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**A review of seclusion and restraint
practices in New Zealand**

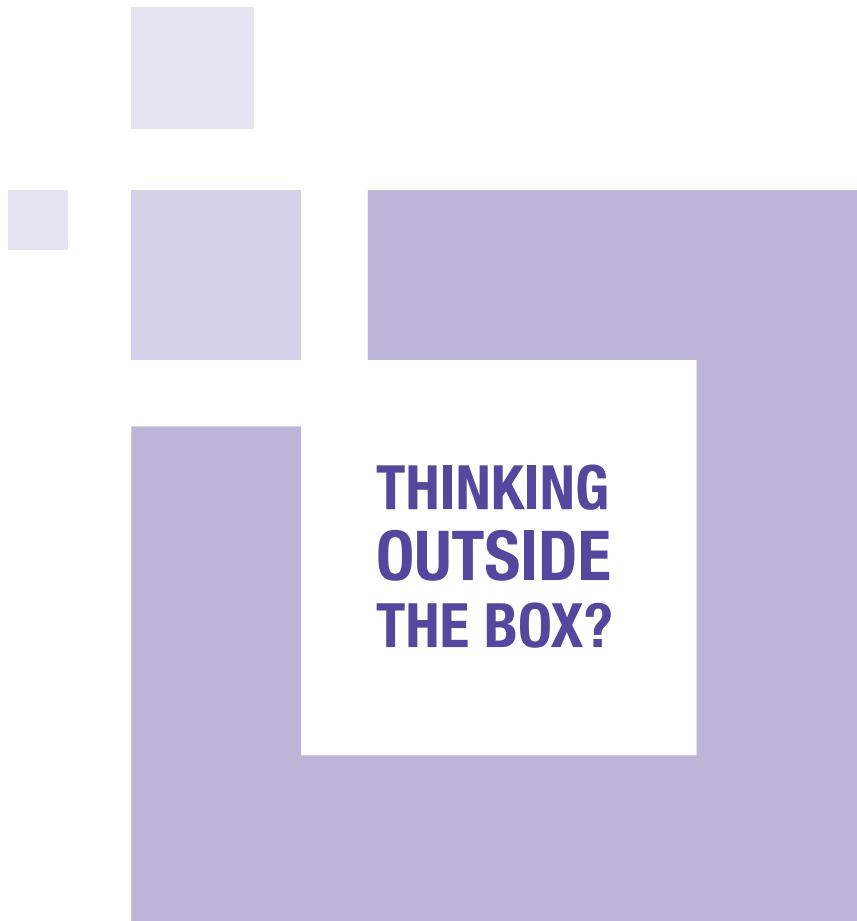
Dr Sharon Shalev

Purea Nei

Purea nei e te hau *Let me be cooled by the breeze*
Horoia e te ua *And washed by the rain*
Whiti, whitia e te ra *And warmed by the shining sun*
Mahea ake ngā poraruraru *My troubles will be gone*
Makere ana ngahere *And the knots binding me undone*

E rere, wairua e rere *Let my spirit fly*
Ki nga ao o te rangi *To the clouds in the sky*
Whiti, whitia e te ra *And warmed by the shining sun*
Mahia ake ngā poraruraru *My troubles will be gone*
Makere ana ngahere *And the knots binding me undone*

Henare Mahanga (Ngāti Hine) / Dr. Hirini Melbourne (Ngai Tūhoe)



**A review of seclusion and restraint
practices in New Zealand**

Dr Sharon Shalev

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Right Commission, 2017

This report was commissioned by the
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Foreword

The following report has been produced by Dr Sharon Shalev, who has completed an independent review of seclusion and restraint practices in a number of New Zealand detention settings.

Dr Shalev is an international expert in the field of solitary confinement and seclusion. She is a research associate at the Centre for Criminology at the University of Oxford and a Fellow of the Mannheim Centre for Criminology at the London School of Economics and Political Science. She completed her doctorate on American Supermax Prisons, is the author of the influential Sourcebook on Solitary Confinementⁱ and has recently completed a comprehensive study of segregation units and close supervision centers in England and Wales.ⁱⁱ

Dr Shalev is well qualified to comment on the practices in place in our country. We are very grateful to her for accepting the commission to undertake this work and for providing an independent perspective on New Zealand practice. This report sets out her observations and recommendations based on her visits to selected New Zealand detention facilities during October and November 2016.

