoners will have a condition comparable to 'mental disability'. Mental disorders including personality disorders are very prevalent amongst the prison population. These conditions could arguably fall within the ambit of r 45(2) as they diminish mental functioning.

However, regardless of the definition of 'mental disability' the purpose of the rule is clear; it seeks to prohibit solitary confinement where the conditions of confinement will have a deleterious effect on the health of the prisoner beyond the typical negative health effects associated with isolation. As such, this purpose of (where possible) minimising solitary confinement for those who it will impact their health in an unjustifiably negative manner is one worth following.

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[168] OPCAT Findings Report, above n 4. See for example the treatment of prisoner A.
[169] This prohibition has been echoed by the SPT.
[170] As discussed in Chapter 2.
[171] There are a small portion who self-harm as attention-seeking behavior and do not suffer from any mental disability *per se*. However, that is not to suggest that attention-seeking behaviour and mental disability are mutually exclusive.

Furthermore, the Committee Against Torture recommend a prohibition on solitary confinement on those with 'psychosocial disabilities'. Although this term is left undefined, psychosocial disabilities refer to both the medical and social effects of a disability.[172] With this in mind a personality disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, is consistent with psychosocial disability.[173] Therefore, there is a strong mandate to avoid solitary confinement of prisoners with personality disorders.

The Human Rights Committee, the UN body charged with implementing the ICCPR, argued that prolonged use of solitary confinement may breach Art 7 and as such amount to cruel, inhumane or degrading punishment or treatment. Although, the Committee did not define prolonged solitary confinement, the Mandela Rules provide guidance. They state that prolonged solitary confinement is confinement for a consecutive time-period longer than 15 days. New Zealand has consistently breached this prohibition. Over a 5-year period (ending June 2017) the duration of confinement in ARU was; more than 20 days in 9%, between 8 and 20 days in 16%, and less than 7 days in 75% of instances.[174] Throughout this period there were 1650 instances in which solitary confinement lasted more than 20 days.[175] This amounts to a clear and obvious breach of the Mandela Rules.

As it currently stands tie-down beds are acceptable methods of restraint in New Zealand. However, it has been argued that tie-down beds breach the prohibition on inherently degrading or painful forms of restraint.[176] Dr Sharon Shalev, in a report commissioned by the Human Rights Commission, has called for New Zealand to immediately abolish their use.[177] As a result, similar jurisdictions who are parties to OPCAT, such as England and Wales have ceased using tie-down beds as a form of restraint.[178] Furthermore, tie-down beds are prohibited in New Zealand's mental health settings.[179] To be consistent with the equivalence of care requirement

[172] As discussed in Istvan Hoffman and Gyorgy Konczei "Legal Regulations Relating to the Passive and Active Legal Capacity of Persons with Intellectual and Psychosocial Disabilities in Light of the Convention on the Rights of Persons with Disabilities and the Impending Reform of the Hungarian Civil Code" (2010) 33 *Los Angeles International and Comparative Law Review* 143.
[173] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, Washington, 1994).
[174] Official Information Request, above n 105.
[175] Official Information Request, above n 105.
[176] Nelson Mandela Rules, above n 17, r 47(1).
[177] Shalev, above n 83, at 24.
[178] Shalev, above n 83, a 24.
[179] OPCAT Findings Report, above n 4, at 22.

it can be argued Corrections must follow suit. This issue is by no means clear-cut. In extraordinary circumstances a tie-down bed may well be the only method of restraint appropriate for the specific self-harm risks posed by a prisoner.[180] In this sense despite being inherently degrading, abolition may be inappropriate.

The UN Committee Against Torture has advised that the use of restraints should be minimised with the eventual goal of eliminating them entirely. However, for this to occur alternative options need to be developed that will minimise the risks associated with self-harming prisoners. Measures to minimise their use will be discussed in Chapter 4.

Part C of the Corrections Regulations mandates that there is "no privacy screening" in ARUs between the cameras and the toilet. In practice, prisoner dignity is further curtailed by the fact that "anyone in the office, including visitors, can see the footage."[181] Furthermore, Corrections have no policy to prevent people of different genders from viewing this undignified footage. The Ombudsman discussed this issue in the OPCAT Findings Report. However, Corrections felt that in the interest of safety the infringement on privacy was necessary. But, the "ability of prison staff to access footage of prisoners undertaking their ablutions constitutes degrading treatment"[182] and as such breaches the requirement to avoid cruel, inhumane or degrading treatment or punishment. This breaches Art 16 of CAT and Art 7 of the ICCPR and is inconsistent with the requirement for prisoners to toilet in a decent manner as provided by the Mandela Rules. Clearly, the manner in which surveillance operates in ARU's has not struck the right balance between maintaining safety and ensuring the prisoner is afforded reasonable dignity.

The provision of healthcare within New Zealand prisons breaches the equivalence of care principle enshrined in r 24. Prisoners are prejudiced when it comes to being committed to forensic facilities under the MH(CAT) Act 1992.[183] People are more easily committed when coming directly from the Courts or community based sentences. Although resource constraints mean that someone will miss out, it is unacceptable for 'mentally disordered' offenders to remain in a non-therapeutic environment awaiting appropriate care. Furthermore, it breaches

[180] This was the only means that was deemed appropriate for minimising the self-harm risk that Prisoner A posed. See OPCAT Findings Report, above n 4.
[181] OPCAT Findings Report, above n 4, at 9.
[182] At 5.
[183] Wakem, above n 123, at 153.

the prohibition on imposing solitary confinement on prisoners who suffer from mental illness.

Corrections Officers receive no extra training when they are assigned to ARUs. This is a potential breach of Rule 49 requiring additional training in order to obviate the need for restraint. How this can be achieved will be discussed in Chapter 4.

