

Thematic Report: Older Prisoners

The lived experience of older people in
New Zealand prisons



INSPECTION TEAM

Rebecca Gormley	Principal Inspector
Steven Bell	Inspector
Don Govender	Inspector
KyMBERLEY Jack-Thomson	Inspector
John Kinney	Inspector
Tracy Tyro	Inspector
Katrina Wolfgramm	Inspector
Fiona Irving	Principal Clinical Inspector

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Office of the Inspectorate – *Te Tari Tirohia*

Department of Corrections – *Ara Poutama Aotearoa*

Private Box 1206

Wellington 6140

New Zealand

Telephone: 04 460 3000

Email: inspectorate@corrections.govt.nz

Web: <https://inspectorate.corrections.govt.nz/>

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Office of the Inspectorate *Te Tari Tirohia*

Our whakataukī

Mā te titiro me te whakarongo ka puta mai te māramatanga

By looking and listening, we will gain insight

Our vision

That prisoners and offenders are treated in a fair, safe, secure and humane way.

Our values

We acknowledge the Department of Corrections' values: **rangatira** (leadership), **manaaki** (respect), **wairua** (spirituality), **kaitiaki** (guardianship) and **whānau** (relationships).

Office of the Inspectorate values:

Respect We are considerate of the dignity of others

Integrity We are ethical and do the right thing

Professionalism We are competent and focused

Objectivity We are open-minded and do not take sides

Diversity We are inclusive and value difference



Foreword

This is the first thematic inspection carried out by the Office of the Inspectorate. This work complements the prison inspections regime, which has now transitioned into its second phase of announced and unannounced follow-up prison inspections.

Following my appointment, I made a commitment to ensure the work of my Office was future focused to address the challenges for people in the care of the Department of Corrections. In determining which areas to examine, I considered older prisoners to be a priority.

Our approach to this important work has been through the lens of the lived experience of older people who are, or recently have been, in prison.

We interviewed 95 individuals, aged 65 years or older, observed the environment in which they are detained and examined the regimes under which they are managed.

I have made one overarching recommendation, that is, that Corrections should develop, appropriately resource, and implement a comprehensive Older Prisoners' Wellbeing Strategy to respond to the age-related needs of older prisoners. The report highlights a number of areas of focus that I urge Corrections to consider in the development of its strategy.

When such a strategy is implemented, my Office will decide how best to oversee the changes which are made to manage older prisoners.

The increasing ageing prison population is not unique to New Zealand. Many jurisdictions across the world face the same challenges.

With the launch of the Hōkai Rangi strategy,¹ and its focus on the principles of humanising and healing, Corrections is now better placed to redirect effort and resources to deliver a service which meets the demands of an ageing prison population.

This report makes for challenging reading because it reflects real people in real situations. It is, I believe, a positive and solutions focused examination of the challenges faced by older prisoners and staff.

I hope that by hearing the voices of those in custody and of staff we make their journey visible and foster a change in approach to one based on individual needs.

I commend this report to you and the opportunity it presents.

I understand, of course, that the development and implementation of a new strategy, as envisaged in my overarching recommendation, will take time and likely incur additional costs for Corrections. In this regard, I encourage Corrections to prioritise my suggested areas for consideration. I emphasise the need for ownership and implementation of this strategy to ensure focus and pace with this important work.

I am confident that if a strategy is developed, implemented and embedded, this will bring about the real change that is needed.



Janis Adair
Chief Inspector of Corrections

¹ https://www.corrections.govt.nz/resources/strategic_reports/corrections_strategic_plans/hokai_rangi

Executive Summary

The past few decades have seen an increase in the number of older prisoners (aged 65 and older) in New Zealand. This demographic shift is largely due to longer prison sentences and increased numbers of people serving sentences for historic sex offences. The numbers are forecast to continue to grow.

Older prisoners present a range of mainly health-related issues which require special management to ensure their imprisonment is safe and humane.

The prison environment, prisoner regimes and support services are typically designed for younger prisoners. In response to this, many comparable jurisdictions, including England, Scotland and Canada, have developed strategies for the needs of their older prisoner populations.

This thematic inspection provides insight into the current treatment of, and conditions experienced by, older prisoners. It provides the Department of Corrections with an early warning of the risks and challenges associated with managing older prisoners.

The areas examined in depth are: environment, safe and humane treatment, health and wellbeing, purposeful activity, rehabilitation and reintegration, post-release support and staff training.

This report finds, overall, that older prisoners' basic needs are generally being met. Most Corrections staff we spoke with and observed demonstrated innovation, care and respectful decision-making. However, there is an increasing demand for prisons to provide care home-type environments for many older prisoners and for staff to support their specific needs.

The report makes one overarching recommendation: that Corrections should develop, appropriately resource, and implement a comprehensive Older Prisoners' Wellbeing Strategy to respond to the age-related needs of older prisoners.

Further, Corrections is urged to consider a number of identified areas as part of the strategy. These include ensuring that older prisoners are placed in an environment appropriate to their needs, restraints are only used if absolutely necessary, more specific accommodation for older prisoners is provided, rehabilitation and reintegration support can be more easily accessed, and health oversight is increased. The report highlights the need for more training to enable staff to respond effectively to the age-related needs of older prisoners.

Overall, it is hoped that the recommendation will help prisons better manage the increasing numbers of older people in Corrections' care.

Our recommendation

Recommendation

Corrections should develop, appropriately resource, and implement a comprehensive Older Prisoners' Wellbeing Strategy to respond to the age-related needs of older prisoners.

Areas for consideration

Environment

1. Corrections should consider whether unit and cell placement decisions for older prisoners are informed and supported by health staff, and the rationale appropriately recorded.
2. Corrections should consider whether on entering prison, older prisoners, where possible, are placed in lower security units where their age-related needs can be met.
3. Corrections should consider whether each prison should, where possible, have a low security unit where older prisoners can be accommodated together when requested, with their health and wellbeing needs met.
4. Corrections should consider making accommodation adaptations to meet the needs of older prisoners, including more disability cells with appropriate showers and raised toilets, removable beds, grab rails, shower seats and lowered emergency alarm buttons.
5. Corrections should consider whether all prisons have emergency alarms available that can be worn around an older prisoner's neck when required.
6. Corrections should consider whether older prisoners can easily access areas such as health facilities.

Safe and humane treatment

7. Corrections should consider whether older prisoners should have restraints applied only when no lesser form of control will be effective, it is the least intrusive method, and it is applied for the shortest time necessary.
8. Corrections should consider whether the use of restraints on older prisoners is consistent across prisons. Health staff should have input into custodial plans to use restraints on older prisoners, and exemptions should be applied where appropriate.
9. Corrections should consider whether older prisoners are exempt from inter-prison transfers, where possible, where the sole purpose is for managing the prison population.
10. Corrections should consider whether custodial and health staff work together to assess older prisoners' age-related needs when journeys are planned, including the type of transport vehicle suitable for escort and transfer.

Health and Wellbeing

11. Corrections should consider training custodial and health staff to identify and manage older prisoners with challenging behaviours due to their mental and/or physical health decline, particularly in units like the High Dependency Unit.
12. Corrections should consider future accommodation options for older prisoners that meet varying levels of health or age-related needs, while supporting those prisoners to maintain contact with their family and whānau.
13. Corrections should consider undertaking a full health assessment of every older prisoner's age-related needs, respond to those needs, and collate the data centrally, to support the development of older prisoner health policy and practice.
14. Corrections should consider whether health staff receive dedicated training on managing older prisoners' health, including undertaking effective age-related health assessments.
15. Corrections should consider whether health staff take into account older prisoners' motor skills and cognition, when considering self-administration of medication and/or personal hygiene needs.
16. Corrections should consider whether prisoners who require continuing care are treated in an environment that is appropriate to their needs.
17. Corrections should consider whether each prison health centre has a lead nurse with specialist knowledge and oversight of older prisoners' care.
18. Corrections should consider annual mental health screening for all older people in prison and ensure that specific guidance on completing older persons' mental health checks is provided.
19. Corrections should consider reviewing compassionate release guidelines, informed by policy work currently underway.

20. Corrections should consider health staff commencing advanced care planning conversations with all older prisoners.

Purposeful Activity

21. Corrections should consider whether older prisoners, including those in high security accommodation, can access a range of age-appropriate purposeful activity.
22. Corrections should consider ways to support older prisoners if they cannot work and have little or no financial assistance from family and whānau.
23. Corrections should consider improving older prisoners' access to audio visual links to support regular contact with family and whānau who are unable to visit.

Rehabilitation and Reintegration

24. Corrections should consider whether older prisoners understand their offender plan and how Corrections will support them to be prepared for their parole hearing.
25. Corrections should consider how older prisoners are supported to obtain timely access to necessary rehabilitation programmes.
26. Corrections should support older prisoners serving preventive detention sentences to be prepared for their parole hearing.
27. Corrections should consider long-term supported accommodation options and whether spaces are available to house eligible older prisoners.
28. Corrections should consider the effects of institutionalisation on older prisoners' motivation and support them to be prepared for their parole hearing.

Post-release support

29. Corrections should consider continuing to support the development of staff practice to ensure older prisoners receive consistent and equitable access to effective release plans.

Staff Training

30. Corrections should consider whether custodial staff working with older prisoners have access to training and information on how they can best respond to older prisoners' needs.

Introduction

New Zealand prisons and older prisoners

1. Over the past few decades New Zealand has seen a steady increase in the prison population. Accompanying this has been the growth of the older prisoner population. In the six years to 28 February 2019, the number of prisoners in the 65 years and older age group increased by 61% (see Figure 1 below). On 28 February 2019, there were 313 prisoners (including four women) aged 65 years and older, which represented just over 3% of the total prison population (see Figure 2). Ninety-four percent of these prisoners were aged between 65 and 79 years of age, with 21 male prisoners aged 80 and over.
2. The Justice Sector 2018 Projection estimates that an increase of 1,900 prison beds is likely to be required over the next 10 years.² Given the expected growth in the proportion of the New Zealand population aged 65 years and over,³ and that older prisoners tend to serve longer sentences due to their offence types, it is forecast that the older prison population will continue to grow.
3. Older prisoners have several distinct features when compared to the prisoner population as a whole. A smaller proportion are female (1.3% percent versus 7% percent of the total population), and a significantly lower proportion are Māori (21.7% percent versus 51.7% of the total prison population), see Figures 3 and 4 below. The criminal histories of older prisoners, including their current offences, are more likely to feature sexual offences (see Figure 5 below) than is the case for prisoners generally.

² Justice Sector Projections 2018-2028, Ministry of Justice, accessed 10 October 2019 <https://www.justice.govt.nz/assets/Documents/Publications/Justice-Sector-Prison-Projection-Report-2018.pdf>. Note, this report was updated on 27 May 2020.

³ National population estimates, Statistics New Zealand, accessed 10 October 2019 <https://www.stats.govt.nz/information-releases/national-population-estimates-at-30-june-2019>

4. Similarly, older prisoners tend to be serving longer sentences (see Figure 6 below), and this trend has become more marked over time. This reflects the high numbers who are in prison for sex offences.
5. Older prisoners in New Zealand fall into three categories that are typically confirmed in international research,⁴ including: those serving long sentences, habitual offenders who have returned to prison many times, and individuals who are sentenced late in life.
6. Compared to the general prisoner population, older prisoners may present with a range of health-related issues (such as heart and respiratory disease, cancer, arthritis, diabetes and dementia, as well as histories of substance abuse) which require special management to ensure that their imprisonment is safe and humane. Further, the usual long-term health conditions associated with ageing are frequently more acute within the prisoner population.
7. Additionally, there is variation within this age group, with different levels of mobility, general health, and participation in constructive activities, work and programmes. While some people 65 years and older are in relatively good health, others experience considerable age-related challenges.
8. To date, prisoners 65 years and older have not been managed by Corrections as a distinct group, and information about their specific needs is limited. While the emergence of a growing older prisoner population is not unique to New Zealand and has been studied internationally, as far as we are aware no local research has been conducted on this group. As such, this thematic inspection aims to address this knowledge gap.

Inspection criteria

9. To prepare for our older prisoner thematic inspection, inspectors undertook a review of local and international research, inspection reports from other jurisdictions (including inspections undertaken by Independent Oversight Mechanisms) and other guiding documentation on the needs of older people (including older prisoners) in care. We used this information, along with our *Inspection Standards*,⁵ to inform our inspection criteria and lines of inquiry. The information was also used to ensure our assessments of the treatment and conditions experienced by older prisoners was objective.
10. The purpose of our older prisoner thematic inspection was to:
 - » understand the age-related needs of older prisoners to support their quality of life outcomes, giving priority to those identified as having high and complex health and/or psychosocial needs,
 - » identify the opportunities and challenges associated with managing a growing number of older prisoners, including larger numbers of long serving prisoners,

⁴ United Nations Office on Drugs and Crime: Handbook on Prisoners with Special Needs

⁵ The *Inspections Standards* describe the standards of treatment and conditions we expect a prison to achieve. The Standards derive from the United Nations Standard Minimum Rules for the Treatment of Prisoners ('the Nelson Mandela Rules') and the HM Inspectorate of Prisons Expectations (England's equivalent criteria for assessing the treatment of and the conditions for men in prisons). https://inspectorate.corrections.govt.nz/data/assets/pdf_file/0018/39042/Inspection_Standards.PDF

- » consider the preparation for release and on-going support required to enable appropriate levels of self-care in a custodial setting and future independent or supported living in the community, and
 - » reflect on Corrections' current policy and practice in relation to how well it supports the needs of older prisoners.
11. Like all our prison inspections, our assessment for this thematic inspection was guided by four key principles:
- » **Safety:** Prisoners are held safely.
 - » **Respect:** Prisoners are treated with respect for human dignity.
 - » **Rehabilitation:** Prisoners are able, and expect, to engage in activity that is likely to benefit them.
 - » **Reintegration:** Prisoners are prepared for release into the community and helped to reduce their likelihood of re-offending.⁶

Inspection process

12. Between 25 June and 30 July 2019, inspectors visited Northland Region Corrections Facility, Rolleston Prison, Christchurch Women's Prison, Tongariro Prison, Whanganui Prison, Mt Eden Corrections Facility, Auckland Region Women's Corrections Facility, Auckland South Corrections Facility (operated by Serco), Rimutaka Prison and Arohata Prison. Six inspectors were involved, including the Principal Clinical Inspector.
13. Inspectors invited a selection of eligible prisoners and offenders to participate in formal interviews. Individuals who agreed gave consent for their information to be included in a report that would later be publicly available, and were informed that they could withdraw from the interview at any time.
14. Inspectors formally interviewed 88 prisoners in 10 prisons. We also interviewed seven offenders on parole who had recently been released from prison. Numerous prison staff were informally interviewed across all sites.
15. On 17 December 2019, we provided the Corrections National Commissioner with a draft of this report. The National Commissioner responded on 8 April 2020, and the response has been appended to this report.
16. This report describes what we found during our thematic inspection. We have chosen to report our observations and information gathered according to key themes including: environment, safe and humane treatment, health and wellbeing, purposeful activity, rehabilitation and reintegration, post-release support and staffing.
17. This report includes quotes and case studies based on the prisoners we met and spoke with for this inspection. Personal details have been anonymised and the location of female prisoners removed to protect the privacy of the individuals interviewed. We did not include case studies of female prisoners due to the small numbers involved, to protect their privacy. Quotes from staff have also been anonymised.