The views expressed by Dr Shalev do not necessarily represent those of the Human Rights Commission or the individual National Preventive Mechanism partners. However, they provide an important catalyst for further discussion and action.

Dr Shalev's report highlights a number of serious issues. These include:

- A high use of solitary confinement and restraint
- Overrepresentation of ethnic minority groups in solitary confinement and restraint incidents

i <http://www.solitaryconfinement.org/sourcebook>

ii Deep Custody: the use of segregation and close supervision centres in England and Wales (2015) (<http://solitaryconfinement.org/uploads/DeepCustodyShalevAndEdgar.pdf>)

- A small but persistent number of ‘chronic’ cases where solitary confinement and restraint were used for prolonged time
- The placement in solitary confinement of people belonging to vulnerable groups
- Impoverished physical environments for people who are secluded, segregated or isolated
- Indications that seclusion and restraint are not always used as options of last resort
- Concerns regarding the record keeping associated with seclusion and restraint in various settings
- Limited access to basic provisions
- Limited access to confidential complaint mechanisms

Overview

Dr Shalev’s report is focussed on facilities that are subject to monitoring under the Optional Protocol to the Convention Against Torture (“OPCAT”). The Crimes of Torture Act 1989 designates four organisations as “National Preventive Mechanisms” or “NPMs” responsible for OPCAT monitoring. These agencies are the Office of the Ombudsman, the Office of the Children’s Commissioner, the Independent Police Conduct Authority and the Inspector of Service Penal Establishments.ⁱⁱⁱ The New Zealand Human Rights Commission is designated as the Central National Preventive Mechanism (or “CNPM”). As CNPM the Commission acts as a coordinator for the joint activities of the NPMs and is responsible for liaison with the Subcommittee on the Prevention of Torture.

The facilities that the NPMs are responsible for monitoring include prisons, health and disability units, police cells, Child, Youth and Family care and protection units and youth justice residences. There are other environments in which forms of seclusion or restraint or similar practices can occur such as schools or rest homes. Dr. Shalev’s report is confined to those environments currently covered by the OPCAT framework and does not consider seclusion or restraint in other situations.

Background

Funding for this report was obtained by the Human Rights Commission from the United Nations Office of the High Commissioner for Human Rights (“OHCHR”) through the UN Subcommittee on the Prevention of Torture Special Fund.

iii <https://www.hrc.co.nz/your-rights/human-rights/our-work/opcat/>

The fund supports projects designed to assist with the implementation of recommendations made by the Subcommittee during country visits.

The Subcommittee on the Prevention of Torture visited New Zealand in 2013. In relation to seclusion and restraint practices, the Subcommittee recommended the immediate cessation of the practice of holding prisoners in prolonged detention in disciplinary cells based on perceived security risk and that the protection of vulnerable detainees should not be achieved at the cost of their own detention conditions.

Many of the agencies responsible for monitoring New Zealand detention facilities have had longstanding concerns about the use of seclusion and restraint in different settings. The issue has also been addressed by the United Nations Committee against Torture, most recently in concluding observations made following New Zealand's 6th periodic review in 2015. The Committee recommended that New Zealand:

- limit the use of solitary confinement and seclusion as a measure of last resort, for as short a time as possible, under strict supervision and with the possibility of judicial review; and
- prohibit the use of solitary confinement and seclusion for juveniles, persons with intellectual or psychosocial disabilities, pregnant women, women with infants and breastfeeding mothers, in prison and in all health-care institutions, both public and private.^{iv}

In 2014 the United Nations Committee on the Rights of Persons With Disabilities, also recommended in its concluding observations, that immediate steps be taken to eliminate the use of seclusion and restraints in medical facilities.^v

The report was commissioned to provide an independent perspective on seclusion and restraint practices in several different detention contexts and to identify examples of good practice as well as areas that require improvement to inform future NPM activities.