Conclusion

The primary inconsistency is the use, often for prolonged periods of time, of solitary confinement for at-risk prisoners, with mental health issues. Both prolonged confinement and confinement of those with mental disabilities is expressly prohibited. Solutions must focus on ways in which these instances can be reduced. Recommendations must work towards the utopian aim of eliminating the use of restraints as argued by the Committee Against Torture.

There are a number of instances where New Zealand's current practice conflicts with human rights obligations, in particular, the Mandela Rules. However, merely identifying inconsistencies without proposing alternatives is of little practical use. Unless a more humane option is suggested this prima facie breach may be warranted. At-risk prisoners are particularly difficult to manage and their immediate safety must be paramount. Ensuring this safety may require acting in a manner that is contrary to human rights standards, especially the Mandela Rules. Therefore, solutions must be two-fold. They must attempt to prevent prisoner's from becoming at-risk. This may involve diverting some prisoners into a more therapeutic environment. However, this will not be a panacea. The treatment of at-risk prisoners in prisoner must be modified to minimise the anti-therapeutic effects of their treatment.

Chapter 4: A Way Forward?

"If I might be permitted, I wish to end with some special pleading for future work to be done dealing with the particular issues faced by prisoners who suffer from mental illness"[184]

The current treatment of at-risk prisoners causes substantial psychological harm. This treatment is often inconsistent with New Zealand's human rights obligations and demands action that will produce better therapeutic outcomes. It will be argued that this can be achieved by amending the definition of 'mental disorder' and establishing therapeutic communities (TC) for the treatment of personality disordered individuals.

Personality disordered offenders are often excluded from health services because of their diagnosis or behaviour.[185] In 2006 "A Systematic Review of the Interface between Mental Health/Addiction Treatment and the Criminal Justice System" found that:[186]

> Typically [personality disordered] individuals have extensive histories of self-harm and frequent admissions into hospital in the community. These prisoners often spend lengthy periods of time in At-Risk Units, which can lead to deterioration in their condition. At-Risk Units are not designed for long stays and are staffed by corrections officers rather than health professionals. Forensic care for severe personality disordered prisoners is usually offered as respite for crisis management. However, some severely personality disordered individuals may also benefit from the supported reintegration process offered in forensic care.

Accordingly, a more effective therapeutic approach to the treatment of prisoners with personality disorders is proposed. Before specific changes that achieve this are discussed the insights of therapeutic jurisprudence (TJ) must be expounded. The way forward is underpinned by the principles of TJ.

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[184] Justice Suzan Glazebrook "Foreword" in in John Dawson and Kris Gledhill (eds) *New Zealand's Mental Health Act in Practice* (Victoria UP, Wellington, 2013) 7 at 9.
[185] OPCAT Findings Report, above n 4, at 39
[186] Cabinet Business Committee paper "A Systematic Review of the Interface between Mental Health/Addiction Treatment and the Criminal Justice System" (September 2006) as cited in Report of Mel Smith, Ombudsman Following a Reference by the Prime Minister Under Section 13(5) of the Ombudsmen Act 1975 for an Investing into Issues Involving the Criminal Justice Sector at (November 2007) at 96.

A. What is Therapeutic Jurisprudence?

TJ is an approach to legal issues that seeks to minimise anti-therapeutic effects whilst maximising therapeutic benefits. TJ isn't a 'theory' as such but rather "a field of enquiry – in essence a research agenda."[187] TJ is a lens through which legal problems can be considered. It can be described as "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects."[188] TJ attempts to approach socio-legal problems with the intention of achieving better outcomes that are consistent with human rights.

In the 1980's TJ emerged in the field of mental health law through the seminal work of David Wexler.[189] However, its application has spread to a range of different legal fields.[190] Historically, criminal justice has focussed on punishment whereas mental health law has centred around the idea of treatment.[191] A TJ consistent approach means these two priorities are not mutually exclusive. TJ mandates the promotion of therapeutic initiatives for prisoners. Concurrently, any adverse effects on well-being must be minimised.

TJ is applicable to the treatment of at-risk prisoners. A TJ consistent approach would require that solitary confinement for at-risk prisoners be reduced given the anti-therapeutic effects.[192] The applicability of TJ in this sphere has been reinforced by Warren Brookbanks. He argues "the ongoing problem of mental disorder amongst prison inmates is possibly the single most distinctive area in which therapeutic jurisprudence has the potential to impact corrections practice."[193] The treatment of at-risk prisoners must be considered through a TJ lens in order to promote better therapeutic outcomes.

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[187] David Wexler "From Theory to Practice and Back Again in Therapeutic Jurisprudence: Now Comes the Hard Part" 37 Monash U L Rev (2011) 33 at 33.
[188] Christopher Slobogin "Therapeutic Jurisprudence: Five Dilemmas to Ponder" in BJ Winnick and DB Wexler (eds) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Carolina Academic Press, Durham NC, 1996) at 767.
[189] Michael King *Non-adversarial justice* (The Federation Press, NSW, 2009).
[190] See Wexler and Winnick, above n 188.
[191] Astrid Brigden "Therapeutic Jurisprudence and Good Lives: A Rehabilitation Framework for Corrections" 37 *Australian Psychologist* 180 (2002).
[192] See Chapter 3.
[193] Warren Brookbanks "Therapeutic Jurisprudence and its Role in Corrections" in W Brookbanks (ed) *Therapeutic Jurisprudence: New Zealand Perspectives* (Thomson Reuters, Wellington, 2015) at 174.