⁶ The four principles (or close variations) are used by prison inspectorates in the United Kingdom and Australia, among others. They are consistent with the principles of the Nelson Mandela Rules and the purpose and principles of the Corrections Act 2004.

OLDER PRISONER POPULATION SNAPSHOT AS AT 28 FEBRUARY 2019

Figure 1: Actual and projected growth of prisoners aged 65+

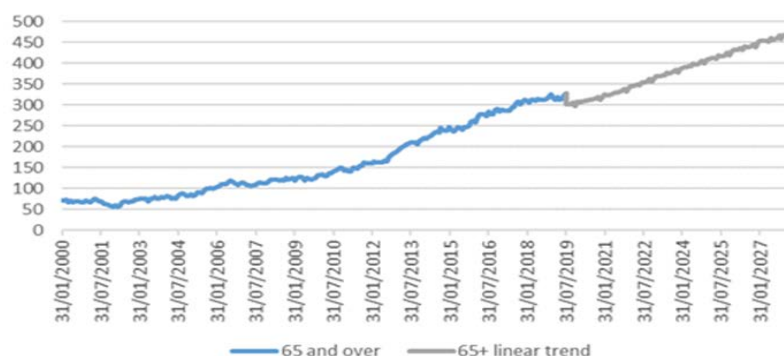


Figure 2: Prisoners by age

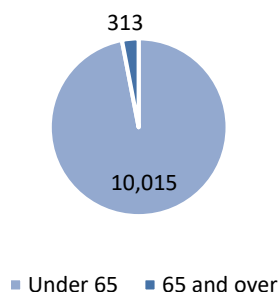


Figure 3: Gender of prisoners

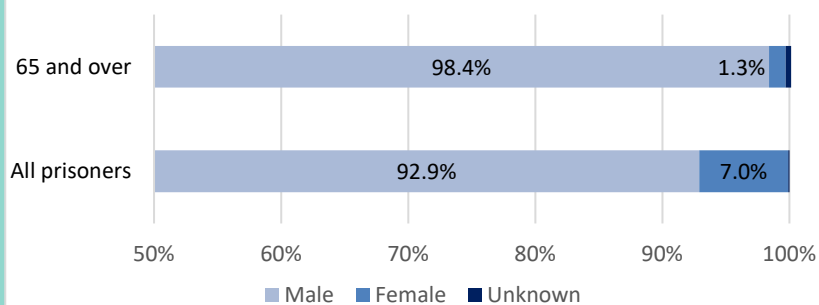


Figure 4: Ethnicity of prisoners

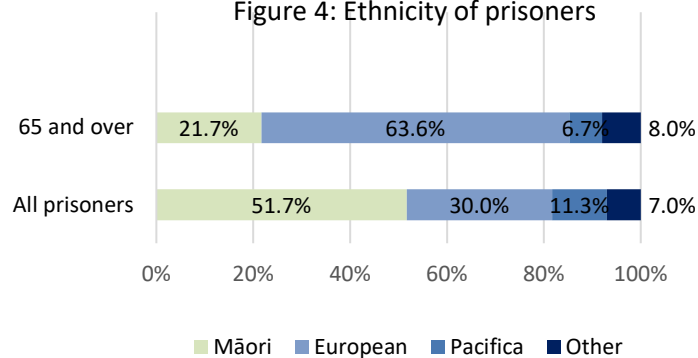


Figure 5: Offence type for prisoners aged 65+

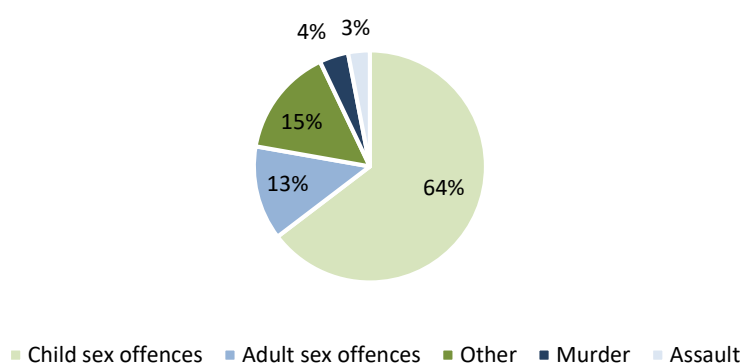


Figure 6: Sentence length for prisoners aged 65+

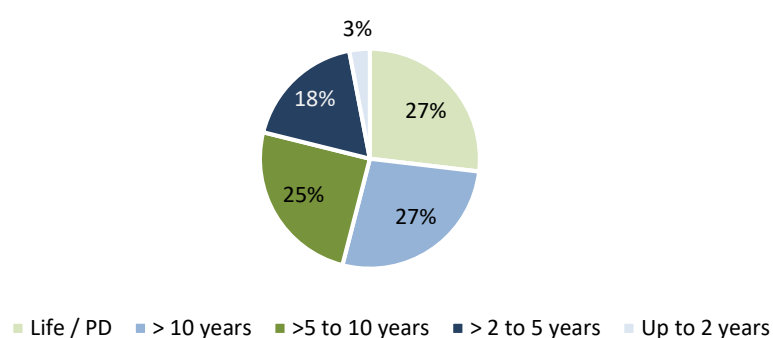


Figure 7: Security classification for prisoners aged 65+

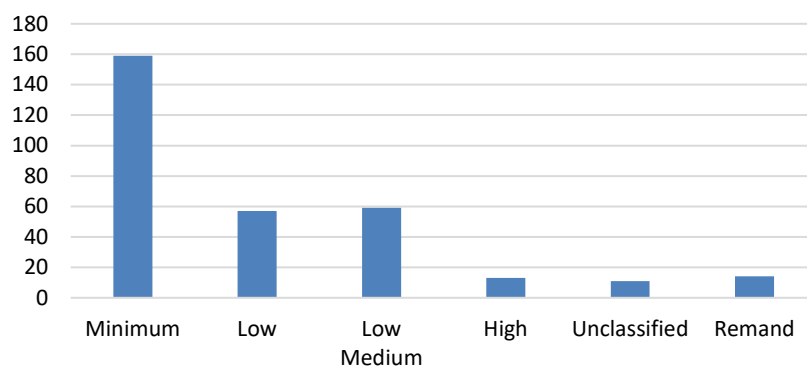


Figure 8: Segregation classification for prisoners aged 65+



Environment

18. It is generally accepted that prisons are designed for younger and able-bodied people.⁷ For older prisoners, whose physical or cognitive abilities are declining, the prison environment can be extremely challenging. Double bunked cells, limited disability cells, limited accommodation adaptations (e.g. grab rails, ramps, emergency alarm buttons and shower seats) and long walking distances to various facilities, including health centres and programme rooms, are some of the issues older prisoners face when in prison. Some researchers have described this experience as a 'double punishment', as older prisoners are naturally exposed to a harsher prison environment than younger prisoners.⁸
19. With the older prisoner population growing at a faster rate than any other prisoner age group, combined with the suitability of current prison facilities, the decision about where to house older prisoners is a matter that needs serious consideration. According to the United Nations Handbook on Prisoners with Special Needs, most older prisoners are best placed in the general prison population, taking into account any special accommodation requirements they may have. Older prisoners who need more one-on-one care should instead be placed in smaller specialised units.⁹

Residential Units

20. Most of the older prisoners we met were largely able-bodied and able to take care of themselves most of the time. Consequently, they were living in a variety of residential units across the prison network, mainly housed alongside other prisoners in either low security units or self-care units.

⁷ Baidawi et al (2011) 'Older Prisoners – A challenge for Australian Corrections.' *Trends & issues in crime and criminal justice*, no. 426, pp 1-8.

⁸ ibid; Trotter C, & Baidawi S (2015) 'Older Prisoners: Challenges for inmates and prison management.' *Australian & New Zealand Journal of Criminology*, Vol. 48(2), pp 200-218.

⁹ Atabay, T (2009) *Handbook on Prisoners with Special Needs*. New York, United States of America, United Nations Publication.

21. Some older prisoners were housed in smaller units that had unofficially become older prisoner units. Rata Unit at Rolleston Prison is a 20-bed annex, with a gate leading into the main 60-bed unit, that is used specifically for prisoners over the age of 60. Similarly, Waikeria Prison has a 20-bed annex, attached to a 60-bed unit (also called Rata), that is used to house older prisoners or those with health needs.

"The best thing about this unit is the freedom. [I] can come into the dining room to get a coffee any time. No bars. Not locked up." [Older prisoner – Rolleston Prison]

22. The prison network's only specialist unit is the High Dependency Unit (HDU) at Rimutaka Prison. This is a 30-bed unit for male prisoners who have ongoing and complex health or disability needs as a result of ageing or other medical conditions, and who require additional assistance with their activities of daily living.

"I didn't know anything about this unit when I first came into prison ... A lot of tension was taken away when I came up here because the facilities and care you receive are so good." [Older prisoner – HDU, Rimutaka Prison]

23. Some older prisoners were housed in high security units alongside other mainstream or remand prisoners. Others were housed in high security units allocated to prisoners placed in voluntary segregation for their personal safety. Prisoners in high security units were on restricted regimes, had limited time out of cell and fewer opportunities to participate in programmes or physical exercise. We reviewed several older prisoners' high security placements. Some of these placements seemed unnecessary or unreasonable based on the information contained in prisoners' files and our face to face interviews. We did not find any evidence that prisons had applied the Remand Management Tool¹⁰ to any older prisoners we interviewed, which could support their placement in low security units.
24. Overall, prisoners we spoke with were satisfied with their accommodation. They considered the design and layout of low security units to be more favourable than high security units because they often have single cells, increased unlock times, open campus style units and communal spaces for socialising. Lower security prisoners tended to help older prisoners feel safer.

Adaptations

25. Most high and low security residential units we visited were not adapted in any way for older prisoners. For instance, they did not have grab rails by the toilets or showers.¹¹ All cells had emergency alarm buttons, although these were located high on the wall and could not be reached from the floor if a prisoner slipped and fell.

¹⁰ The Remand Management Tool is used to ascertain the risks a remand prisoner presents and determine their placement and level of custodial supervision. It can support remand prisoners being managed as low security instead of high security, which is the default.

¹¹ In fact, grab rails are more commonly removed because they can and have been used in the past as ligature points by vulnerable prisoners.

"I recently slipped on the floor inside my cell and could not reach the duress button, located above my bed. I just sat on the floor until I regained the ability to move and climb into my bed." [Older prisoner – Mt Eden Corrections Facility]

26. In the HDU, as well as emergency alarm buttons in all cells, prisoners have personal emergency alarms hung around their necks in the event of a fall.

"I have an emergency button that I hang around my neck. I've used it a few times. They're [staff] very prompt when I press it." [Older prisoner – HDU, Rimutaka Prison]

27. We noted during our visits that most cells housing older prisoners were not disability cells. Some units we visited had only one disability cell that was wheelchair accessible with a shower and toilet appropriately fitted for those with disabilities. However, even these disability cells were not always properly adapted. For example, the position of the in-cell emergency alarm button remained too high. During our visits, some older prisoners were allocated to disability cells. Other units we visited, that did not have a disability cell, had a communal shower that was either wheelchair accessible or had a grab rail beside any steps plus a shower seat and an emergency alarm button in the shower.
28. The HDU at Rimutaka Prison is a good example of what adaptations can be made in a prison. All HDU prisoners had hospital beds, their own showers and raised toilets in their cells. The unit is all single level and wheelchair accessible. Cell doors are each painted in a different colour so prisoners with dementia can more easily identify their cell. The HDU also has its own health clinic facility and its own transportation vans that are wheelchair accessible.
29. Corrections does not currently have any operational policies or procedures that deal specifically with the day to day management of older prisoners, other than those discussed in this report. However, some policies inadvertently assist older prisoners' needs to be met, such as the ability to access additional bedding.
30. During our inspection, several older prisoners across different prisons told us they had difficulty operating the self-service kiosks in their units.¹² Consequently, they were excluded from promptly accessing the services and information they wanted. Older prisoners told us that staff often helped and provided them with information in person instead and/or paper forms, including canteen order forms.

Double bunking

31. Although it was relatively uncommon, we found some older prisoners were allocated to double bunked cells. These cells vary and can have either bunkbeds, with one bed above the other, or two beds side by side.

"I'm double bunked. My cell mate has health problems as well. But where do you put them? If you put them in a single cell, they're all [housed] upstairs so how do they walk up the stairs? So instead we're in double cells." [Older prisoner – Auckland South Corrections Facility]

32. To be placed in a double bunked cell, prison staff conduct a Shared Accommodation Cell Risk Assessment (SACRA) which takes into consideration

¹² Kiosks allow prisoners to submit canteen orders, put in meeting requests and read legislation.

several factors including (but not limited to) an individual's security classification, offender history, age group and alerts. Staff must also consider whether a prisoner could be vulnerable due to his (or her) age, and whether the prisoner has any ongoing physical conditions.

33. During our inspection we found that some older prisoners were double bunked at the request of health staff, who believed the arrangement provided an extra layer of oversight should the older prisoner experience a medical event when they were locked in their cell.
34. Most older prisoners slept on the lower bunk, but some did not. In one unit, we found an older prisoner who was sleeping on his mattress on the floor as he was unable to climb the steps to the top bunk. When we alerted staff to this man's situation during our visit, he was promptly reassigned to another cell.
35. Although these cases are largely isolated instances, staff need to take more care when considering the practicalities of housing two older prisoners together in one cell with bunkbeds. Further, in all instances involving bunkbeds, staff need to consider formally assigning prisoners to either the top or lower bunk depending on their needs and physical capability.

Access to essential support facilities

36. Overall, we found that older prisoners could gain reasonable access to essential facilities such as the health unit or programme delivery rooms. Most older prisoners we spoke with were physically capable of walking short distances and we were told that staff generally adapted their walking pace to reflect a prisoner's capability.
37. The case study below describes the experience of one older prisoner we spoke with who was residing in a standard cell that did not have suitable support facilities. He had been placed in that unit because it was closer to the health centre than other units, and staff believed his care needs could be better monitored.