Cooperation and Engagement

Dr Shalev, the Commission and the NPMs have received a very high degree of cooperation from the staff at relevant detention facilities, and the respective responsible government ministries, departments, and district health boards. It is heartening to see an openness and willingness to identify areas for improvement to enhance compliance with human rights standards.

iv https://www.hrc.co.nz/files/2814/3192/5666/CAT_Report_May_2015.pdf

v <http://docstore.ohchr.org/SelfServices/FilesHandler>.

People who have experienced seclusion and restraint practices have also shared their thoughts and views. Gaining a better understanding of the impacts of being restrained or isolated has been identified as something that the NPMs need to look into further. That will provide important information about the impact of these practices on people who are directly affected.

We are grateful to those who took the time and made the effort to participate in this work and look forward to exploring these issues further.

There was also a high level of engagement from clinical professional bodies and associations, many of whom were troubled by a perceived tension between ensuring the safety and well-being of service users while simultaneously making sure that facility staff, or others, were protected from harm. The decisions and actions required from staff, sometimes on a daily basis, were clearly a source of concern and anguish for those involved. Dr Shalev has noted from her visits that there appeared to be high levels of risk aversion and that staff safety could sometimes take precedence over the comfort or rights of patients and prisoners. Again, this area needs attention. It is important to get this difficult balancing act right and to consider the perspectives of staff as well as service users.

Observations

The relevant domestic legislation and regulations were examined. The more significant of these are reproduced in the appendices to Dr Shalev's findings. Some statutory provisions are more consistent with the principles upheld in international human rights laws and standards than others. There also appears to be scope for greater alignment of legislation to provide more coherency across different sectors in relation to seclusion and restraint related frameworks and safeguards. Further work needs to be undertaken to assess these requirements in more detail and to advocate for positive change.

Dr Shalev noted the work being undertaken by Te Pou o te Whakaaro Nui ("Te Pou") to reduce the use of seclusion and restraint.^{vi} Te Pou is a national centre of evidence based workforce development for the mental health, addiction and disability sectors. It is funded by the Ministry of Health and the organisation has taken a lead in developing a range of tools to support inpatient mental health services to reduce seclusion and restraint. These activities include workforce training programmes such as SPEC (Safe Practice Effective Communication), use of sensory modulation tools and the development of a local version of the Six Core Strategies. The latter framework incorporates evidence based approaches that have been proven effective in reducing seclusion and restraint events. Dr

vi <http://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102>

Shalev suggests that the knowledge and resources developed by Te Pou could be further developed for application in other settings, such as corrections facilities, police custody and child and youth environments.

Consideration of Dr. Shalev's recommendations

The report is based on visits carried out by Dr Shalev in late 2016. As such, it represents a snapshot of what was observed and noted by her at that time. While this report was being finalised a number of agencies advised that they had already implemented, or were in the process of implementing, some of Dr Shalev's recommendations. For example, Corrections advised that the "silver rooms" had been decommissioned on 1 March 2017 and improvement initiatives that are underway include a review of "at risk" prisoners and a strategic plan to provide a greater level of mental health, alcohol and drug support to prisoners. This is encouraging. The NPMs applaud these efforts.


The NPMs will now consider each of Dr. Shalev's recommendations and use this report to inform future work with detaining agencies, including the development of appropriate monitoring and follow up activities. The NPMs will also continue to work with the relevant authorities and agencies to try and reduce the prevalence of seclusion and restraint in different settings and to improve the way that it is carried out in those circumstances where it is necessary.



David Rutherford
Chief Commissioner,
Human Rights Commission




Robert Bywater-Lutman
Inspector of Service Penal Establishments,
Office of the Judge Advocate General



Judge Andrew Becroft
Children's Commissioner,
Office of the Children's Commissioner



Judge Sir David Carruthers
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Authority



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Chief Ombudsman,
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Executive Summary

Background:

The report examines the use of seclusion and restraint across different detention contexts in New Zealand. It is based on visits to seventeen different places of detention including prisons, health and disability units, a youth justice residence, a children's care and protection residence, and police custody suites, which took place between 26 October 2016 and 11 November 2016. It is also based on material provided before, during and after those visits, including some extensive data sets.