B. Proposed Legislative Reform to the Mental Health (Compulsory Assessment and Treatment) Act 1992

The current definition of 'mental disorder' has some inherent flaws. The descriptive nature of the 'abnormal state of mind' limb means that some people who may benefit from compulsory treatment will not be considered 'mentally disordered'.[194] The interpretive approaches adopted by the courts and MHRT have partially remedied this.[195] But there remains uncertainty since 'abnormal state of mind' is not defined in the Act. Furthermore, the definition of 'mental disorder' is applied by non-legal actors who may not be cognizant of these interpretive approaches or the latest judicial decision.

The proposed reform seeks to ensure that: individuals who will benefit from compulsory psychiatric treatment receive it; the safety of the community is maintained; potential for abuses of psychiatry is avoided. The proposed amendment broadens the range of mental illnesses that fall within the ambit of 'mental disorder', whilst incorporating a stricter 'treatability' test to avoid abuses of psychiatry and indefinite confinement. The exclusionary criteria (s 4) and consequential limb remain unchanged. The proposed amendment is consistent with the idea that:[196]

> persons should be admitted involuntarily only if there is a therapeutic purpose to the admission. This does not necessarily mean that medication must be provided, as a wide range of rehabilitative and psychotherapeutic approaches may be implemented. A lack of therapeutic success does not imply a lack of therapeutic purpose, and involuntary admission can be justified if the person is receiving therapeutic care, even if the available treatments are not able to completely cure the person's condition.

[194] See discussion in chapter 1.
[195] The dynamic interpretation is discussed in detail in Chapter 1.
[196] Melvyn Freeman, Soumitra Pathare and others *WHO Resource Book Mental Health, Human Rights and Legislation* (World Health Organisation, 2005) at 51.

Proposed Amendment to the MH(CAT) Act – Definition of 'Mental Disorder'

Section 2 - mental disorder, in relation to any person, means:

(a) a mental disorder (whether of a continuous or an intermittent nature) as defined in DSM-V;[197]

(b) for which there is available treatment that is capable of preventing the 'mental disorder' from worsening or alleviating any of the symptoms;

of such a degree that it -

(a) poses a serious danger to the health or safety of that person or of others; or

(b) seriously diminishes the capacity of that person to take care of himself or herself;—

and **mentally disordered**, in relation to any such person, has a corresponding meaning

The reformed first limb would be termed the 'diagnostic limb'.[198] This limb requires that the symptoms meet the diagnostic requirements of a mental disorder as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM).[199] The undefined wording of the 'abnormal state of mind' limb risks uncertain and inconsistent application. Incorporating the DSM into the statutory provision will remedy this by ensuring certainty and consistency in terms of diagnostic criteria. The introduction of the DSM will have the effect of substantially broadening the scope of conditions that fall within the definition of 'mental disorder'. The DSM includes, for example, various personality disorders and substance abuse disorders.[200] However, the s 4 exclusionary criteria will ensure that disorders that are inappropriate for compulsory psychiatric treatment, such as substance abuse disorders, are not subject to the Act.[201]

A broad definition of 'mental disorder' does create the potential for abuses of psychiatry.[202]

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[197] American Psychiatric Association, above n 173. There should also be provision for the legislation to update when new editions of the DSM are released.

[198] This terminology is proposed as it reflects the diagnostic nature of the enquiry

[199] This approach is considered best practice in Fistein, above n 38.

[200] As well as all other common mental disorders that would fall within the current definition of mental disorder. See DSM, above n 197.

[201] Despite this fact substance abuse disorders would still not fall within the definition of mental disorder. This is because it would not be considered "necessary" to commit someone to compulsory psychiatric treatment solely because of a substance abuse disorder. Mental Health (Compulsory Assessment and Treatment) Act 1992 s 27(3).

[202] See Chapter 1.

However, the exclusionary criteria (s 4) and treatability requirement mitigate against this.[203] Amongst economically developed Commonwealth countries there has been a move towards a broader definition of 'mental disorder'.[204]

The Centrality of Treatment

Currently, s 66 of the MH(CAT) Act affords 'everyone the right to appropriate treatment'. However, s 66 only aids interpretation when assessing whether someone is 'mentally disordered'.[205] In this sense, it is not a mandatory requirement but rather a relevant consideration when determining 'mental disorder'.

Ensuring the primacy or centrality of treatability is consistent with TJ. The proposed amendment ensures that every individual subject to compulsory treatment will receive some therapeutic benefit. The available treatment must be capable of alleviating any of the symptoms or preventing the suffering of an anti-therapeutic effect through the deterioration of the condition.

Explicitly incorporating treatability into the definition of 'mental disorder' allows for the law to react more appropriately to the issue of personality disorders. The inclusion of 'personality disorders' within the definition of 'mental disorder' without this treatability requirement would be inappropriate.[206] The diagnostic criteria for 'personality disorders' is a contentious issue.[207] When faced with violent individuals who pose a grave danger to society there is a temptation to apply the label of 'mental disorder' and direct their confinement. However, a person requiring "purely custodial care should not be kept in a psychiatric facility as an involuntary patient."[208] The treatment requirement mitigates against this potential abuse of psychiatry. Section 66 often achieves this outcome. However, it only aids interpretation because it is outside the definition of 'mental disorder'. This risk is mitigated by including a treatability requirement in the definition of 'mental disorder'.

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[203] This is seen as good practice by the WHO. See Freeman and Pathare, above n 196.
[204] See Fistein and others, above n 38.
[205] See Chapter 1
[206] The WHO Resource book states that if including 'personality disorder' into legislation then must have "substantial legal provisions to prevent misuse" Freeman and Pathare, above n 196, at 22.
[207] Diagnosis is uncertain and at times unscientific. See: Lee Clark "Assessment and Diagnosis of Personality Disorders: Perennial Issues and an Emerging Reconceptualization" (2007) 58 *Annual Review of Psychology* 227.
[208] Freeman and others, above n 196, at 51.