Case study A

Mr A suffers from various illnesses and uses specialist mobility equipment to move around.

He is accommodated in a standard single cell on the ground floor of a unit. A nurse visits Mr A twice a day to issue medication and attend to his other health issues as required.

Mr A tells us: *"there could be a lot more done for people like me – those with disabilities. Having a frame over the top of the bed to help pull myself up like what they have in the hospital would be very helpful".*

Although Mr A speaks favourably about staff, who respond to him when he needs assistance in the night, he says: *"I worry about falling here. The emergency button is located up quite high. If I fall how will I reach it? If a button could be at the floor level then you can press the button and call for help. If I fall, I have to use my walking stick to tap on the button to get some help."*

Staff comment to us that even if they moved him to another unit, the cell design would be the same. *"The emergency button will still be up high and there will still be obstacles in the cell that could be a risk to him if he falls – for example, the metal privacy screen, toilet etc."*

Mr A says he manages OK with the shower with staff help. *"[At my last prison] they had a shower with a seat attached to the wall that could go up and down. That was much better. At least one shower in every unit should have one."*

Staff say unit cleaners have been helping him clean his cell and change his bedding. However, the unit cleaners say they don't like doing this and believe it is a health and safety issue for staff and other prisoners.

"He should really be in another unit which has a disability cell. We have tried to get him into another unit ... in saying that, he probably gets more care here ... and we're around more to keep observation on him." [Staff member]

Health staff tell us they are doing all they can to get Mr A into the HDU, but he has been declined on the basis that his health needs are not considered severe enough and there are also no beds available.

38. In the above case, staff were well intentioned, however they were limited by the support facilities available at the prison. Consequently, Mr A's complex care-related needs were not met. Although custodial and health staff were doing their best to manage Mr A's needs, his placement was impacting on his health and the health and wellbeing of other prisoners in the unit.
39. The case study of Mr B, below, highlights how appropriate support facilities promote effective healthcare and wellbeing for older prisoners.

Case study B

Mr B is an older prisoner with limited mobility who requires personal care and mobility assistance.

When Mr B first arrived in prison directly from court, staff were unaware of all his medical needs.

Mr B was allocated to a unit that catered for prisoners with ongoing medical needs. Health staff informed custodial officers of his medical needs and advised that he was to be checked hourly as he could not reach or activate the cell's emergency alarm button.

Of his time spent in the unit, Mr B said: *"Nothing against [this prison], but I was initially in an ordinary cell with a fixed bed and the nurses couldn't get around the other side of the bed to help me. It was difficult but they made the best of a difficult situation."*

Within a few days of his original placement, health staff arranged for Mr B to be transferred to the HDU at Rimutaka Prison.

All cells in the HDU are larger, to accommodate disabilities, and have hospital beds. The unit has a hoist so staff are able to manoeuvre people more easily and safely.

Mr B tells us: *"The healthcare here is excellent. In the morning they come in, they hoist me out of bed and help me shower and dress – then I'm ready for the day".*

Areas for consideration

1. Corrections should consider whether unit and cell placement decisions for older prisoners are informed and supported by health staff, and the rationale appropriately recorded.
2. Corrections should consider whether on entering prison, older prisoners, where possible, are placed in lower security units where their age-related needs can be met.
3. Corrections should consider whether each prison should, where possible, have a low security unit where older prisoners can be accommodated together when requested, with their health and wellbeing needs met.
4. Corrections should consider making accommodation adaptations to meet the needs of older prisoners, including more disability cells with appropriate showers and raised toilets, removable beds, grab rails, shower seats and lowered emergency alarm buttons.
5. Corrections should consider whether all prisons have emergency alarms available that can be worn around an older prisoner's neck when required.
6. Corrections should consider whether older prisoners can easily access areas such as health facilities.

Safe & humane treatment

Use of restraints

40. The United Nations Standard Minimum Rules for the Treatment of Prisoners (SMR) states: *"discipline and order shall be maintained with no more restriction than is necessary to ensure safe custody, the secure operation of the prison and a well ordered community life."*¹³
41. The Office of the Inspectorate's *Inspection Standards* reflects this rule with Standard 60, which states: *"Prisoners are held in a safe environment where security is proportionate to risk and not unnecessarily restrictive"*.¹⁴
42. Our standard aligns with those from other oversight mechanisms which have considered how appropriate it is for prisons to restrain the movement of older prisoners and those with acute health issues. In 2017, the Prisons and Probation Ombudsman in England and Wales reported that a prisoner's individual risk assessment should be based on the actual risk the prisoner poses at the time and must take into full account the prisoner's health.¹⁵
43. During our thematic inspection, several older prisoners mentioned being restrained while being transported to hospital and then during their hospital appointment. Prisoners told us they found the practice degrading and unreasonable. Many of the prisoners we spoke with had significant health issues and were physically incapable of running away.

¹³ SMR 36

¹⁴ Office of the Inspectorate. (2019). *Inspection Standards – Criteria for assessing the treatment of and conditions for prisoners*. Retrieved December, 12, 2019 from https://inspectorate.corrections.govt.nz/_data/assets/pdf_file/0018/39042/Inspection_Standards.PDF

¹⁵ Prisons & Probation Ombudsman. (2017). *Learning from PPO investigations. Older Prisoners*. Retrieved October, 31, 2019 from https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhjkmgw/uploads/2017/06/6-3460_PPO_Older-Prisoners_WEB.pdf

"Even when you get a mammogram you have the handcuffs on. That's a bit hard you know. Do they expect me to run away?" [Older female prisoner]

"I was escorted [to the hospital] by an officer, sometimes using the short handcuffs. When going to the bathroom I was cuffed up on the long chain handcuffs. I was also chained to my bed. I felt disgusted. I wouldn't chain my dog up like that." [Older prisoner – Rolleston Prison]

44. Some prisoners also reported that hospital health staff had to request the restraints be removed so that they could complete their medical examination.

"I was handcuffed in the hospital ... The nurse had to tell the staff member to take the handcuff off so I could go in the MRI." [Older prisoner – Rolleston Prison]

45. The case of Mr C, below, highlights how the prisoner's perceived risk, as opposed to actual risk, can lead to the unreasonable use of restraints.

Case study C

Mr C is a minimum-security older prisoner serving a long sentence. He has health conditions and requires constant mobility support. Due to his ongoing health conditions, Mr C attends hospital regularly.

A health alert stipulates Mr C is *"unable to travel in a caged van or wear waist restraints"*.

Mr C tells us he was handcuffed for a medical escort to the hospital up until he received a scan. At all other times, he was wearing *"short cuffs"* or *"long chain cuffs"* which were attached to a staff member.

A risk assessment for Mr C states that he was to *"remain double cuffed to an Escort Officer at all times during his appointment unless required by treatment to be removed. In such an event, the short cuff is to be replaced with a long cuff ... When using toilet facilities, the prisoner is to remain hand cuffed to the officer. The officer must remain in the same room as the prisoner when using toilet facilities."*

If this is not possible, the door to the toilet facilities is to be ajar but not locked. The long hand cuff chain goes around the door and remains attached to both the prisoner and officer."

46. Corrections' policy stipulates that waist restraints in conjunction with handcuffs may be used for any escort (or part of an escort) if the risk assessment deems that degree of restraint necessary. However, prison directors can use their discretion if a prisoner is assessed by a health practitioner as unsuitable.
47. In Mr C's case, the level of restraint used appeared to be disproportionate to his actual risk at the time of the escort. The decision to use this level of restraint appeared to place too much weight on Mr C's offending history rather than his actual risk.
48. The use of restraints in Mr C's case was also inconsistent with practice at other prisons. Older prisoners at Tongariro Prison told us that because they were minimum security prisoners, regardless of their convictions, they were not restrained during their medical appointments. These older prisoners spoke favourably about this practice:

"I had an operation in hospital. I went up in the van and sat in the front. No handcuffs. I had a hospital escort but wasn't cuffed. They treated me well." [Older prisoner – Tongariro Prison]

49. Similarly, the HDU has a dispensation for 24 prisoners exempting them from being handcuffed during transport and while in hospital.

"We have 24 prisoners (of 30) that due to their medical conditions are exempt from waist restraints. This has been signed off by the PD. Handcuffs are brought with the staff just in case they play up as the ones with dementia can get violent." [Staff member - HDU, Rimutaka Prison]

Travel

50. Our *Inspection Standards*¹⁶ state that prisoners should travel in safe and decent conditions. Prisoners should be treated with respect, and attention should be paid to their individual needs.
51. Many older prisoners we spoke with talked about their distress when travelling long distances between prisons in the prisoner escort vehicles. Prisoners said they were placed in steel cages, had no or limited access to toileting facilities and drinking water, had little opportunity for comfort breaks, were required to travel long distances and often did not understand why they were being transferred. Many also described the physical condition of the drive as being particularly hard on their bodies. Prisoner escort vehicles are not fitted with seat belts.

"I had to travel in the van and it was terrible. All stainless steel, and in a cage. And they bounce over the bumps, it was so painful." [Older prisoner – Rolleston Prison]

"I was transported by the truck – most disgusting transport in the world – you're stuck in about a metre and a half square, you're handcuffed, you can't hold onto anything, you're travelling at 100km/ph and it's the noisiest environment you have ever heard ... thank god I have special dispensation now and don't need to be cuffed." [Older prisoner – Whanganui Prison]

"When I was brought up here in the wagon, I was unrestrained in the back but I was handcuffed. At one point, they had to make a sudden stop and I was thrown off the seat. That triggered my incontinence and I hated sitting in it so much so now I don't like travelling." [Older prisoner – HDU, Rimutaka Prison]

52. We found the way shorter escort journeys or transfers were undertaken varied across prisons. Some prisoners told us about their negative experiences in escort vans when they had to take shorter journeys (to court or hospital). Some prisoners were exempt from travelling in the escort van due to their health issues and were approved to travel by car instead. As mentioned earlier, prisoners in the HDU travel in a dedicated transport van, equipped with a wheelchair lift and seatbelts.

"I can no longer get in the van because of the steps. Now they take me in a car. I'm not handcuffed in the car or when I'm in the hospital." [Older prisoner – Whanganui Prison]

¹⁶ Standard 10.

"I went [to the hospital] in the van that they have specifically for this unit. That was a better form of transport. I was not handcuffed." [Older prisoner – HDU, Rimutaka Prison]

53. Corrections' External Movements policy¹⁷ states that all escorts in excess of four hours travelling time require a written journey plan which must include a rest break. During the rest break prisoners are entitled to drinking water and the use of a toilet. Food supplied should be aligned to normal mealtimes (if applicable) and noted in the journey plan. The policy for rest breaks also specifies that waist restraints should be removed for a minimum of thirty minutes before re-application. The provision of appropriate rest breaks may be more significant for older prisoners due to their age-related health needs or reduced mobility.
54. The case of Mr D, below, describes an inter-prison transfer to Rimutaka Prison.

Case study D

Mr D is an older prisoner who receives medication twice a day for his long-term health conditions.

Mr D was transported between prisons, for the purpose of managing the prison population, on a prisoner escort vehicle from Mt Eden Corrections Facility (MECF) to Rimutaka Prison.

After leaving MECF, Mr D travelled to Auckland Prison and then to Spring Hill Corrections Facility (SHCF) where he stayed the night. The following day, Mr D left SHCF at about 7am. The prison escort vehicle he was travelling in stopped at Tongariro Prison (approximately three and a half hours drive away) to allow the prisoners to have fresh air and sandwiches. The vehicle then continued to Manawatu Prison (approximately three hours drive away), where they stayed for about one and a half hours. During this time, Mr D was not allowed to leave the vehicle. The vehicle then continued to Rimutaka Prison (approximately two hours drive away) where Mr D was escorted off the vehicle at about 9pm.

Mr D was provided with water for the journey but found it difficult to drink in the vehicle because he was wearing waist restraints. He told us he was unable to go to the toilet when he needed to. Mr D said a few prisoners in the vehicle vomited due to motion sickness.

Adding to the stress of the journey, Mr D said he did not know why he was transferred. His family and support people no longer visit Mr D now that he is in Wellington.

55. In the case of Mr D, it appeared that staff did not always adhere to the prisoner transport policy, nor did they appear to modify their approach based on the age-related needs of prisoners. Other prisoners we interviewed also mentioned that they were not able to leave the prisoner escort vehicle during a rest break. This requirement was confirmed by staff who told us that prisoners are sometimes not able to leave the vehicle due to the mix of prisoner categories on the escort, the availability of secure facilities to hold prisoners during the rest break, and time pressures. We were told that prisoners can request a disposable urinal (a 'Travel

¹⁷ Prisoner Operations Manual M0.4.

John') prior to leaving prison or at a rest break. However, staff told us they do not brief prisoners prior to departure so it is likely most prisoners would not know a 'Travel John' was available.

Staying safe

56. Older prisoners, like other prisoners, should be held in an environment where they not only feel safe, but their mental health and wellbeing is protected. International literature suggests that as a consequence of poor health and varying degrees of frailty, older prisoners face a greater risk of violence and intimidation than younger prisoners. Further, due to the strong focus on prisoner control and prison safety by prison management, older prisoners are more likely to avoid drawing attention to themselves and subsequently can be forgotten by staff in a prison's high-pressure environment.¹⁸
57. Most of the older prisoners in lower security units we spoke with during our inspection were placed on voluntary segregation and said they felt safe in their units. However, this was generally not the case when we spoke with older prisoners housed in high security units. Some high security prisoners told us that their level of mobility, rather than their age, contributed to how safe they felt. For example, some of those with limited mobility reported that they were cautious about getting knocked over by younger prisoners in communal areas and would try to avoid socialising in these areas. Others shared that the stigma attached to their offending could lead to bullying and violence from other prisoners.

"Younger prisoners always say unkind stuff to child sex offenders. Younger prisoners used to group outside my cell and call me names. When I was in [another unit] prisoners poured urine along the window ledge to intimidate me."
[Older prisoner – Northland Region Corrections Facility]

58. For those prisoners who felt safe in low security units, many told us it was because other prisoners in the unit looked out for them or there was a level of camaraderie. These older prisoners told us they did not mind being mixed with other age groups. For the prisoners living in Rolleston Prison's Rata Unit and in the HDU, many took comfort from knowing there was a higher level of care available to them when they needed it.