The report was commissioned by the New Zealand Human Rights Commission with funding from the UN Subcommittee on the Prevention of Torture, and conducted by an independent expert, Dr Sharon Shalev, of the Centre for Criminology at the University of Oxford, UK.

Key findings:

- Overall, the data revealed a high use of seclusion and restraint in New Zealand, and an overrepresentation of ethnic minority groups, in particular Māori, in seclusion and in prison segregation units, which is a matter of concern. In prisons, women were also much more likely than men to be segregated, and for longer periods.
- Some of the forms of mechanical restraint used were inherently degrading to the individual. Of particular concern was the use of restraint or tie-down beds in prisons and the use of restraint chairs in police custody.
- Stark physical environments and impoverished regimes in seclusion, secure care and segregation units, and in a number of cases no access to basic fixtures such as a call-bell to alert staff, a toilet or fresh running drinking water.
- Access to basic entitlements including daily access to a shower and an hour long exercise in the fresh air were not always guaranteed.

- The physical design and material conditions in the so-called 'At Risk units' in prisons, where vulnerable prisoners were housed, were mostly identical to those in other solitary confinement units. These units may be contrary to international standards which prohibit the placement of prisoners with physical or mental disabilities in solitary confinement.
- Children and young people in Care and Protection residences could be held in separation from their peers in 'Secure Care' units which were identical to prison segregation units. These were inappropriate.
- The deprivation of social interaction which is inherent in all solitary confinement practices was often made worse by the deprivation of other provisions which could have helped to mitigate the harmful effects of seclusion. These included restrictions on family visits and in-room provisions such as books, hobby and craft materials or a TV set.
- A small but persistent number of people in health and disability facilities were subjected to very long-term restrictive measures, and discussion of future plans for these individuals appeared to be focused on variants of seclusion and restraint. For the individuals concerned, prolonged seclusion and /or restraint (and often both) had thus become a chronic state rather than an emergency short term response to an acute situation.
- Review processes were not always robust, and some stays in restrictive conditions were far too long.

Other concerns identified in the report included:

- Seclusion and segregation cells were not always used for their intended purpose.
- Lack of individual autonomy and over-reliance on the goodwill and availability of staff.
- Seclusion and restraints were not always used as emergency last resort tools for the shortest time possible.
- Risk aversion and staff safety taking precedence over the detained individual's rights and needs.
- Blanket restrictive policies being applied to detained individuals, rather than ones tailored to their individual risk and needs.

Good practice observed:

The report identified pockets of good practice in all detention contexts. Examples included units where individuals were able to engage in varied activities, if in separation from others; units where individuals were provided with good information on daily routines and expectations; good multidisciplinary work and family involvement in individual care plans; individualised work to address the needs of the detained person, including work on the events which led to their seclusion or segregation, and; staff being up to date with their training.

Key recommendations:

- The use of seclusion, segregation and all forms of restraints should be significantly reduced, and reserved for the most extreme of cases, and then used only for a very short time.
- Decisions to use seclusion or restraint should be based on an individualised and proportionate risk-needs based approach, and be regularly and substantively reviewed.
- Inherently degrading forms of restraint, in particular restraint beds and restraint chairs, should be abolished altogether.
- Minimum standards for the provision of decent living conditions and essential provisions as set out in human rights instruments must always be met. Specifically, cells and rooms must be of a reasonable size, clean, safe, well ventilated, well lit and temperature controlled. Basic requirements regarding access to fresh air and exercise, food and drinking water must always be adhered to across all detention contexts.
- All cells/rooms must be equipped with a means of attracting the attention of staff, and these must be regularly checked to ensure that they are in good working order.
- Facilities which were found not to be fit for purpose, including the so-called 'pound' punishment blocks in prisons and Wellington police custody suite should be decommissioned as soon as practicable.
- Data on the use of seclusion/segregation/secure care units and the application of restraints should be recorded more fully and analysed for trends and protected characteristics such as age, gender and ethnic origin. The apparent overrepresentation of ethnic minorities, in particular Māori, in seclusion and segregation units in prisons and in health and disability units, and in the application of restraints should be investigated further as a matter of urgency. The higher use of segregation with women in prisons should also be investigated.