Currently, personality disorders are not expressly included (or excluded) from the Act. The wording contained in the 'abnormal state of mind' limb risks that personality disordered individuals who would benefit from compulsory psychiatric treatment may fail to satisfy the definition. Personality disorders have only been deemed 'mental disorders' when the consequential limb has been overwhelmingly established.[209] However, the Act should be able to provide for every situation where a personality disordered individual satisfies the consequential limb and would benefit from compulsory treatment. The proposed legislative drafting is consistent with TJ as it ensures that the law capitalises on any opportunity to provide a therapeutic benefit. The current definition can allow for this to eventuate through the process of dynamic interpretation.[210] However, this should be explicitly provided for in the Act particularly, given that non-legal actors must apply the definition of 'mental disorder'. The introduction of the treatability requirement into the definition of 'mental disorder' ensures this is the case.

The 'consequential limb' remains unchanged. A sufficient nexus between the 'diagnostic limb' and 'consequential limb' must still be established. In other words, the 'mental disorder' must cause a serious danger or failure to take care of oneself.

C. How Would the Legislative Reform Work in Practice?

The way in which the reformed definition of 'mental disorder' would be applied by the Courts, MHRT and psychiatrists must be considered in order to assess whether the reform is favourable. The interpretation of the reformed definition of 'mental disorder' will be substantially simpler and it will ensure that those who *should* be subject to compulsory psychiatric treatment are. The first limb will consist of a two-pronged evaluation. The first line of enquiry is whether the individual has a mental disorder based on the diagnostic criteria in the DSM. This determination is a binary decision capable of straightforward application and should not be subject to dynamic considerations. This evaluation should be made solely by a psychiatrist.

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[209] This was the case in *Waitemata Health v A-G*. Alternatively, if a personality disordered individual has a co-morbid mental disorder they will (and often do) satisfy the definition.
[210] See chapter 1 for an explanation of the dynamic interpretation of 'mental disorder'.

If a mental disorder is present then it must be asked: will compulsory treatment be capable of producing a therapeutic result for the individual? Is treatment capable of improving, or preventing the likely deterioration of the mental disorder? The outcome of this evaluation will depend on the strength of the consequential limb.

The definition should operate in a dynamic manner. Dynamism should occur between the consequential limb and the degree of treatability or the degree of intermittency.[211] If someone does not easily satisfy the consequential limb, then treatment would be required to have the likely effect of improving the condition or preventing deterioration. Alternatively, if someone presents a substantially higher degree of danger it may justify compulsion even where the efficacy of treatment is less certain. The extent to which these terms widen or narrow in scope is essentially a matter for the Courts, MHRT and psychiatrists to decide based on the circumstances of the case. However:[212]

> if a particular condition is not responsive to treatment, or if no treatments are available it is difficult to justify involuntary admission of persons with this condition to a mental health facility … many would argue that this should not be the purpose of mental health legislation.

The treatability requirement also prevents indefinite confinement. If an individual is subject to the Act but treatment has proved futile they will fail to satisfy the treatability requirement and therefore released from compulsory treatment. The particular danger they pose will affect the level of futility at which they are considered no longer treatable.

Evolutionary Benefits – Future-proofing the Definition of 'Mental Disorder'

There are some evolutionary benefits to the reformed definition of 'mental disorder'. The 'mental disorder' must be consistent with the diagnostic criteria of mental disorders in the DSM. The DSM is constantly updated to reflect the latest psychiatric consensus. This reflects the fact that psychiatry, like all sciences, is constantly evolving. This legislative reform allows the law to keep pace with the evolution of psychiatric literature.

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[211] This aspect remains consistent with the previous legislation. See chapter 1.
[212] Freeman and others, above n 38, at 21.

The centrality of treatability has a similar effect. The efficacy of certain forms of treatment for certain conditions has evolved over time particularly when considering personality disorders.[213] Ensuring that treatability is mandatory, when establishing the presence of a 'mental disorder,' ensures that the law will remain consistent with psychiatric best practice.[214]

How Will the Proposed Reform Affect At-risk Prisoners?

At-risk prisoners that are 'mentally disordered' under the current provision will remain so under the amended provision. However, there will be a, potentially, substantial effect on the treatment of personality disordered offenders.[215] For these prisoners, the only consideration will be the treatability of their condition.[216] Is compulsory treatment capable of producing a therapeutic benefit? This is a complicated question that requires expert advice and an extensive knowledge of the individual. In a situation where a personality disordered prisoner has been subject to prolonged solitary confinement in an ARU, it may be argued that the anti-therapeutic effect of this treatment will justify compulsory treatment.[217] This will be subject to whether treatment is predicted to confer some therapeutic benefit. This will allow for New Zealand's treatment of at-risk prisoners to be more consistent with the Mandela Rules, that is by avoiding prolonged solitary confinement.[218]

However, "the power to treat is useless without the means to do so."[219] Scotland's incorporation of personality disorder into the definition of 'mental disorder' was ineffective.[220] Their amended legislation did not increase the number of people considered 'mentally disordered' which suggests the reform had no effect on the treatment of personality disordered individuals.[221] In part the failure of the Scottish legislation failred because Scotland did not