"Best thing in this unit is the inmates. It doesn't matter what colour they are or age, they all work together to help each other. What's most difficult is there are a lot of bad people in here that are quite good – they're not bad people they have just done bad things." [Older prisoner – Rolleston Prison]

"There are no gangs here – the only gang in our unit is the geriatric gang haha."
[Older prisoner – Rolleston Prison]

"Staff are fair and there is no bullying or favourites. There are no issues with gangs; in fact, staff may be pissed off with our laughter." [Older prisoner – Tongariro Prison]

¹⁸ Turner et al (2018). Ageing and dying in the contemporary neoliberal prison system: Exploring the 'double burden' for older prisoners. *Social Science & Medicine*. No. 212, pp 161-167.

59. Records showed staff use of force against older prisoners was low. However, with more prisoners exhibiting challenging behaviours due to their physical and mental health decline, Corrections should consider providing staff with the knowledge and techniques needed to manage age-related challenging behaviours. It was positive to see staff in the HDU already using such techniques.

"We can't physically manhandle prisoners in here – we have to try various ploys to get compliance ... We had one prisoner here who had dementia. He punched a guy, but we obviously can't put him in the management unit. It was his mental problem that caused this not behavioural.

"You also don't argue with the prisoners – you have to just chat with them about their issues. We had one prisoner who was yelling at me and said I interrupted a conversation with his lawyer, which was happening in his head. So, I just said "oh sorry I'll wait". Once he calmed down then I could talk to him again. You have to realise this to work here." [Staff member – HDU, Rimutaka Prison]

Areas for consideration

7. Corrections should consider whether older prisoners should have restraints applied only when no lesser form of control will be effective, it is the least intrusive method, and it is applied for the shortest time necessary.
8. Corrections should consider whether the use of restraints on older prisoners is consistent across prisons. Health staff should have input into custodial plans to use restraints on older prisoners, and exemptions should be applied where appropriate.
9. Corrections should consider whether older prisoners are exempt from inter-prison transfers, where possible, where the sole purpose is for managing the prison population.
10. Corrections should consider whether custodial and health staff work together to assess older prisoners' age-related needs when journeys are planned, including the type of transport vehicle suitable for escort and transfer.

Health and Wellbeing

60. It is well documented that older prisoners often exhibit complex health-related needs at an earlier age than people living in the community. Researchers typically state that this early onset is due to unhealthy lifestyle choices, the natural ageing process or a history of substance abuse.¹⁹
61. It is also now commonplace for prisons around the world to find themselves managing higher volumes of older prisoners than ever before with complex health related needs such as cancer, diabetes, hypertension, heart and lung issues, dementia, chronic loss of hearing or eyesight, as well as poor mental health and general wellbeing. This increasing responsibility is putting prison administrations under significant financial and employment (both health and custodial staff) related pressure.
62. The United Nations Handbook on Prisoners with Special Needs identifies three key recommendations for healthcare of older prisoners:
 - i. to ensure that the medical, nutritional, and psychological healthcare needs of older prisoners are met, with the engagement of a multidisciplinary team of specialist staff,
 - ii. to establish close cooperation with community health services to ensure that specialist care is provided by outside medical services, as necessary, and that prisoners whose needs cannot be met in prison are transferred to civilian hospitals,
 - iii. to provide special programmes addressing mental disabilities, such as depression and fear of dying, as well as individual counselling, as necessary.
63. Corrections' data showed many older prisoners were accessing treatment for cardiac conditions such as high blood pressure, high cholesterol, heart disease

¹⁹ Atabay, T (2009) *Handbook on Prisoners with Special Needs*. New York, United States of America, United Nations Publication; Linder, J. (2015). Health Issues and End-of-Life Care. In J. Kerbs & J. Jolley (Eds.), *Senior Citizens Behind Bars: Challenges for the Criminal Justice System*. (pp. 177-200), Boulder, CO. USA: Lynne Rienner Publishers.

and strokes. Other less common health conditions being treated included respiratory, gastric related conditions, diabetes, mental health and pain.

Health needs

64. Older prisoners we spoke with during our inspection were typically positive about the healthcare they received in prison. Many had received vaccinations and had regular appointments with nurses, doctors and other health providers. Most older prisoners told us they were generally healthy and did not have too many health-related needs that could not be dealt with by the nurses or doctors.

"Healthcare here is better than outside." [Older prisoner – Rolleston Prison]

"The nurses are extremely good. They follow up on you, they check in on you all the time, the more serious ones they see more often." [Older prisoner – HDU, Rimutaka Prison]

65. Some older prisoners we spoke with across the prison network were less satisfied with their access to healthcare and dentistry. Some who needed medical equipment said they had difficulty getting their equipment serviced. Others talked about long waiting times to get glasses or hearing aids. Some older prisoners also reported they struggled financially when having to pay for their hearing aids, especially when they were unable to work and earn money in prison.

"Prison is not made for people who are very sick ... I'm looking at prison as being my death sentence. Sometimes I think what's the use of living, because I know if something happens no one will help." [Older prisoner – Auckland South Corrections Facility]

"It's tricky to decide who can pay and who cannot pay for glasses. ... Hearing aids are also tricky as they cost in the thousands and they have to pay for them as well. The Hearing Aid Association are good as they give us their old ones at a cheaper price..." [Staff member - Whanganui Prison]

66. Some custodial staff raised concerns with us about how they would manage if an older prisoner's health and capability reduced over time and staff had to manage these additional needs in a mainstream unit alongside general population prisoners. Their concerns were typically driven by feelings of inadequacy, including that they had insufficient knowledge, facilities²⁰ or staff numbers to manage older prisoners well. Staff also shared their concerns about how they would manage if a prisoner needed a prompt specialist intervention or care outside the health team's hours of service.

"[We] don't have a strategy to manage the older men, although it's not too bad at the moment. While they are self-managing, we don't have anything different for them. They all keep themselves occupied. The last two we had they ended up in the HDU in Rimutaka Prison. But it's hard. It took about six months to get one prisoner in there ... It depends on their needs as to how we manage them. If they get really bad, they go over to medical. I don't know what we would do if we had multiple prisoners with high needs." [Staff member - Whanganui Prison]

²⁰ Staff told us they often had to 'make do'.

67. Similarly, across the prison network there is no HDU equivalent for older female prisoners with serious medical needs. While currently there is only a small number of older female prisoners, population growth should be closely monitored for women in the 65 and over age group and an appropriate accommodation response developed if necessary.

"I have no idea what we would do if we had a high need [female] older person. We don't have an HDU at the prison and there is not one in the prison estate for women." [Staff member – Christchurch Women's Prison]

68. Staff we spoke with were aware that the HDU at Rimutaka Prison had limited capacity, accommodating just 30 prisoners with complex health needs. We heard from staff it can be hard to get prisoners into the HDU, either because prisoners were assessed as not serious enough to meet the criteria or there were no available beds. In December 2019, five people were waitlisted for the HDU, with the longest having waited ten months to date. It is evident that the needs of older people have increased with demand pressures for this facility.

"It's all about priority [who gets a bed in the HDU], we had two here that had to leave as there were people with greater health needs that needed the room more." [Staff member – HDU, Rimutaka Prison]

Health screening and management

69. As part of the generic Reception Health Screen Assessment, health staff screen each prisoner for disabilities on arrival. The Initial Health Assessment provides a more comprehensive health assessment including questions on mobility, disability and care support. The disability and mobility screens are not mandatory questions and, therefore, age related disability needs may be missed.
70. Corrections does not accurately record the health and wellbeing needs of older prisoners as a distinct cohort, so it is difficult to determine the full extent and prevalence of their age and health-related needs.²¹ Targeted research to gather detailed information about the existing outstanding needs of the older prisoner population would support the future development of effective older prisoner policies and procedures.
71. Older prisoners access healthcare in the same way as other prisoners, which is predominantly to complete a health request form or speak to staff. Custodial and health staff may also identify older prisoners who appear to require additional support and oversight, scheduling regular check-ups for their health and welfare.
72. In 2015, Corrections' Health Services developed an Older Persons Health Strategy aimed at providing holistic care to older prisoners. The strategy provided a three-tiered model of care approach and had an action plan with timeframes and measures for success. We could not find any evidence within health circulars, Frontline (communication channel) or the staff intranet that the Strategy was made widely available to staff at that time.

²¹ The functionality exists in the electronic patient management system to record health needs of older prisoners, however data is not consistently or accurately entered (eg. classifications, screening, medications).

73. During our inspection we found that nursing staff and health centre managers had little knowledge of the Strategy. Further, we found there had been no formal regional or national assessment of whether the measures had been achieved.
74. In April 2019, the Healthcare Pathway policy was updated. This included a healthcare for older patients' section with two new standards and described the minimum assessment components of a 65 years and older annual health check. During our inspection we found that not all nurses have had education or experience in completing some of the assessments included in the annual health check, such as macular degeneration screening for vision, falls assessments or cognitive screening.
75. Nurses we spoke with across several prisons told us they had varying levels of confidence in completing these assessments. As a result, we found that the minimum assessment components were often not being completed.
76. In addition, the annual health check is only required for prisoners who are not already regularly engaged with health services. A review of older prisoners' health data showed most had regular contact with health services and, therefore, annual health checks were not completed.
77. While we found many nurses had experience working in the aged care sector, most nurses told us they had received no specific training from Corrections for managing older prisoner health needs.
78. An effective Older Persons Health Strategy should align with the Ministry of Health's Healthy Ageing Strategy and aim to provide guidance and direction to improve the health and wellbeing of older prisoners where they are experiencing specific and age-related challenges.

Medication and memory loss

79. Corrections' health data shows most older prisoners are prescribed regular medication for their long-term health conditions.
80. Many older prisoners with regular medications told us they were able to hold and self-administer a weekly supply. Many preferred this as they could choose the time which best suited them to take their medication, such as with a meal or before bed.
81. Some prisoners told us they had difficulties opening the foil seal on the medication blister packs and that, when opening, tablets might fall on the floor. Health staff issuing blister packs need to consider the older prisoner's ability to open them safely, as well as their ability to read the small print on the packs.
82. Nurses should also take into consideration an older prisoner's cognition, including memory loss, when issuing medication. One older prisoner we spoke with, who self-administers insulin injections, told us he sometimes forgot whether he had taken his medication. He said there had been occasions where he had not taken a prescribed dose, or he had inadvertently taken two doses.
83. People with dementia can often present with challenging behaviours such as wandering, agitation, disinhibition and, occasionally, sexualised behaviour. Dementia can affect a person's ability to remember, think clearly and communicate with others. It can also cause mood swings and change a person's behaviour and personality.
84. Within the HDU, where several older prisoners with dementia reside, there was no evidence that they were being restrained in any manner. Health and custody staff were observed to have a good understanding of these people's needs and

risks, and staff used distraction and communication to redirect or settle challenging behaviours. We observed that staff would not restrict prisoners' ability to move about the unit but would watch and keep close to them to ensure they would not fall or wander into another person's bedroom. HDU staff we spoke with expressed concern about the number of older prisoners with dementia, and how their unit would cope with a growing older population.

"We need a standalone unit for dementia patients. They need highly qualified staff running it. These guys can flip a switch easily. We have one prisoner with dementia - every evening he packs his bags and waits at the front door expecting his family to come pick him up. Every evening we have to tell him that his family isn't coming. It can be quite hard on the prisoner and on staff." [Staff member – HDU, Rimutaka Prison]

Needs Assessment Service Coordination

85. Corrections is required by Section 75 of the Corrections Act 2004 to provide a primary healthcare service that is "reasonably necessary" and "reasonably equivalent to the standard of healthcare available to the public".
86. Prisoners in the HDU typically receive 'rest home level care' if they require it. Similarly, if a prisoner is housed in another prison and requires personal care support, the prison can arrange for an external provider to assist with this.
87. To receive additional help from an external provider, health staff must first identify prisoners who are unable to independently take care of their daily activities. Those individuals must then be referred to a Needs Assessment Service Coordination (NASC) agency so an individualised care plan can be developed.
88. A care plan may include the provision of items such as mobility aids, raised toilet seats, shower chairs, or grab rails in cells and/or the bathroom area. A care plan can also recommend that a person receives assistance with showering and dressing or they may require greater supervision and support, such as what is typically available in a rest home.
89. During our inspection, we found varying levels of experience with health teams engaging their local NASC agency. Responses from NASC agencies varied, depending on demand for the service.²²
90. Prisoners who have very high and complex needs can also be assessed as requiring continuing care. This is the highest level of care available in community-based hospitals and can include end of life palliative care.
91. Continuing care providers must have a registered nurse available to patients 24 hours a day. People assessed as requiring continuing care require support in many aspects of health and wellbeing. This includes personal care, medication, pain management, assessment and intervention response to illness or injury, and emotional support.
92. We found some prisoners assessed as requiring continuing care were housed in the HDU. Corrections does not have a registered nurse rostered to work and available in the HDU for 24 hours a day. The Ministry of Health's service level agreements with District Health Boards and age-related residential care providers have this requirement.

²² Two nurses in Corrections' Central Region have been given training opportunities with the local disability support services to enable them to carry out needs assessments in prisons.

93. As at 19 September 2019, health centre managers told us there were:
- » five older prisoners who were assessed as requiring continuing care
 - » five older prisoners who had not yet been formally assessed for their long-term care needs, but health centre managers believed they required continuing care
 - » 15 older prisoners in the HDU who may need continuing care soon
 - » two older prisoners housed outside the HDU who were assessed as requiring rest home level care.

Personal hygiene and care

94. During our inspection we found that some older prisoners were trying to manage their own personal hygiene needs without receiving the appropriate assessments that could equip them with necessary disability aids such as crutches, walking frames, grab rails and raised shower stools and toilet seats. For example, some prisoners we spoke with were making do with a basic plastic chair placed in the shower or were preventing slips by placing towels on the floor.

"The floor gets slippery from the shower and you don't get cleaning equipment to clean off the mould. We sometimes lay down a towel, so we don't slip." [Older prisoner – Auckland South Corrections Facility]

95. Different approaches were also being used across prisons to support older people who required assistance with their daily hygiene and care needs. Some older prisoners were asking a 'mate' to help them, and some prisons informally arranged for other prisoners to help older prisoners clean their cells. Some prisons employ healthcare assistants and others have external healthcare providers visiting.
96. Prisoners in the HDU have a treatment plan that includes the prisoner's specific hygiene needs and the tailored interventions that reflect the individual's personal preference. HDU staff told us that sometimes older prisoners decline hygiene care such as showering or shaving, which is their choice.
97. It is important that nursing staff understand how well an older prisoner is managing their own activities of daily living such as personal hygiene, dressing and mobility. Staff should regularly talk to older prisoners and assess their capability and refer them for a NASC assessment when required.