- Confidential and accessible complaint mechanisms must be closely safeguarded in all places of detention, and even more so in units where people are separated from others and thus potentially more vulnerable to mistreatment. People with disabilities and anyone who may have difficulties in accessing the complaints system should be provided with assistance to enable them to do so.
- Oversight mechanisms need to be strengthened, in particular with regard to placement in, and ways out of, seclusion and segregation units. These should be made proportionally more exacting as time in seclusion/segregation progresses. In the case of the 'chronic' stays in solitary confinement (in prisons, health and disability settings), the setting up of a national multi-disciplinary oversight body which includes expertise from outside the detaining agencies, should be considered.

Acknowledgments

Many people contributed to work on this report, and I should like to thank them all. Thanks are due to New Zealand's Human Rights Commission for inviting me to conduct this study and for setting up site visits and meetings. The study was carried out with the co-operation of New Zealand's National Preventative Mechanisms (NPMs), who provided me with invaluable insights on New Zealand's seclusion and restraint practices and accompanied me on site visits, generously offering their time and experience. My thanks to David Rutherford, Chief Human Rights Commissioner, Judge Andrew Becroft, the Children's Commissioner, Judge Peter Boshier, Chief Ombudsman, Judge Sir David Carruthers, Chair of the Independent Police Conduct Authority, Dame Susan Devoy, Race Relations Commissioner, and Paul Gibson, Disability Rights Commissioner, for supporting this project and sharing their extensive knowledge and experience.

Jacki Jones, Chief Inspector COTA, Office of the Ombudsman, was instrumental to this review, from helping to select which sites to visit through to accompanying me on several visits and commenting on drafts of this report. COTA Inspectors Tessa Harbutt, Emma Roebuck and Eric Fairbairn joined different site visits, as did Sarah Hayward and Brian Gardner of the Office of the Children's Commissioner, and Warren Young from the Independent Police Conduct Authority. I am grateful to them all. Thanks are also due to Liz Kinley of the Children's Commissioner's office, for her thoughts and insightful comments on a draft of this report. Many thanks are due to Anneliese Boston for co-ordinating and accompanying me on visits, liaising with both the NPM bodies and the detaining agencies, and providing background materials. Also at the Human Rights Commission, my thanks to Margaret McDonald, Senior Human Rights Specialist, and to Michael White, Senior Legal Advisor, for their assistance in putting together the relevant New Zealand legislation and regulations appended to this report, and to Anna Ashton for helping to get this study off the ground. My thanks to Angela Gruar and Carolyn Swanson of Te Pou, Judi Clements, Chair of the Mental Health

Multi-Agency Group, Toni Ellis of Blackstone Chambers, to activists Anne Helm and Jak Wild and to all those who took the time to meet with me and share their thoughts on, or in some cases, experiences of, seclusion and restraint.

My sincere thanks also to all the many people who engaged with me during my visits – managers, staff, and service users alike, and to the detaining agencies for their co-operation and openness during visits, for allowing us unrestricted access and for their answers to my (many) questions. Particular thanks are due to Auckland Women’s Facility and Rolleston prison for their willingness to accommodate a visit at a very short notice, and to Desley Watkins, Senior Advisor at the Department of Corrections, for organising these, alongside all our other prison visits, and for ensuring that all the information requested (and much more!) was available to us. Thanks also to Jean-Sébastien Blanc of the Association for the Prevention of Torture (APT) for bringing me up to date with the latest on the use of restraints, to Kellie Reeve for her sage advice and insightful comments, and to Louise Finer for reading drafts of this reports and helping to make it better. Last but not least, my thanks to Janet Anderson-Bidois, Chief Legal Adviser to the New Zealand Human Rights Commission for engaging with this project from inception to completion and for her invaluable comments on drafts of this report.