[213] Over time there has been a trend towards personality disorder being consider treatability. For a review of the literature see: Martyn Pickersgill "How Personality Became Treatable: The Mutual Constitution of Clinical Knowledge and Mental Health Law (2012) 43 *Social Studies of Science* 30
[214] The current provision allows for this to a certain extent. The incorporation of s 66 into the interpretive process ensures this is the case.
[215] The size of this will likely be determined by how successful treatment proves to be over time.
[216] Given they already satisfy consequential limb due to risk of self-harm.
[217] But of course, this will still subject to treatability.
[218] Nelson Mandela Rules, above n 17, r 44.
[219] A Maden and others "Treating Dangerous and Severe Personality Disorder in High Security: Lessons From the Regional Psychiatric Centre, Saskatoon, Canada" (2004) 15 *Journal of Forensic Psychiatry and Psychology* 375 at 376.
[220] Mental Health (Care and Treatment) (Scotland) Act 2003 s 328.
[221] See: Lindsay Thomson Personality disorder and mental health legislation in the UK Commentary on... Personality disorder and the mental health Act 1983 (amended) (2010) 16 *Advances in Psychiatric Treatment* 336 at 336.

provide forensic facilities appropriate for personality disordered individuals as they had been advised.[222] Accordingly, a forensic psychiatric facility appropriate for treating personality disordered offenders must be established in New Zealand for the reform to have the desired effect.

D. Establishing Therapeutic Communities for the Treatment of Personality Disordered Prisoners

Available treatment can be achieved by creating therapeutic communities (TC) targeted specifically at treating personality disordered individuals. TC's have been found to reduce levels of self-harm.[223] TC's have been successfully used to treat sex offenders[224] and substance addicts.[225] TC's have been used to treat personality disordered individuals in Canada,[226] England[227] and the Netherlands.[228]

Lessons from the Treatment of 'Dangerous and Severe Personality Disordered'(DSPD) Individuals

The evidence concerning the effectiveness of compulsory psychiatric treatment for personality disordered individuals is scarce. TC's have been used to treat 'dangerous and severe personality disordered' (DSPD) individuals in England and the Netherlands. Although specific provisions

[222] They were advised to do so by Forensic Mental Health Services Managed Care Network *Report of the Working Group on Services for People with Personality Disorder* (2005).
[223] J Bennett and R Shuker "The Potential of Prison Based Democratic Therapeutic Communities" (2017) 13 *Int J Prison Health* 19.
[224] Michael Brookes "Supporting Uniformed Officers Delivering Therapy Within a Prison Therapeutic Community for Sexual Offenders" 15 *Mental Health Review Journal* 40. The treatment of personality disordered sex offenders has also been successful. For discussion see Geraldine Akerman "Undertaking Therapy at HMP Grendon with Men Who Have Committed Sexual Offences" in Richard Shuker and Elizabeth Sulivan (eds) *Grendon and the emergence of forensic therapeutic communities: Developments in Research and Practice* (Wiley-Blackwell, 2010).
[225] George Leon "'The Gold Standard' and Related Considerations for a Maturing Science of Substance Abuse Treatment. Therapeutic Communities; A Case in Point" (2015) 50 *Substance Use and Misuse* 1106.
[226] Maden and others, above n 219. The violence reduction programme in Saskatoon Canada is not a forensic therapeutic community per se. But, it is specifically targeted at personality disordered individuals with a strong therapeutic focus.
[227] See generally Richard Shuker and Elizabeth Sulivan (eds) *Grendon and the emergence of forensic therapeutic communities: Developments in Research and Practice* (Wiley-Blackwell, 2010).
[228] See Judith De Boer-van Schaik and Frans Derks "The Van Der Hoeven Hoeven Clinic: a Flexible and Innovative Forensic Psychiatric Hospital Based on Therapeutic Community Principles" in Richard Shuker and Elizabeth Sulivan (eds) *Grendon and the emergence of forensic therapeutic communities: Developments in Research and Practice* (Wiley-Blackwell, 2010).

differ, in general a DSPD individual is someone who:[229]

(a) has a 'severe personality disorder', and
(b) presents a significant risk of serious harm from which the victim would struggle to recover, and
(c) the risk presented is functionally linked to the personality disorder.

The success of DPSD units is murky given the "impoverished knowledge base."[230] In England it has been argued the Fens Unit has improved mental health and reduced the risk of reoffending in a cost-effective manner.[231] However, many experts are far more pessimistic.[232]

The purpose of DSPD units is to "detain individuals who [are] considered to be threats to the public, while at the same time providing the mental health care required to reduce the risk they present."[233] However, critics argue the overriding concern is to control those individuals that poses the gravest danger to society.[234] DSPD Units are therefore home to some of the most troubled and problematic individuals. The desire to control these dangerous individuals was a "populist law and order action."[235] Treatability was not a criteria for admission to a DSPD Unit.

The proposed reform will involuntarily treat those personality disordered offenders who will benefit most from treatment. The focus on treatability, as opposed to risk management, will inevitably produce better results.

The Gold Standard for Involuntary Treatment – The Van Der Hoeven Clinic

The Van Der Hoeven Clinic is a Dutch TC that has had substantial success in involuntary

[229] In the Netherlands it is not exclusively for personality disordered individuals but they make up the vast majority. For a comparison between the systems see: Judith De Boer, Sean Whyte and Tony Maden "Compulsory Treatment of Dangerous Offenders with Sever Personality Disorders: A Comparison of the English DSPD and Dutch TBS Systems" (2008) 19 J Forens Psychiatry Psychol 148.
[230] Kevin Howells, Gopi Krishnan and Michael Daffern "Challenges in the Treatment of Dangerous and Severe Personality Disorder" (2007) 13 *Advances in Psychiatric Treatment* 325 at 325.
[231] Jac S Evershed "Treatment of Personality Disorder: Skills-based Therapies" (2011) 17 *Advances in Psychiatric Treatment*, 206
[232] See Peter Tyrer "The Successes and Failures of the DSPD Experiment: the Assessment and Management of Severe Personality Disorder (2010) 50 *Med Sci Law* 95.
[233] Pickersgill, above n 213, at 36.
[234] Alibhe O'Loughlin "The Offender Personality Disorder Pathway: Expansion in the Face of Failure?" (2014) 53 *The Howard Journal of Criminal Justice* 173.
[235] James Beck "Dangerous Severe Personality Disorder: The Controversy Continues" (2010) 28 *Behavioural Sciences and the Law* 227 at 325.