Nutrition

98. Good nutrition is an essential component for good health and, as people age, their nutritional requirements change.
99. Many of the health conditions common to older people can be the result of poor nutrition throughout their life. These factors are then compounded by changes that naturally occur with the ageing process. Strokes, heart disease, diabetes, osteoporosis and cancer are among the most common diseases affecting older persons and all these diseases are diet-affected.²³
100. At Corrections' prisons, meals are prepared in line with approved national menus, which provide each prisoner with a diet that meets Ministry of Health Food and

²³ World Health Organisation. *Nutrition for older persons*. Retrieved November 11, 2019 from <https://www.who.int/nutrition/topics/ageing/en/index1.html>.

Nutrition Guidelines. Older prisoners residing in self-care units can cook their own meals. Auckland South Corrections Facility has its own menu and prisoners can select their meal type from their cells.

"The meals seem pretty good. I'm able to supplement my dinners with veggies we grow in the veggie garden." [Older prisoner – Whanganui Prison]

"The food is good, I can't complain." [Older prisoner – Rimutaka Prison]

"I have been in other prisons and had the Corrections diet. It is much easier to stay healthy here ... where you get enough exercise [and] you can control your food intake." [Older prisoner – Auckland South Corrections Facility]

101. Health centre managers can recommend a special diet (in addition to what is available on the national menu), based on health and nutritional needs. At one prison we found the health centre manager had arranged for some older prisoners to receive protein snack boxes, in addition to their usual meals, to meet their nutritional needs.
102. During our inspection, staff were concerned about the quality of food available to older people. They told us that more soft food is needed so prisoners with few or no teeth could manage. Meals in general needed to be smaller and more appetising. Similarly, staff were concerned about the amount of bread prisoners received, particularly given the majority were unable to be physically active. We acknowledge the reduction in bread allocation since the new national menu was introduced in October 2019.
103. Due to swallowing difficulties, some prisoners in the HDU require pureed meals or thickened fluids, which are prepared in the general prison kitchen. The Principal Instructor for catering advised that great care is taken when preparing these special meals, to ensure there are no lumps. There is a good communication between the kitchen and health staff so concerns about the quality of meals can be rectified quickly.

Mental Health

104. Mental health issues in the older prisoner population are often under-reported. International research suggests this may be because individuals develop mental health issues while they are in prison. Further, older prisoners may under-report how they are feeling due to fear it could affect their likelihood of gaining parole or because they think staff and other prisoners will judge them. There is also the suggestion that because older prisoners are typically less disruptive than younger prisoners, prison managers consider them a lower priority and therefore do not give reasonable consideration to their mental health needs.²⁴
105. Despite the under-reporting, international research suggests that more than half of ageing prisoners experience some sort of mental health issue while in prison, and many are at risk of developing mental and neurological disorders. The most common include depression, post-traumatic stress disorder, anxiety, feelings and

²⁴ Baidawi et al (2011) 'Older Prisoners – A challenge for Australian Corrections.' Trends & issues in crime and criminal justice, no. 426, pp 1-8.

actual experiences of social isolation, and worry about their likelihood of dying in prison.²⁵

106. Older people in prison consistently have more incidence of mental health disorders than older people in the community.²⁶ Adults in their 60s generally have the lowest rates of suicide across all age-groups in the community, however, suicide rates for older men begin to rise from 70 years.²⁷ In the New Zealand prison system, only two men over the age of 65 years have died by suicide in the last 15 years.²⁸
107. As part of health services, nurses attend mandatory primary mental health training which covers mental health in older people.
108. During our inspection, older prisoners gave us a mixed response about their feelings of depression, loneliness and anxiety. Due to the nature of their offending, many prisoners we spoke with no longer had contact with their families or whānau. For some, this created feelings of loneliness and depression. Others appeared as stoic and told us they did not like to bother health staff with how they were feeling. Being able to talk to fellow prisoners and staff helped some older prisoners avoid feeling lonely or depressed.

"I do feel lonely in prison – I hate being away from my wife. I know she gets a bit distressed about the separation too." [Older prisoner – Rimutaka Prison]

"I feel scared and want to go home. At my age I feel that I am being forgotten." [Older prisoner – Tongariro Prison]

"It's all getting quite on top of me in here, feelings of depression and anxiety. I don't speak to a psychologist at all. They just chuck me in the cell and that's it. We're locked up 20 hours of the day. I have nobody in this unit that I talk to and relate to." [Older prisoner – Whanganui Prison]

109. During our interviews at one prison, an older prisoner told us he and several others in the unit had feelings of depression but did not want to speak up for fear they would be moved to an Intervention and Support Unit.²⁹ The HDU was also an unpopular option among some older prisoners we spoke with because it was unfamiliar and they understood it was a particularly restrictive environment.
110. As part of the older prisoner annual health assessments, health staff are required to review a prisoner's general mental health and complete cognitive screening. Similarly, custodial staff are more likely to identify signs of mental distress if they are familiar with the signs, through their day to day observations and interactions with prisoners.
111. During our inspection, we found that annual health assessments focussed primarily on older prisoners' physical health with limited or no mental health or cognition screening, as required.

²⁵ Ibid.

²⁶ Indig, D, Gear, C, and Wilhelm, K, Comorbid substance use disorders and mental health disorders among New Zealand prisoners. Wellington: Department of Corrections; 2016.

²⁷ Te Pou. Older Adults in New Zealand, Sept 2011.

²⁸ The men were aged 69 (died in 2005) and 70 (died 2011).

²⁹ Intervention and Support Unit aims to provide a therapeutic space for prisoners vulnerable to suicide and self-harm.

112. As mentioned previously, most older prisoners have regular contact with health services, so they do not typically receive annual screening for many age-related health issues. Their encounters with health services relate solely to the management of long-term health conditions and acute presentations.
113. Although many prisoners told us they did not know what mental health services were available to support them, some older prisoners were grateful for the support they had received from mental health professionals.

"I've dealt with mental health ladies here on two occasions. They have been brilliant. Staff here recommended that I talk to the mental health nurse. It wasn't easy – us men tend to not deal with our emotions. But she came in and she really helped me handle my emotions. The second time I got down, I was getting to the point that I knew I should talk to them again. At the same time, staff here approached me about it. And that's how I talked to them again. But they were really great. I tell the guys here to contact them because the programmes are tough. They kind of put you down. But the mental health people, they bring you up. It really helps." [Older prisoner – Rolleston Prison]

End of Life Care

"I've had prisoners who have been terminal that don't want to leave [the prison] so we nurse him in our health centre if necessary... We wouldn't be able to manage if there was more than one person requiring that level of care." [Health staff member – Whanganui Prison]

114. With the growing ageing prison population, Corrections has to respond to an increasing number of deaths from terminal illnesses and old age. Between 1 January 2015 and 5 November 2019, 30 older prisoners died due to assumed natural causes.³⁰ Some of these deaths were the result of an illness, for example cancer and heart disease, or a respiratory disease, such as pneumonia. Sixteen of the deaths occurred at Rimutaka Prison, with the majority in the HDU.
115. Prisoners affected by a terminal illness are entitled to receive an End of Life Care plan from Corrections, just as they would from their primary health carer if they lived in the community. An End of Life Care plan is intended to ensure that people who are dying are able to express what is important to them about their care and can live as comfortably as possible until they die.
116. In April 2019, Corrections' End of Life Care Guidelines were incorporated into the Healthcare Pathway policy. The guidelines relate to prisoners who are likely to die within the next 12 months and ensure they have the right to be involved in all decisions related to their care, including end of life care. The Healthcare Pathway policy specifically refers to End of Life, Advanced Directives and Not for Cardio Resuscitation Order (NCPR) orders,³¹ however it does not refer to the overarching concept of advance care planning.
117. The Health Quality and Safety Commission describes advance care planning as the process of thinking about, talking about and planning for future healthcare and end of life care, and that "anytime" is the right time to have an advanced care planning discussion with a patient and it does not have to wait until a patient is

³⁰ Data obtained from the Office of the Inspectorate's death in custody database. No prisoners aged 65 and older died of assumed unnatural causes during this period.

³¹ A Not for Cardio Resuscitation order means Corrections Health Service and custodial staff will not attempt to resuscitate a prisoner when they stop breathing and/or their heart stops beating.

in their last few months. Advance care planning should be an on-going conversation which is revisited periodically. These conversations may lead to a documented advanced directive about a person's healthcare management.

118. Advance care planning can make it easier for health professionals and others to make appropriate treatment and care decisions on the patient's behalf, if necessary.
119. In the HDU, we identified that 13 prisoners had signed NCPR forms. Another two prisoners at other prisons had signed the form. Considering the number of older prisoners, and older people with serious medical conditions in prison, this number is low. Without an NCPR order, staff may commence cardio-pulmonary resuscitation on an older prisoner, which may not be their wish.
120. Research has found that older people are thinking about dying and touching on it in casual conversation, but most do not know that their preferences can make a difference and influence their outcomes. The research showed a clear message that people want their clinicians to bring it up in conversation.³²
121. We noted some good examples of how medical officers picked up on an older prisoner's language and instigated a conversation from which an advanced directive had been completed. For example, during a routine review the prisoner joked "*if I make it out of here*". The doctor took the opportunity to talk about what the prisoner would like to happen if he collapsed and his heart stopped. The prisoner told the doctor firmly that if he were to collapse without a pulse, he would not want any intervention, and he wished to be allowed to pass away without attempts to prolong his life.
122. Based on the Health Quality and Safety Commission advance care planning guidelines, it would be useful for health staff to consider having advance care planning conversations with all older prisoners, not just those who were approaching their end of life or likely to die within 12 months.
123. During our inspection we spoke with Mr E and the case study below shares his experience with the End of Life Care planning and management process.

Case study E

Mr E is an older prisoner who has a terminal illness and several other serious health issues.

In December 2018, after declining to receive health treatment, health staff and Mr E created an End of Life Care plan together to outline Mr E's future care. As part of the plan, Mr E also signed a NCPR form.

In the coming weeks it became clear to health staff that Mr E's health was deteriorating. A palliative care plan was developed and incorporated into the End of Life Care plan, and a palliative care specialist was enlisted for additional support.

Mr E's physical and mental health continues to be closely monitored by health and custodial staff and he receives visits by a mental health clinician daily and a GP several times a week.

³² Health Quality & Safety Commission New Zealand. *5 steps for health care workers*. Retrieved 1 December 2019. <https://www.hqsc.govt.nz/our-programmes/advance-care-planning/how-to/for-health-care-workers/>

Mr E refused to be transferred to the HDU at Rimutaka Prison because he is content with his care and considers the prison staff and fellow prisoners to be his only friends and family.

"I receive a lot of support from the staff in the unit. It is very difficult on staff though due to the pressures that they have to deal with in relation to my health," he says.

Staff accept Mr E's wishes around receiving no health treatment but are aware of the pressure for themselves: *"Staff do have the extra worries about whether Mr E is going to die in the unit or not. There is a feeling that some staff do not want to deal with the possibility of finding him dead in his cell. So, although we help and support him, it is a difficult situation."*

Compassionate release

124. Under the Parole Act 2002, the New Zealand Parole Board may *"direct that an offender be released on compassionate release... [if] the offender is seriously ill and is unlikely to recover."*
125. The Parole Board website says:

"Compassionate releases are not initiated by the Board. An application must be made in writing, along with supporting medical opinion, to be considered. The legislation sets out clear guidelines for the New Zealand Parole Board to follow. The Board acts very quickly on compassionate release applications, as they almost always involve terminal illness. In such cases, the Board chairperson generally makes a referral on the day an application is received and a panel considers it soon afterwards. As always, the Board assesses community safety in making its decision and can impose standard and special conditions on release, including residential restrictions. Where applications for compassionate release are declined, offenders are free to apply for reconsideration by the Board at any point should their circumstances change."
126. Between 1 November 2015 and 20 September 2019, 32 applications were made to the Parole Board, with 20 receiving compassionate release. Of those 20, three were from prisoners aged 65 and older. The number of compassionate release applications appears to be increasing, with 12 applications made in the 2019 calendar year (the Parole Board approved five).
127. Our inquiries with staff and older prisoners revealed that the application process is not well understood
128. When a prisoner is identified by health services as seriously ill and unlikely to recover, the health centre manager completes a form indicating this. The form is then shared with several staff across Corrections and health staff must arrange a conversation with the prisoner.
129. It is then left to the prisoner to decide if they wish to proceed with a compassionate release application or not. Corrections' staff will help progress an application when a prisoner (or their lawyer) requests assistance because they are unable to progress the application themselves.
130. If a prisoner wants their application to proceed, the prison director appoints a staff member to take responsibility for managing the application. The process involves several stages, including the involvement of staff from health, custodial, case management, the High Risk Response Team and Community Corrections.
131. For this inspection, we reviewed 11 death in custody investigation reports for older prisoners completed by the Inspectorate since January 2018. Several observations emerged from our review including:

- » There is a lack of detailed guidance for staff on the compassionate release process.
- » Not all older prisoners who had a serious illness and died from assumed natural causes were identified for their compassionate release eligibility.
- » Of the 11 reports reviewed:
 - Two applications for compassionate release were actively being developed at the time of the person's death
 - One application was declined by the Parole Board Chair because death was not considered imminent
 - Another application was withdrawn by the prison before it was submitted
 - Staff raised the option of applying for compassionate release with three older prisoners, but applications were not forthcoming for two of them because they believed they would be declined.³³ The third prisoner did not apply because he reportedly accepted the fact he would die in prison.

132. We also identified that finding suitable accommodation for prisoners eligible for compassionate release was often difficult and time consuming for staff. Healthcare providers, including rest homes and family and whānau members, are reportedly reluctant to care for a prisoner with a history of sexual offending. HDU staff said they had sometimes found suitable accommodation but, by the time the compassionate release process had been completed, the secured bed was no longer available as it could not be held indefinitely.

"Finding accommodation to allow them to be released is a big problem. Rest homes don't want them. And it's only getting more difficult. This can have a big impact on compassionate release." [Staff member – HDU, Rimutaka Prison]

133. The case of Mr F, below, demonstrates how an effective End of Life Care plan and compassionate release process can work for a prisoner.

Case study F

Mr F is an older prisoner who is serving a long sentence. Prior to his conviction, Mr F was diagnosed with cancer. Once in prison, Mr F declined chemotherapy treatment. Several years later, Mr F was diagnosed with terminal cancer. He again declined to undertake chemotherapy and further treatment, and an oncologist estimated he had only a few months left to live.

Shortly after his latest cancer diagnosis, health staff initiated an End of Life Care plan. Mr F also signed a NCPR form. Mr F had a NASC assessment, however, he was declined funding for an End of Life Care contract, which would provide for his healthcare requirements in the last three months of his life. The assessor determined Mr F was not in the final few months of life.