treatment of personality disordered offenders. The TBS system is similar to the DSPD programme.[236] The Clinic has "evolved into one of the most out-standing forensic treatment and rehabilitation centres in The Netherlands for offenders with severe DSM-IV axis II personality disorders [and mental disorders more generally]."[237]

The Clinic has the lowest rates of recidivism compared to any other forensic psychiatric facility in the Netherlands.[238] For this reason it provides excellent guidance on how to effectively manage dangerous prisoners with personality disorders. The approach of the Van Der Hoeven clinic is based on four key principles:[239]

(i) Promote re-socialisation
(ii) Replicate 'normal' life as far as possible
(iii) Group living and encouragement of 'shared responsibility'
(iv) Ensuring safety without using mechanical or physical features.

The Van Der Hoeven Clinic is separated into 'living groups' based on the characteristics of their condition. This is the underlying rationale for proposing a facility specifically for those with personality disorders. Safety is ensured by developing extensive knowledge of an individual prisoner's needs and risk factors. The Van Der Hoeven Clinic provides evidence that personality disordered offenders can be treated effectively in a TC. New Zealand should adopt this model.

The Gold Standard for Voluntary Treatment – HMP Grendon

HMP Grendon has achieved considerable success in the treatment of personality disordered individuals. The purpose behind creating Grendon was to treat prisoners with personality disorders.[240] Admission to Grendon is on a voluntary basis. As of 2010, 86% of the prisoners at Grendon suffered a personality disorder.[241] Prisoners treated at Grendon tend to experience a reduction in criminogenic risk and improvement in psychological well-being.[242] Rates of

[236] De Boer, Whyte and Maden, above n 229.
[237] De Boer-van Schaik and Derks, above n 228, at 45.
[238] De Boer-van Schaik and Derks, above n 228.
[239] De Boer-van Schaik and Derks, above n 228.
[240] J Bennett "Introduction" in Richard Shuker and Elizabeth Sulivan (eds) *Grendon and the emergence of forensic therapeutic communities: Developments in Research and Practice* (Wiley-Blackwell, 2010) 1.
[241] Bennett, above n 242, at 15.
[242] Richard Shuker and Margaret Newton "Treatment Outcome Following Intervention in a prison based therapeutic community: a study of the relationship between reduction in criminogenic risk and improvement in psychological well-being" (2008) 10 *Brit Journal of Forensic Practice 33*

suicide and self-injurious behaviour (SIB) are low at Grendon. For example:[243]

> Grendon's rate of SIB is approximately 29 incidents per 1000 prisoners per year, compared to a rate in the mainstream prison service of between 130 and 137 incidents per 1000 prisoners per year. There is no evidence that these low rates can be explained by selection effects into or out of the prison.

This demonstrates the ability of TC's to minimise self-harm and improve mental health. Personality disordered offenders who are placed in TC will be less likely to be considered at-risk and subject to the harmful effects of this status as discussed in Chapter 2.

Establishing Therapeutic Communities in New Zealand

For the proposed legislative change to be effective, New Zealand needs to learn from the international successes and failures of TC's that treat personality disorders. Although the cost-effectiveness and overall efficacy of DSPD units is disputed, it is clear that involuntary treatment of personality disordered individuals *can* be successful.

The treatability requirement will ensure that those who occupy TC's are more amenable to treatment than those that were often identified as DSPD. The effectiveness of DSPD units is not directly relevant as a result. Instead the aspects that made the TC units successful (or not) must be used to guide New Zealand's development of these units. There have been constant and substantial developments in the treatment of personality disordered offenders.[244] New Zealand must seek to adapt its approach as new evidence comes to light.

The scientific literature concerning the treatment of personality disorders suggests that voluntary treatment is more effective.[245] The success of HMP Grendon and other TC units, reinforce the literature. For this reason, similar facilities should be made available in New Zealand. This will ensure personality disordered individuals who do not satisfy the consequential limb of 'mental disorder' are treated in a therapeutic manner. Failure to do so risks exposing these vulnerable individuals to the harmful effects of prison. Appropriate

[243] Adrienne Rivlin "Suicide and Self-injurious Behaviours at HMP Grendon" in Richard Shuker and Elizabeth Sulivan (eds) *Grendon and the emergence of forensic therapeutic communities: Developments in Research and Practice* (Wiley-Blackwell, 2010) at 266
[244] Pickersgill, above n 213.
[245] Pickersgill, above n 213.

treatment will prevent the deterioration of the mental health of personality disordered individuals. Personality disordered individuals are particularly susceptible to self-harm.[246] A preventative approach will ensure that these individuals are not subjected to the harmful effects associated with being classified as an at-risk prisoner, as outlined in Chapter 2.

Given resource constraints, the voluntary and involuntary TC's could be combined into one. However, the most effective approach would be to have a TC located outside of the prison for involuntary treatment and a voluntary TC located inside the prison. This will allow for involuntary patients to be transferred to the voluntary facility if they are willing to do so. This will allow for the continuation of treatment when no longer considered 'mentally disordered'.

A Theoretical Framework for Voluntary Admission

The following criteria should govern the decisions for who is admitted to a voluntary based TC:

(i) The prisoner must voluntarily opt to be admitted

(ii) A clinical psychologist must identify the presence of 'personality disorder' as defined in DSM.[247]

(iii) The decision should be based on the overall justification for admission. When assessing justification any relevant circumstances must be considered. Whether the prisoner's personality disorder will fit with the current group of prisoners is relevant. Justification may also rest on how treatable individual prisoners are given the nature of their personality disorder.

The proposed legislative reform and adoption of TC for personality disordered individuals will result in better therapeutic outcomes for many. The consequence of this will be a reduction in the number of at-risk prisoners. Inevitably there will still be some individuals who fall between the cracks. For these individuals, there are a number of specific reforms that will promote the well-being of at-risk prisoners.

[246] This is particularly the case for those with borderline personality disorder. See for example: Mark McFetridge and others "Borderline personality disorder: patterns of self-harm, reported childhood trauma and clinical outcome" (2015) 1 *BJPsych* 18.
[247] American Psychiatric Association, above n 173.

E. ARU's, Healthcare and the Prison Environment

ARU's are a necessary feature for the short-term management of at-risk prisoners. The aforementioned legislative reforms will divert some at-risk prisoners away from prison. Inevitably though, some prisoners will be subjected to an ARU (and where necessary mechanical restraints). However, there are some specific changes that will ensure this treatment minimises anti-therapeutic effects in a manner consistent with TJ.

The current suicide training for Corrections Officers is basic. Corrections Officers undergo a 6-week training course with a module on suicide prevention. Additionally, staff undergo a two-day Suicide Prevention Awareness Training to help identify suicidal ideation and self-harm. While these measures are useful training should be on-going and more thorough. The prevalence of personality disorders justifies specific training on the management of personality disorders.[248] Specific training in the management of those with a personality disorder will promote therapeutic outcomes for this particularly vulnerable group of prisoners.

Corrections Officers working in ARU's do not receive additional mental health or suicide awareness training. This is ill-advised as they are working with problematic prisoners who have complex mental health needs. Staff who work in ARU's should be specialists who have undergone extensive training in suicide prevention. Currently staff working in ARU's are rotated frequently.[249] Specialist training will ensure that at-risk prisoners are treated as therapeutically as possible. Additionally, extra training to reduce the use of restraint will be consistent with the Mandela Rules.[250]

A higher level of training can be achieved by having at least some permanent staff in the ARU's. This will promote positive staff-inmate relationships which have been found to reduce rates of suicide and self-harm.[251] Having permanent, well-trained staff will allow the development of meaningful and trusting relationships between staff and those held in

[248] As advocated for in OPCAT Findings Report, above n 4.
[249] OPCAT Findings Report, above n 4.
[250] Nelson Mandela Rules, above n 17, r 49.
[251] Toby Harris *Changing Prisons, Saving Lives*: *Report of the Independent Review into Self-Inflicted Deaths in Custody of 18-24 Year Olds* (July, 2015).

ARU's.[252]

One way of achieving a therapeutic environment would be to create specialist ARU's in selected prisons. However, this approach would result in increased prisoner transfers. Transfers could move at-risk prisoners away from their family and to an unfamiliar environment which could exacerbate self-harming behaviour. For this reason, it is desirable that all prisons create an ARU with permanent, well-trained staff. However, resource constraints may mandate specialist ARU's in selected prisons.

Manawatu Prison does not have an ARU. The COTA Report in January 2016 considered the substitute facility as not fit for purpose. An appropriate ARU must be established in order to promote the health and well-being of prisoners at Manawatu Prison.

These specific changes will ensure that the negative psychiatric effects arising from the current treatment of at-risk prisoners (as described in Chapter 2) is minimised. However, the general prison environment also has a substantial effect on the well-being of prisoners. Almost all prisoners have substance abuse issues.[253] Any measures that seek to address these underlying issues will have flow-on effects to prisoner mental health and the prevalence of self-harm.[254]

Additionally, any measures that increase meaningful activity will have a positive result on a prisoner's mental health.[255] Increased time in cells or isolation results increases the risk of suicide.[256] Purposeful activity can be either work experience or education. Providing education improves relationships between staff and inmates.[257] Furthermore, improved education will increase the prisoners' prospects for the future and inevitably decrease the likelihood of self-harm. As it currently stands prisoners are only entitled to free education if they would be

[252] The lack of meaningful contact between inmates and staff was considered a problem in OPCAT Findings Report, above n 4.
[253] For detailed statistics refer to the introduction.
[254] For critical analysis of the shortcomings of rehabilitation programmes and areas of reform see: Roger Brooking *Flying Blind: How the Justice System Perpetuates Crime and the Corrections Department Fails to Correct* (ADAC, Wellington, 2011).
[255] J Macguire *Offender Rehabilitation and Treatment Effective Programmes and Policies to Reduce Re-offending* (John Wiley & Sons, Chichester, 2003).
[256] Howard League for Penal Reform "*Preventing Prison Suicide"* (2016) HLPR <http://howardleague.org>.
[257] Elizabeth Stanley *Human Rights and Prisons: A Review to the Human Rights Commission* (Human Rights Commission, Auckland, July 2011) at 48-49.

eligible for it under the Education Act or if seeking to improve poor literacy skills.[258] The availability of education should be expanded. Currently, less than half of all prisoners are involved in education.[259]

In addition to education, opportunities for work experience should also be increased. Currently, 59% of prisoners are involved in some sort of work experience.[260] These initiatives help the prisoner prepare for life after prison by increasing employability. Ensuring that prisoners are engaging in meaningful activity, as much as possible, will help decrease their sense of hopelessness. Although, New Zealand has made significant strides in this area further progress is crucial.

Self-harming prisoners present difficult problems for the Department of Corrections and Criminal Justice system more generally. These problems, however, are not without solutions. There is a way forward.