Four days after Mr F's End of Life Care contract application was declined, he was transferred to a rest home with continuing care facilities, under Temporary Release

³³ One prisoner did not apply because they had no family/external support in the community and the other was told they did not have a qualifying illness.

conditions. Mr F began to receive palliative care that was not available in prison. While in the rest home's hospital facility, Mr F was accompanied by hospital escorts employed by Corrections.

An application for compassionate release was initiated the day Mr F moved into the rest home. The Parole Board approved Mr F's compassionate release two days later.

134. The case of Mr G, below, illustrates how complex processes involving a range of parties can result in unnecessary delays.

Case study G

Mr G is an older prisoner who is serving a sentence of more than five years. Following his conviction, Mr G was diagnosed with severe health conditions.

Mr G was transferred to a prison that was better equipped to deal with his health needs, and an End of Life Care plan was put in place. As part of this plan, Mr G signed a NCPR form.

Shortly after his diagnosis, a compassionate release application was created and sent to a prison manager. Three weeks later, the prison sent the draft application to Community Corrections. Six weeks passed before Community Corrections completed its suitability assessment of the proposed release address. By chance, a probation officer informed the High Risk Response Team about the compassionate release application. Notification to the High Risk Response Team is usually made at the same time the application is shared with Community Corrections. The High Risk Response Team assessed the application for any risks to community safety.

Approximately 10 weeks after the prison director was notified by the health centre manager, the completed application, along with all the necessary supporting information, was submitted to the Parole Board.

135. We understand that Corrections is currently reviewing procedures associated with applications for the compassionate release of seriously ill prisoners.

Areas for consideration

11. Corrections should consider training custodial and health staff to identify and manage older prisoners with challenging behaviours due to their mental and/or physical health decline, particularly in units like the HDU.
12. Corrections should consider future accommodation options for older prisoners that meet varying levels of health or age-related needs, while supporting those prisoners to maintain contact with their family and whānau.
13. Corrections should consider undertaking a full health assessment of every older prisoner's age-related needs, respond to those needs, and collate the data centrally, to support the development of older prisoner health policy and practice.
14. Corrections should consider whether health staff receive dedicated training on managing older prisoners' health, including undertaking effective age-related health assessments.

15. Corrections should consider whether health staff take into account older prisoners' motor skills and cognition, when considering self-administration of medication and/or personal hygiene needs.
16. Corrections should consider whether prisoners who require continuing care are treated in an environment that is appropriate to their needs.
17. Corrections should consider whether each prison health centre has a lead nurse with specialist knowledge and oversight of older prisoners' care.
18. Corrections should consider annual mental health screening for all older people in prison and ensure that specific guidance on completing older persons' mental health checks is provided.
19. Corrections should consider reviewing compassionate release guidelines, informed by policy work currently underway.
20. Corrections should consider health staff commencing advanced care planning conversations with all older prisoners.

Purposeful Activity

136. As with other aspects of the prison environment, opportunities for employment, education, recreation and exercise are typically designed with the needs of younger prisoners in mind. Research suggests that older prisoners' physical capabilities, not just their chronological age, can impact their participation in meaningful activities. Many older prisoners are unlikely to be seeking access to education, including vocational training opportunities, to the same extent as younger prisoners who are more likely to seek employment opportunities on release. Similarly, literacy and numeracy classes that largely target younger prisoners are often of little interest or are unsuitable for the needs of older prisoners.
137. According to the United Nations Handbook on Prisoners with Special Needs, *"counselling, education, vocational training and other programmes need to be adapted to [prisoners'] individual needs and circumstances, including age and health-related needs and length of sentence"*. Special activity programmes that offer older prisoners the opportunity to learn a new skill, such as art and crafts, are considered beneficial, along with quiet spaces where older prisoners can read, play cards and board games and socialise with one another.³⁴
138. During our inspection, we found older prisoners had varying degrees of access to appropriate meaningful or purposeful activities depending on the prison they were in, their physical and mental capability and their personal motivation. Older prisoners tended to keep busy by reading books (including taking part in book clubs and visiting the library), playing board games and cards, doing puzzles, speaking to the chaplain or volunteers, or watching television.
139. Almost half of the older prisoners we spoke with enjoyed some sort of work, such as working in the prison gardens, cleaning or helping in the prison library. Many relied on this small amount of income to buy 'extras' from the prison canteen, because they had little or no financial support from family and whānau.

³⁴ Atabay, T (2009) *Handbook on Prisoners with Special Needs*. New York, United States of America, United Nations Publication, page 138.

140. Prisoners housed in high security units had reduced opportunities for purposeful activity. Many reported that their days were long and boring. Due to the restricted unlock regimes, they had limited opportunities to participate in any activities other than walking around the unit.

"There is nothing here for older people. We're semi-retired – we've worked our whole life. You come to prison and it's taken away from you. We have nothing to do. Some of us can't read because of eyesight and don't have glasses. Older guys can only play cards but that's it. We need a unit just for older guys. Where do we go for a walk? We walk around on concrete all day. It's not helping my health being in the cold and sitting on a bench all day." [Older prisoner – Auckland South Corrections Facility]

"I am currently locked up for 23 hours per day due to the number of regimes being managed in the unit. I try to remain active, but I have difficulties with the yard regime. I'm fearful that other prisoners engaged in physical activity will knock into me in the yard. I asked to be able to remain in the unit during yard time, but this request was declined." [Older prisoner – Rimutaka Prison]

141. Some older prisoners choose not to participate in activities and avoid asking for help to get around. Staff were not always proactive about checking in with older prisoners to find out why they didn't participate and what might encourage them to engage.

"I stay in my cell every day. The unit has no toilet in the yard." [Older prisoner – Northland Region Corrections Facility]

"There are a few older prisoners at the site who, because of their age and deterioration in health, are not able to do a lot and there is not a lot for them to do ... They are not part of our general population of prisoners who are aged between 25-45, who are going home and who will go to work. They are already retired; they do not fit the mould that Corrections has in terms of 'what is he going to do for employment when he is released?'" [Staff member – Northland Region Corrections Facility]

Physical Exercise

142. Some older prisoners could not access physical exercise opportunities due to their deteriorating health and/or their location in the prison. Prisoners across most prisons told us there were no exercise opportunities or special activity initiatives tailored specifically to their physical needs and capabilities. Health and safety requirements designed to keep people safe and well during exercise, including the need to pass a physical activity readiness assessment, also limited access for some older prisoners. Similarly, where exercise equipment was available in the units, many said it was either unsuitable or it was monopolised by younger prisoners.

"I got turned down from the gym due to health. I'm getting short of breath because I'm not doing enough walking. Our block hasn't been to the gym in over a week. The cardio room – it's first in, first serve. I walk in the yard outside when it's warm." [Older prisoner – Auckland South Corrections Facility]

143. New Zealand Ministry of Health guidelines suggest that those aged over 65 should aim for 30 minutes of moderate-intensity physical activity five days a week. Regular exercise can help improve overall health and wellbeing, reduce the risk of chronic diseases and lower the chance of injury.³⁵
144. Prisoners housed in low security units generally had greater access to exercise. Due to the nature and layout of the low security units, many were able to walk in the fresh air regularly or attend a gym session. In one prison, staff set up a walking group where prisoners were taken outside the unit and walked a 20-minute loop at their own pace. Another prison set up an exercise programme specifically for those aged 50 or older called Young at Heart.

"I go to the gym ... I've been fortunate that I signed up to Young at Heart for people over 50. It goes for one hour three days a week." [Older prisoner – Auckland South Corrections Facility]

145. Older prisoners housed in low security units who did have access to meaningful and purposeful activities reported feeling much happier and content. Some activities provided older prisoners with the opportunity to give back, while others were able to learn new skills.

"I work in the nursery 8am-2pm, Monday-Friday. I enjoy it – 95% of guys here love working at the nursery. It's freedom. You're outside the unit and you meet regular people." [Older prisoner – Rolleston Prison]

"I do crochet or knitting. I'm knitting a jersey for one of the babies in the [mothers with babies] unit and I have done a few blankets for them too. I give all my blankets away." [Older female prisoner]

"I go to work every day – so I keep myself active ... I'm very fortunate, I have my guitar and sing in my room, and I play with the unit band and that keeps me happy ... I try to influence the other guys, that you always have to be doing something otherwise you just sit around and moan." [Older prisoner – Whanganui Prison]

Support for Māori prisoners

146. Sixty-five percent of men in prison aged 65 and over are New Zealand European (compared with 21% Māori and 7% Pacific descent). Most of the older prisoners we interviewed who identified as Māori said they were able to practise their culture through opportunities such as kapa haka groups, although there was some suggestion it was simply tokenism and staff did not fully understand the importance of tikanga and culture.

"Different nationalities of staff ... have no concept of what is culturally significant to the Pacific fale or even the Māori whare. It can be above their head ... I've done the three-day sleepover in the whare – it was thought provoking when I think about my whakapapa. The facilitators were very good at what they did." [Older prisoner – Auckland South Corrections Facility]

³⁵ Ministry of Health. (2013). *Guidelines on Physical Activity for Older People (aged 65 years and over)*. Retrieved November 11, 2019, from <https://www.health.govt.nz/publication/guidelines-physical-activity-older-people-aged-65-years-and-over>.

"[There are] some Māori-based programmes at the site but if there is 75% or 85% Māori and Pacific women in prison then why aren't we having a karakia for the women, why only in the spiritual centre which is not open 24 hours? Where is the kaupapa Māori in this prison to support the women going to parole, help with their language, teaching the babies their own language..." [Older female prisoner]

"I am a kaumātua. There are cultural activities every morning for nearly an hour. It brings the unit together. We have pōwhiri, and there is a cultural advisor on site. Local Iwi also come to the site." [Older prisoner –Tongariro Prison]

Access to family and whānau

147. Long sentences and the nature of some criminal offending can contribute to eroding ties and bonds with whānau and friends, factors which are important and can assist in community reintegration.³⁶ Research suggests the loss of whānau contact and the death of family and friends can greatly influence the mental wellbeing of older prisoners, particularly older female prisoners.³⁷ Older prisoners, often due to their age and the length of their prison sentence, on release face a greater challenge to re-establish whānau connections that have been lost or damaged.³⁸
148. Many older prisoners we spoke with did not receive visits from whānau and friends. Reasons included because these people may have passed away, could not afford to visit or found it too difficult to visit because of their age, own health needs and the distance they needed to travel for the visit. Many prisoners also told us their whānau were no longer interested in maintaining ties due to the nature of their offending. In some cases, the prisoners' family and whānau were their victims.

"What is needed in this unit is an AVL – a lot of these people have come from over the country and cannot afford to visit. We could do whānau huis and general visits." [Staff member – HDU, Rimutaka Prison]

"I want to transfer back to a prison in [location]. There I can see my kids all the time and get visits. I can't get that here. I've been waiting for a new pin to use the telephone so I can call them. I want them to sort it. I miss my family and getting the support I need from them." [Older female prisoner]

149. Of those who did receive visits, many had visits from volunteers or community members.
150. Although maintaining whānau ties through visits was often unattainable, many older prisoners were able to remain in contact by telephone.

³⁶ Office of the Correctional Investigator. (2019). *Aging and Dying in Prison: An Investigation into the Experiences of Older Individuals in Federal Custody*. Retrieved November 14, 2019, from <https://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20190228-eng.pdf>

³⁷ Atabay, T (2009) *Handbook on Prisoners with Special Needs*. New York, United States of America, United Nations Publication.

³⁸ Blevins, K & Blowers, A. (2015). Community Reentry and Aging Inmates. In J. Kerbs & J. Jolley (Eds.), *Senior Citizens Behind Bars: Challenges for the Criminal Justice System*. (pp. 201-222), Boulder, CO. USA: Lynne Rienner Publishers.

"I phone my family and I write them letters. I don't have visits here because they have to travel and they're older than me ... It's great that we have the phone in the room." [Older prisoner – Auckland South Corrections Facility]

"My family say it's too far to travel and it becomes lonely. I get to speak to them but it's not the same when you can't see them. I don't feel physically or mentally well when I can't see my family and friends." [Older prisoner –Tongariro Prison]

151. Some prisoners chose not to use the telephone because they had difficulty hearing and instead wrote letters. Others had no family or whānau to support them financially and if they were not or could not be employed (for health reasons) they often had no other means to buy phonecards.

Areas for consideration

21. Corrections should consider whether older prisoners, including those in high security accommodation, can access a range of age-appropriate purposeful activity.
22. Corrections should consider ways to support older prisoners if they cannot work and have little or no financial assistance from family and whānau.
23. Corrections should consider improving older prisoners' access to audio visual links to support regular contact with family and whānau who are unable to visit.

Rehabilitation & Reintegration

152. The United Nations Standard Minimum Rules require that all prisoners receive equal access to rehabilitation and other opportunities, without discrimination. This expectation is also reflected in the Office of the Inspectorate's *Inspection Standards*. The United Nations Principles for Older People adopted a more targeted expectation, stating that "*Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.*"³⁹
153. International research shows that counselling, offending behaviour and other treatment programmes must consider age, health and offending related needs as well as the social vulnerabilities, such as fear of dying, frequently experienced by older prisoners.⁴⁰
154. In addition, research notes there may be a degree of staff bias that affects older prisoners' access to treatment. These perceptions can include that older prisoners are less suitable and require higher levels of social support or individualised treatment to support their participation. Staff may also prioritise younger prisoners as they are identified as a higher risk and having a higher perceived likelihood of successful reintegration.⁴¹
155. Similarly, it is widely accepted in research that older prisoners can be more difficult to resettle into the community compared with younger prisoners. This

³⁹ Office of the United Nations High Commissioner for Human Rights. (1991). *United Nations Principles for Older Persons*. Retrieved November 13, 2019, from <https://www.ohchr.org/Documents/ProfessionalInterest/olderpersons.pdf>

⁴⁰ Atabay, T (2009) *Handbook on Prisoners with Special Needs*. New York, United States of America, United Nations Publication. pp 129.

⁴¹ Snyder, C., van Wormer, K., Chadha, J., & Jagers, J. Older Inmates: The Challenge for Social Work (2009). *Social Work*, vol 54. No. 2. pp 117-124.

can in part be attributed to older prisoners requiring support for complex health needs and having lower levels of family and whānau and social support.