[258] Section 78(2) Corrections Act 2004. See Brooking, above n 254, for criticisms of the fact that, in practice, this law is flouted.
[259] Auditor-General *Department of Corrections: Managing Offenders to Reduce Reoffending* (Office of the Auditor- General, Wellington, 2013) at [7.12]
[260] Department of Corrections "Working with Offenders – Employment Activities" <www.corrections.govt.nz >

CONCLUSION

"There is a dissonance between the purposes and services of the justice system compared to the needs of suicidal people or those with mental health problems."[261]

The treatment of at-risk prisoners is currently inadequate. Solitary confinement can be harmful to anyone that is subjected to it. Two key factors increase the risk of harm; prolonged confinement and mental health issues. The prevalence of mental health issues amongst prisoners is staggeringly high.[262] Treatment in a ARU and for a prolonged is by no means a rarity. In the 5-year period (ending June 2017) there were 1650 instances where solitary confinement was in excess of 20 days.[263] Undoubtedly, the majority of the individuals in these cases suffer from mental health issues. The psychological harm of this reality to these individuals (and their families) is not quantifiable. Needless to say something must be done to reduce the frequency and duration of the use of ARU's.[264]

The current approach to the treatment of at-risk prisoners is inconsistent with a number of human rights obligations. It breaches the respective prohibitions on psychosocial and mental disabilities.[265] Similarly, the 1650 instances referred to above breached the Mandela Rules, r 44 and arguably the ICCPR.[266] Although these breaches are unenforceable that do suggest that New Zealand has substantial room for improvement in the treatment of at-risk prisoners.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 determines which individuals are subject to compulsory psychiatric treatment. The classification of prisoners as a 'mentally disordered' is made by legal and non-legal actors alike and rests solely on whether an individual falls within the definition of 'mental disorder'. However, given the shortage of forensic psychiatric beds[267] it is currently common practice for prisoners deemed 'mentally

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[261] Marc Daigle "Mental Health and Suicide Prevention Services for Canadian Prisoners" (2007) 3 *Int J Prison Health* 163 at 163.
[262] See Indig, Gear and Wilhelm for the latest statistics, above n 7.
[263] Official Information Request, above n 105.
[264] Some solutions occur prior to imprisonment. These are outside the scope of this dissertation. See for example: Bruce Winick and David Wexler *Judging in a therapeutic key: therapeutic jurisprudence and the courts* (Carolina Academic Press, Durham, 2003).
[265] As discussed in Chapter 3.
[266] The Human Rights Committee, the UN body charged with implementing the ICCPR, argued that prolonged use of solitary confinement may breach Art 7 and as such amount to cruel, inhumane or degrading punishment or treatment.
[267] Psychiatric bed shortage

disordered' to be 'waitlisted'.[268] This is inconsistent with the equivalence of care principle enshrined in human rights obligations and domestic law.[269] Capacity *must* increase to avoid this reality. Prisons are not substitutable for specialist mental health facilities.

The definition of 'mental disorder' comprises of two limbs. The consequential limb is easy to establish for at-risk prisoners considering the danger they pose to themselves. However, substantial contention surrounds the first limb. The Courts, MHRT and psychiatrists been reluctant to apply this limb to personality disordered individuals. The reason being in a psychiatric sense personality disorders are not considered treatable.[270] Personality is ingrained and enduring.

However, personality disordered prisoners "cannot be safely and effectively managed in the prison environment."[271] What I propose is a new way of approaching the issue of personality disordered prisoners.

This requires legislative reform to the definition of 'mental disorder'. This reform has the effect of widening the scope of conditions that can be deemed 'mental disorders'. The proposed legislative reliance on the DSM ensures diagnostic consistency, particularly given personality disorder diagnosis is so contentious. Broadening the scope has the potential for abuses of psychiatry to occur. However, this is mitigated by making treatability a mandatory requirement. The consequential limb is unchanged and easily established for at-risk prisoners. Therefore, the only relevant consideration for personality disordered at-risk prisoners will be whether their condition is treatable. Ten years ago, this would have been a straight forward answer. However, there is a growing body of evidence that suggests personality disorders can be responsive to treatment such as psychotherapy.[272]

For the reform to have any effect, the development of facilities the treat personality disorders must be developed. There are numerous examples of good (and bad) practice from overseas

[268] Wakem, above n 123, at 153.
[269] Mental Health (Compulsory Assessment and Treatment) Act 1992, S 75(2). See chapter 3 for human rights obligations relating to equivalence of care.
[270] In the sense that they are not 'curable'. Evidence does, however, suggest that treatment can have positive effects on their behaviour and subsequently the risks they pose.
[271] Report of Mel Smith, above n 19, at 96.
[272] Pickersgill, above n 213.

that can guide New Zealand's approach. Therapeutic communities should also be made available, within the prison, to prisoners who voluntarily wish for treatment.

It goes without saying, these proposed reforms are ambitious. They are not foolproof and not particularly inexpensive. But, what is the alternative? The status quo? Something must be done.

APPENDIX

Items and Features of ARU's: Corrections Regulations 2005, Sch 2

Part C: Items and features of cells for prisoners at risk of self-harm

(i) A cut down knife located outside the cell but in the vicinity.
(ii) A window that allows a complete view of the inside of the cell from a vantage point outside the cell door.
(iii) Artificial lighting that is controlled only from outside the cell.
(iv) Furniture and fittings within the cell that are free from features that could facilitate self-harm (in particular hanging or garrotting).
(v) Intercom, alarm, or call button.
(vi) No privacy screening or any other barrier that prevents a full view of the cell from the door window.

Part D: Additional feature for cells accommodating prisoners at risk of self-harm

(i) Located close to the prison's health centre

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