Access to case managers

156. Case managers work directly with prisoners to identify their rehabilitation and reintegration needs and support them to lead an offence-free life following release from custody.
157. In general, most older prisoners we spoke with knew who their case manager was. Those who did not were located in prisons with staffing pressures in case management (e.g. due to higher staff turnover, vacancies or higher numbers of people completing their training pathway or developing their experience).
158. Many older prisoners spoke with us about their perceived low levels of contact with their case managers and, in particular, their feelings of anxiety and stress due to upcoming parole hearings. It was apparent during our inspection that some older prisoners felt the need for more contact and reassurance from their case managers in the lead up to parole hearings.
159. Older prisoners who knew their case manager generally appreciated their case manager's efforts, but many expressed concerns about how "stressed" or "overworked" case managers appeared to be. They felt this was the reason why they could not see their case manager as often as they would like. It is likely that many prisoners, including older prisoners, do not fully understand the case management process.

"I know who my case manager is. I've had him for four months. He's done a lot – he's organised whānau hui, checked I have people coming to Parole, checked I am prepared before I go to the Board. He's done everything I've wanted him to do." [Older prisoner – Auckland South Corrections Facility]

"My parole [hearing] is set for [date]... I keep asking about relevant paperwork for the Parole Board and I am receiving no feedback. No contact with a case manager." [Older prisoner – Northland Region Corrections Facility]

Access to rehabilitation programmes

160. Older prisoners gave us a mixed response about their ability to participate and complete rehabilitation programmes. We noted that around half of the prisoners we interviewed told us they had completed their required programmes.
161. Some older prisoners we spoke with, many of whom were in prison for child sex offences, attributed their perceived inability to access rehabilitation programmes in a timely manner to the long or indeterminate sentences they were serving. Some prisoners serving lengthy sentences also told us they felt they were considered a lower priority because programme places were limited. Some older prisoners also told us they declined to participate in programmes because they feel "too old".

"I'm too old to do programmes. I can't do very much because of my health." [Older prisoner – HDU, Rimutaka Prison]

"I don't want to go to a programme. I once upon a time went to prison and did a programme and then I re-offended again. So, I don't see the point as it didn't

work. And I don't want to have to listen to everyone's problems." [Older prisoner – Rolleston Prison]

162. Individuals are selected for the Special Treatment Unit rehabilitation programmes by principal psychologists, who exclusively manage and access the programme waiting lists. Eligible prisoners are placed on a waiting list according to their parole eligibility date. Prisoners serving short sentences may be placed on a programme earlier if they have a statutory release date within the next 12-18 months and would have insufficient time left on their sentence to wait until a later programme.
163. Prisoners may also have to wait longer if they present with responsivity concerns that prevent their engagement in the programme. At times prisoners may also be prioritised for programme placement in response to Parole Board hearings.
164. Our inquiries confirmed that there are long waiting lists for child sex offending programmes. At the time of our inspection, a principal psychologist advised there were 379 prisoners waiting to attend a Special Treatment Unit,⁴² most of whom were past their parole eligibility date. There were 444 prisoners waiting to access the Short Intervention Programme for Child Sex Offenders.
165. Several prisoners acknowledged to us that they were resigned to dying in prison because they would not achieve parole. Participation in programmes is intrinsically linked to prisoner eligibility for early release on parole. When access to programmes for older prisoners is not facilitated and supported or older prisoners choose not to engage due to low levels of motivation, this can impact negatively on their ability to successfully gain parole. This, in turn, increases the burden on the prison system with an increasing volume of older prisoners serving real or self-imposed 'life' sentences.
166. The example of Mr H below, illustrates the priority for rehabilitation programmes applied to prisoners who are motivated, appropriately supported and serving shorter sentences.

Case study H

Mr H is an older prisoner who is serving a short sentence of less than four years.

Mr H speaks highly of the support he receives from prison staff and his case manager.

At Mr H's first appearance before the Parole Board he was declined because he was an untreated sex offender and he was informed he would appear again in one year.

Mr H was invited by the Parole Board to apply for a Section 26 application to bring his hearing date forward if he completed a sex offender rehabilitation programme.

Mr H was advised he must transfer to another prison to complete his rehabilitation programme.

"I have an excellent case manager. I'm due to go to a programme soon which I'm very happy about. I have a positive attitude in which to maximise the course. I will apply for a Section 26 [and] I am determined to not come back."

Mr H has the support of his family and, as a result, he has accommodation arranged for when he is released.

⁴² Seventy prisoners were tentatively scheduled for treatment and were awaiting a comprehensive assessment, 163 had responsivity concerns, 116 were waitlisted to be considered for assessment at a later date, and 30 were waiting to be screened.

Mr H completed the rehabilitation programme and gained work in the prison's nursery while he awaited his parole hearing.

167. In contrast, Mr I is an older prisoner who previously completed offence focussed programmes in prison and went on to reoffend. Mr I is not motivated to complete a rehabilitation programme during his current sentence and is resigned to spending the rest of his life in prison.

Case study I

Mr I is an older prisoner serving a long sentence.

Mr I previously completed child sex offender programmes in prison and in the community. Mr I is waitlisted to complete a further child sex programme in prison. However, due to his previous completion of the programme and low motivation he is currently placed at the bottom of the waiting list.

Mr I became eligible for parole several years ago. *"Because I don't have any support on the outside my chances of being released are pretty remote. I don't expect I will get released. I don't see my case manager as often as I could. In my case, I still have years to go until I'm released so nothing changes ... I declined to go to courses because I know I won't get out. I've done the sex offences course ... so I don't want to do any more again. I've got a parole hearing coming up in next year, so we'll see."*

Mr I has also undertaken counselling for earlier trauma in his life. He thinks he keeps ending up back in prison in part because he doesn't have any real support in the community.

Mr I says: *"If I were to get out, I don't have any accommodation to go to. I would need robust support. I've been in for many years now so I would need help."*

Preparing for reintegration

168. For many older prisoners, particularly those who have no family or whānau to support them, finding suitable long-term accommodation in the community is difficult. Long-term care homes and privately-owned rest homes may refuse to take former prisoners, either due to their offences or because they require specialist care to maintain their and others' safety. As with access to rehabilitation programmes, the lack of suitable accommodation can have a negative effect on an older prisoner's ability to achieve early release or parole.⁴³

"Finding accommodation is a big problem. Rest homes don't want them. When we first opened, we had one case manager who dealt with everyone here and helped find accommodation as they had the contacts ... Now we have multiple case managers ... We get lawyers up here all the time to help with their parole and find accommodation. The wrap-around services are necessary ... [We have one prisoner with dementia who, because of his illness, is] becoming more challenging so rest homes won't take him." [Staff member - HDU, Rimutaka Prison]

⁴³ Atabay, T (2009) *Handbook on Prisoners with Special Needs*. New York, United States of America, United Nations Publication.

169. Older prisoners we spoke with had mixed responses about their ability to access suitable accommodation to enable their release. Some said they had accommodation available with their family. However, for the majority this accommodation still needed to be deemed suitable by Community Corrections. Others told us they were relying on being able to access community based supported accommodation services⁴⁴ provided by agencies like Anglican Action or the Salvation Army.

"My last parole hearing they told me to come back in a few months to have everything sorted. I'm going into a Salvation Army home when I get out. I've heard they're brilliant ... I had a field rep come to the prison and speak with me about the whole process, what I needed to do and what to expect. I'm really looking forward to going into the houses." [Older prisoner – Rolleston Prison]

170. Around half of the prisoners we spoke with told us they did not have accommodation arranged. Many said this was the primary reason they had previously been declined parole.

"I was stood down from parole last year for 12 months because I did not have any accommodation to go to if I was released. Since that time, I still don't have any accommodation sorted yet." [Older prisoner – HDU, Rimutaka Prison]

171. The case study below highlights some of the impediments faced by older prisoners convicted of child sex offences when appearing before the Parole Board. As a result, most of these prisoners remain in prison well beyond their parole eligibility date.

Case study J

Mr J is an older prisoner who has spent a significant period of his life in prison. Mr J became eligible for parole some time ago.

While in prison, Mr J completed a child sex offender programme as well as individual treatment with Corrections' psychologists. Mr J was assessed as having a medium-high risk of re-offending.

Mr J was offered a place in a community-based supported accommodation service shortly before his scheduled parole hearing.

In preparation for his parole hearing, Mr J completed all activities required as part of his reintegration pathway, including engaging his community-based support people and completing several guided release activities.

Immediately prior to his parole hearing, Mr J was advised that his placement in the supported accommodation service had been withdrawn because Community Corrections re-assessed the accommodation as no longer suitable. At his hearing, the Parole Board said Mr J could only be paroled following the identification of suitable supported accommodation.

⁴⁴ Supported accommodation providers offer wrap-around support services and accommodation to offenders who have served at least two years in prison, are motivated to remain crime-free and do not have any significant barriers such as complex mental health issues. Intended as a shorter term accommodation solution, the lack of long-term accommodation options has meant offenders often remained in the service for longer than intended.

Two months later Corrections informed the Parole Board that the same supported accommodation service could now house Mr J. He was granted parole and released.

172. During our inspection we also identified that staff have an inconsistent approach to how they ensure prisoners are connected to the right type of accommodation or providers. Due to a shortage of available accommodation placements generally, older prisoners may be placed in accommodation that is unsuitable or cannot fully support their needs, including health-related needs. The decision-making appeared to be more effective in regions that had a dedicated accommodation adviser with comprehensive knowledge of each accommodation option and bed availability. We acknowledge that Corrections is developing a National Accommodation Operating Model to provide staff with improved information about what accommodation options are available.

The impact of preventive detention

173. Rule four of the United Nations Standard Minimum Rules for the Treatment of Prisoners states that the sole purpose of a prison sentence can only be achieved if the period of imprisonment is used to ensure, so far as possible, the individual's reintegration into society when released so they can lead a law-abiding and self-supporting life.⁴⁵
174. In New Zealand, preventive detention is an indeterminate sentence. Generally, a preventive detention sentence is issued by the judiciary after a series of violent offences or a pattern of persistent sexual offences. While prisoners serving preventive detention can be released on parole, they are managed by Corrections for the rest of their life and may be recalled to prison at any time. For Corrections, this means that many prisoners serving preventive detention will remain in custody, many will develop age-related needs or perhaps even require palliative care.
175. The purpose of the preventive detention sentence is "to protect the community from those who pose a significant and ongoing risk to the safety of its members".⁴⁶ In September 2019, 323 prisoners were serving preventive detention sentences. Of those, 61 were aged 65 or older (19%) and all were men with histories of sexual offending.
176. Older prisoners serving preventive detention sentences are less likely to be released from prison compared with prisoners aged under 65 on preventive detention. Eighty-two percent of older prisoners serving preventive detention had passed their parole eligibility date. Forty percent of those older prisoners were between six and 10 years beyond their parole eligibility date.
177. Many older prisoners serving preventive detention face barriers to release. We reviewed Parole Board outcomes for older prisoners who were identified as being past their parole eligibility date. Barriers included their ability to access necessary

⁴⁵ United Nations Office on Drugs and Crime. (2015). *Standard Minimum Rules for the Treatment of Prisoners*. Retrieved November 11, 2019, from <https://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20190228-eng.pdf>.

⁴⁶ Sentencing Act 2002 – Section 87(1).

rehabilitation programmes or individual psychological treatment,⁴⁷ access to suitable accommodation on release⁴⁸ or the absence of family, whānau or community support.⁴⁹

178. As a result, older prisoners serving preventive detention have typically attended multiple Parole Board hearings during their time in prison. Twenty-one prisoners (42%) had attended 11 or more hearings and five prisoners (10%) had attended more than 20 hearings.
179. Currently, Corrections has no targeted strategy or pathway that will support prisoners serving preventive detention sentences to gain release from prison. More research is required to fully understand the experience of preventive detention prisoners.
180. The case of Mr K, below, illustrates the difficulties faced by older prisoners on preventive detention, particularly for those with histories of child sexual offending, when trying to find accommodation and achieve parole.

Case study K

Mr K is an older prisoner who has been in prison for many years for serious sexual offending against children. Mr K was most recently assessed by a psychologist as having a medium-low risk of re-offending.

In prison, Mr K completed a child sex offender programme and several other necessary rehabilitation programmes.

Mr K has family who support and visit him regularly in prison.

A few years ago, Mr K was pre-approved for housing by a community-based supported accommodation provider upon his parole release. However, Mr K was denied parole due to the Parole Board's ongoing concern for risk to the community.

Mr K was approved to undertake four guided release opportunities in the community, including meeting with his supported accommodation provider and support people to discuss his safety plan. For reasons beyond Mr K's control, none of the four guided release opportunities occurred.

At Mr K's next Parole Board appearance, the Parole Board was informed that the pre-approved accommodation was now unavailable. Mr K's application for parole was again declined.

At his next Parole Board hearing, Mr K was advised that his accommodation pre-approval had been withdrawn because Community Corrections recently deemed the accommodation unsuitable for his needs. Mr K was again declined parole due to the lack of suitable and available accommodation. The Parole Board requested Mr K to reappear in six months to allow Community Corrections sufficient time to identify alternative accommodation.

⁴⁷ Poor English language skills, literacy or learning difficulties, health and mental health issues, low motivation and large volumes of prisoners on the waiting list with sentence end dates coming up appeared to be the most common factors preventing access.

⁴⁸ We identified that access to suitable accommodation was the most common reason older prisoners on preventive detention sentences could not gain release. Accommodation options typically did not meet older prisoner needs, especially with regard to secure care for those experiencing dementia or rest home level care for those needing help with their day to day care.

⁴⁹ Fifty-two percent of people had no family and whānau support and 24% had limited support.

At his next Parole Board appearance, Mr K's lawyer confirmed that the original accommodation provider had again agreed to house Mr K upon his release, at an alternative address. Mr K has maintained his relationship with the accommodation provider over the years he has been in prison. The Parole Board advised Mr K that he could be released as soon as Community Corrections confirmed its support for the alternative address.

Mr K reappeared before the Parole Board six months later, with his accommodation confirmed. The Parole Board approved Mr K for release on the condition that he completed two guided release opportunities to his approved accommodation and Community Corrections office.

Areas for consideration

24. Corrections should consider whether older prisoners understand their offender plan and how Corrections will support them to be prepared for their parole hearing.
25. Corrections should consider how older prisoners are supported to obtain timely access to necessary rehabilitation programmes.
26. Corrections should support older prisoners serving preventive detention sentences to be prepared for their parole hearing.
27. Corrections should consider long-term supported accommodation options and whether spaces are available to house eligible older prisoners.
28. Corrections should consider the effects of institutionalisation on older prisoners' motivation and support them to be prepared for their parole hearing.

Post-release support

181. In the 12 months to November 2019, around 7,800 prisoners were released from prison. Some were released because they had served their full sentence (or half for those sentenced to two years or less), while others were released because they were paroled or, for a small number, granted compassionate release due to a terminal illness and imminent death. Regardless of the reason for the release, a prisoner's reintegration into society has implications not only for the person being released but also their family, whānau and the wider community.
182. Research suggests that for older prisoners, being released back into the community is even more problematic. As we have acknowledged throughout this report, prisons are largely focused on the needs of younger prisoners who comprise the vast majority of the prison population. Younger prisoners also have a higher perceived risk of re-offending and higher perceived chances of successful rehabilitation and re-integration. Similarly, post-release planning and support on release are largely focused on younger prisoners' needs.⁵⁰
183. Older prisoners, particularly those who experience higher levels of chronic illness, often need additional support when making the transition into the community. Similarly, as discussed in the previous section, those who have been in prison for extended periods of time (for example those on preventive detention) are more likely to have difficulty adjusting to living in the community, particularly if they have lost whānau support. The lack of available and affordable housing, as well as financial concerns, all contribute to concerns facing older prisoners. These concerns are often amplified for older sex offenders, due to potential fears of assault and negative media exposure.⁵¹
184. During our inspection, we interviewed seven older people who had recently been released into the community. We asked them about the support they received in

⁵⁰ Baidawi et al (2011) 'Older Prisoners – A challenge for Australian Corrections.' *Trends & issues in crime and criminal justice*, no. 426, pp 1-8.

⁵¹ Ibid.

the lead up to their release. Although all received some form of assistance, there was no consistency as to the type of assistance provided.

185. In the lead up to release, case managers are required to create a release plan to help a prisoner transition from prison to the community. The release plan is designed to cover all parts of a prisoner's transition including community support, accommodation and health services. The intensity of the release planning will vary depending on the person's risks, needs and responsivity factors.
186. As part of the release planning, case managers consider the benefits of guided release opportunities. Corrections considers guided release as an important part of the release planning process for prisoners who have served long sentences. Guided release provides an opportunity for prisoners to address their reintegrative needs prior to their final release, such as visiting their accommodation, opening a bank account and shopping for clothes.
187. Two of the prisoners we interviewed had taken part in at least one guided release. Some were visited by a Work and Income representative in prison who assisted them to apply for their government superannuation allowance.

"If I had nothing to come out to, I would have wanted to stay in prison as everything is done for you and you are looked after with a place to live and food provided." [Released older offender]

"When I came out [one month ago], I felt like I didn't exist. There was nothing with my name on it, I had no job and no family friend support. And I still feel like that at the moment." [Released older offender]

188. Once released from prison, offenders can access government superannuation, but many wanted to work to ensure they had enough income to live comfortably. Some people told us they needed more help from Corrections staff to find a job or update their CV before they were released from prison.

"I thought they [case managers] would have been more organised. I asked about my driver's licence when I was still in prison as I knew it was going to expire. Yet nothing happened. That should have been organised before I got out. I also don't have a CV. Why couldn't this have been arranged before I left? ... and I'm still waiting on a community [services] card." [Released older offender]

"I am suffering now, I have not been able to find a job... Employers don't want to employ anyone with a criminal record." [Released older offender]

Healthcare

189. Successful reintegration of older prisoners requires them to be connected to healthcare services. Older prisoners are more likely to have health problems, so connection with healthcare providers in the community is necessary as soon as possible.⁵² Most older prisoners however, due to the length of time they have

⁵² Blevins, K & Blowers, A. (2015). Community Reentry and Aging Inmates. In J. Kerbs & J. Jolley (Eds.), *Senior Citizens Behind Bars: Challenges for the Criminal Justice System*. (pp. 201-222), Boulder, CO. USA: Lynne Rienner Publishers.

been imprisoned, have either forgotten who their previous general practitioner was, been unenrolled, or have been released to a new community.⁵³

190. As part of the release plan, the prison's health centre manager is responsible for ensuring a health plan is in place when a prisoner is released. In cases when a prisoner is released unexpectedly, there may not always be time to put a health plan in place.
191. When a person is released from prison, they receive up to one month's supply of their medication as part of their health plan.

"If they haven't got a doctor, we get them into a practice – we have a few practices who will accept our patients. When they leave, we give them a month's worth of medication, and I also talk to the prison director so I can pay for their first doctor visit and their first set of medication. When prisoners are released, they only get \$350 with their Steps to Freedom [grant]. Some of their medication can be very expensive and we don't want them to leave and not be able to afford medication." [Staff member – Whanganui Prison]

192. For the prisoners we interviewed, all but two people had medical support in place at the time of their release.

"Prison medical is pretty good, gave me enough medication before I had to see doctor." [Released older offender]

"I had to go and get another doctor [and] pay \$70 for my first visit, and no one in prison assisted me to connect with a doctor in the community." [Released older offender]

Steps to Freedom

193. When someone is released from prison they may be entitled to a Steps to Freedom grant of \$350 from Work and Income. The grant is designed to help cover an individual's initial costs, including food, housing or clothes.⁵⁴
194. While all received the Steps to Freedom grant, some commented that the amount was not enough.

"[Getting my Steps to Freedom] this time was OK, as my superannuation was activated a week later. Other times this was not enough, after one pays for clothing, food, pay for transport or rent there is nothing left." [Released older offender]

Community services

195. As discussed in the previous section, many older prisoners face difficulties accessing suitable accommodation. This can be because they have no family, whānau or community support, their criminal history or due to their complex or age-related healthcare needs.

⁵³ According to the Ministry of Health, an individual is automatically unenrolled from their medical centre if they have been absent from that practice for three years. <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/national-enrolment-service>.

⁵⁴ Work and Income 2019, Ministry of Social Development, accessed 14 November 2019, <https://www.workandincome.govt.nz/products/a-z-benefits/steps-to-freedom-grant.html#nullv>

196. During our interviews with recently released offenders, they each told us they had accommodation arranged before they left prison. However, for some the accommodation they went to was only a temporary arrangement and they were having difficulty finding long-term accommodation.
197. For those who utilised supported accommodation services, all were positive about the level of support they were offered by providers.

*"I was absolutely amazed with the help and support from everyone concerned."
[Released older offender]*

"The assistance by [provider name] is excellent. They continue to support me in so many ways. They assist me with transport to my counselling sessions, and also with my shopping." [Released older offender]

Area for consideration

29. Corrections should consider continuing to support the development of staff practice to ensure older prisoners receive consistent and equitable access to effective release plans.

Staffing

198. Prison managers and their staff deal with a multiplicity of high-risk problems and behaviours every day. As a result, there may be a tendency for staff to become overly focused on maintaining the good order and security of the prison at the expense of a fairer and more humane response. This focus can lead to a prison staff culture which adheres to the 'sameness principle' or 'institutional thoughtlessness', the concept that every prisoner should be treated the same. As with other groups, the older prisoner cohort is diverse and differs in needs and abilities when coping with life in prison. This pressure on staff to treat all prisoners the same can lead some staff to inadvertently discriminate against older prisoners by failing to recognise and accommodate their age-related needs.⁵⁵
199. According to the United Nations Handbook on Prisoners with Special Needs, staff who supervise and care for older prisoners should receive age-specific training to enable them to work constructively and effectively with this cohort of prisoners.⁵⁶
200. During our investigation, we found most staff had not received any age-specific training from Corrections. Many staff told us they typically treated older prisoners the same as other prisoners, although they recognised the need to adapt when the need was obvious. For example, some staff mentioned they slowed their walking pace to accommodate prisoners who could not walk quickly. However, a greater proportion of staff acknowledged that they did not actively consider the age-related needs of older prisoners and often relied on individual older prisoners to alert them to any difficulties they were experiencing. This approach is problematic and brings its own risks when older prisoners typically have a tendency to keep to themselves and avoid causing trouble.

⁵⁵ International Committee of the Red Cross. (2018). Ageing and Imprisonment. Workshop on ageing and imprisonment: identifying and meeting the needs of older prisoners. Summary Report. Retrieved November 11, 2019, from <http://hdtse.fr/detention/ageing-and-imprisonment-summary-report.pdf>

⁵⁶ Atabay, T (2009) *Handbook on Prisoners with Special Needs*. New York, United States of America, United Nations Publication.

201. In specialised units, such as Rata Unit in Rolleston Prison and Rimutaka Prison's HDU, staff are invited to apply for positions and are specifically selected to work in those units. Although they do not receive any specific age-related training, staff in those units said they were selected because they had the right attitude to care for older prisoners.

"We get interviewed to see if we have the right attitude for dealing with the prisoners in here. If you can't help the health assistant to change a nappy, then this isn't the right place for you." [Staff member – HDU, Rimutaka Prison]

"When we first started, we had basic training on what to expect ... This has stopped now. When a new prisoner comes in ... we get an in-depth health advice form." [Staff member – HDU, Rimutaka Prison]

"Staff don't get trained up to come into Rata Unit. But staff are selected for Kia Marama,⁵⁷ so those skills are transferable to Rata Unit. A senior psychologist is involved in the selection of staff." [Staff member – Rolleston Prison]

202. Most older prisoners we spoke with told us staff in their units were approachable and respectful, and they appreciated the assistance they received. For many older prisoners, their relationships with staff became personally significant given their frequent isolation or estrangement from their family and whānau. Several prisoners also expressed concerns about the stress they could see staff experiencing due in part to understaffing.

"The staff here are really good. I can go to them if I have problems. They're professional and treat me with respect." [Older female prisoner]

"90-95% of staff here are brilliant. They helped me when my [family member] died. They care for you and they're available. The PCO has really helped me with my parole." [Older prisoner – Rolleston Prison]

"Staffing here is a major problem. Lately it's just been staff shortages ... They're trying to do the best they can, but you have to approach the approachables." [Older prisoner – Auckland South Corrections Facility]

"Staff are approachable and usually get things sorted fairly quickly. They are always fair, treat everyone the same, [and] they keep an eye on the older ones." [Older prisoner – Tongariro Prison]

"I am treated the same as other prisoners, there is no consideration for me being a prisoner who is older than most others." [Older prisoner – Northland Region Corrections Facility]

Area for consideration

30. Corrections should consider whether custodial staff working with older prisoners have access to training and information on how they can best respond to older prisoners' needs.

⁵⁷ A Special Treatment Unit for sex offenders.

Appendix A - Images



Image 1. Auckland Region Women's Corrections Facility horticultural gardens



Image 2. Auckland South Corrections Facility disability cell shower (high security)



Image 3. Auckland South Corrections Facility disability cell (self cares)



Image 4. Rimutaka Prison reading room (unit 8)



Image 5. High Dependency Unit cell with hospital bed (Rimutaka Prison)



Image 6. Northland Region Corrections Facility bunk bed and ladder

Appendix B – National Commissioner's response



7 April 2020

Janis Adair
Chief Inspector
Department of Corrections

By email: janis.adair@corrections.govt.nz

Tēnā koe Janis

Re: Thematic report on the lived experience of older people in New Zealand prisons

Thank you for completing this first thematic inspection on the experience of older people in prison. I'm confident the thematic programme of work, particularly when at its foundation is the voice of people in prison and our staff, will provide a new window into our strengths and opportunities for innovation or improvement.

I'm proud that your team found that not only were the basic needs of older people in prison met but that staff also demonstrated innovation, care and respectful decision making. It's also clear that their experience in the unit communities they live in are important. It is positive most described feeling safe, some because their peers in the unit 'looked out for them' and for others in more specialist units like the High Dependency Unit (HDU) that they had a sense of comfort from knowing there is higher level of care available to them. In my view the HDU is an excellent service and facility which provides an important benchmark in our network for services at the highest level of need. The expertise of staff across frontline disciplines who work with the men in this unit is also an invaluable resource and their knowledge can be utilised as we make enhancements to enable best practice at all levels of need across the network. As an example, I was particularly encouraged that staff in the HDU had already adopted a different approach to managing challenging behaviours exhibited because of mental or physical decline. These staff will be best placed to inform any custodial guidance or training material in this area.

As your report notes, at only three percent of the overall prison population, older people (those aged over 65 years) are a small proportion. The small group size does not however match the scale of their needs which, as your report outlines, create challenges and pressures on our services. Many of this group present with high and complex health needs which stretch our existing services. Similarly, the risk profile of this group featuring sexual offending against children creates challenges for rehabilitation and reintegration services and planning. These needs also create a challenge for us, in how to ensure they are able to have a meaningful life both in

prison, in some cases until their end of life, or in assisting them to prepare for a safe release into the community. Further, we can expect and must plan for growth in this population.

It is also important for me to note here that many of the report observations do not exclusively apply to people over 65 years of age. When focused on health needs, it is well understood here and in other jurisdictions, that in the prison population age-related health needs are likely to be prevalent much earlier than 65 years of age. I acknowledge in the New Zealand setting I also must be conscious that Māori people currently make up a smaller proportion of the older prisoner population and therefore to provide equitable care and equal opportunity to live well longer we must ensure our strategy and services are not constrained by age. In contrast your report also notes that most of the older people were largely able bodied and able to take care of themselves most of the time. This means that the approach we take cannot be one size fits all and must be nuanced and adaptable.

Your report recommends we; *develop, appropriately resource, and implement a comprehensive Older Prisoners' Wellbeing Strategy to respond to the age-related needs of older prisoners.* A clear and significant alignment is that our direction is described in our whole of organisation strategy, Hōkai Rangi. At the heart of Hōkai Rangi is oranga or wellbeing. This means we are organising all our effort around this purpose, summarised perfectly in the whakatauki; *kotahi anō te kaupapa: ko te oranga o te iwi* – there is only one purpose to our work: the wellness and wellbeing of people.

Best practice as we already understand it means that the care we provide to people is individualised to meet their needs. To ensure we can better understand and provide for the individual needs of people with age related requirements and have the right services available, a helpful place for us to focus our initial efforts is in the health domain. A robust health framework complemented by a holistic understanding of wellbeing, will provide a solid foundation for each person's plan of care, whether it relate to their health or offending related needs.

Our Health team will lead the development of this framework and are already working to ensure our next steps align with the work in other agencies, particularly the Ministry of Health, who are considering their strategic approach to provision of health services to older people. Similarly, the Office for Seniors will be a helpful resource, given their recently launched *Better Later Life, He Oranga Kaumatua 2019 to 2034* strategy.

The draft report has been shared with the regional commissioners who are committed to improving our care for older people. They and their teams have identified a range of practical steps that could be implemented by regional and frontline staff. These will be discussed with the regional directors of practice delivery to ensure ideas and expertise is shared.

I also finalise this letter at a time where all New Zealanders and our organisation face an unprecedented situation with the threat to life and wellbeing of COVID-19. This threat is particularly significant for those more vulnerable due to their age or health condition. In these times I am reassured that our response ensures staff in prisons and the community can approach this challenge with particular emphasis on vulnerable staff, our partners and people in their care, adapting their approach to meet the needs of each person.

Ngā mihi nui



Rachel Leota
National Commissioner