Sharon Shalev

February 2017

1.

Seclusion and restraint: background, definitions, human rights standards and key principles for assessing their use

a. Background

This report examines the use of seclusion and restraint across different detention contexts in New Zealand. It is based on visits to seventeen different places of detention including prisons, health and disability units, a youth justice residence, a children's care and protection residence, and police custody suites, which took place between 26 October 2016 and 11 November 2016,¹ and on material provided before, during and after those visits, including some extensive data sets.

The majority of visits were conducted in the course of one day, and were centred around the areas where seclusion or segregation took place. Visits typically started with a brief meeting with the unit or institution's manager and key staff, followed by a visit to the relevant unit where we took some time to inspect the physical facilities and daily routines, chat to staff and, where possible, service users. Staff in each of the units visited were asked to describe in detail the individuals housed in the unit at the time, why they were there, and when they were likely to leave. This gave us a sense of who, in practice, ended up in these units. In addition to physically visiting places of detention, each of the places visited was asked to make available, ahead of the visit, pertinent documentation dating back six months. This included, for example, registers of people held in the unit and a sample of personal files, registers of use of force and restraint incidents, daily observations and so on. We also asked for details of the institution's complaint policies and registers of complaints made over the last six months prior to the visit. In prisons, we also asked for registers of disciplinary hearings ('adjudications') in order to better understand why and

1 See Appendix 1 for a list of all the facilities visited.

when segregation was used as punishment, and to get a sense of how it was used in different institutions. Finally, where this was available, we asked for data on incidents of assaults, self harm and staff injuries.²

The visits and data provided a wealth of information which this report can only capture in brief. The report focuses exclusively on seclusion and restraint related practices, and does not address other aspects of conditions of detention and the treatment of people deprived of their liberty more generally. It describes the situation observed and necessarily therefore provides a snapshot of the use of seclusion and restraint at the time of the visits. Plans, aspirations and intentions to reduce the use of seclusion and restraint which were expressed at the time of visits are not reflected in the report, though I am heartened and encouraged to learn of progress towards this goal in recent months, and of the launch of the Department of Corrections' Transforming the Management of At-Risk Prisoners review, and look forward to its findings.

b. Definitions

For the purposes of this report, 'solitary confinement' is defined as the social and physical isolation of individuals in a place of confinement for twenty-two to twenty-four hours a day.³ Though widely used in different places of detention all over the world, very rarely is this form of confinement called 'solitary confinement', as this term appears to be associated with undesirable practices of the past. Instead, depending on the detention context and their proposed aim, solitary confinement units are variously known as 'segregation', 'isolation', 'seclusion', 'de-escalation', 'separation', 'high security', 'supermax' and 'special management' units, to name but a few terms used in this context.

In New Zealand, the terms most commonly used in the different detention settings visited for the purpose of this review were: 'segregation' (of which there are several types, discussed in the following section) in prison settings; 'seclusion', 'de-escalation' or 'low stimulus' in health and disability settings; and, in children and young people's care and protection and youth justice residences, 'secure care' and 'time out'.

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- 2 Unfortunately, this data was not readily available from all the detaining agencies, and is therefore not reviewed here. Once obtained, the data on staff assaults should be examined in more detail.
 - 3 This definition is based on the Istanbul Statement on the Use and Effects of Solitary Confinement (2007) (Full text available at: www.solitaryconfinement.org/Istanbul) and the Mandela Rules. It is intended to include instances where individuals are not held in a room or a cell for 22-24 hours, but are still separated from others. For example, as was the case regarding regulations in children and young people's residences which required those who were held in the Secure unit to spend the majority of the day outside their Secure room (but still within the confines of the Secure unit and in separation from others).

Notwithstanding any minor differences, this review uses the terms 'isolation', 'segregation', 'separation' and 'seclusion' interchangeably with 'solitary confinement', as defined above. It should be noted that in some health and disability facilities, confinement occurred in a physical setting that included more than one room, but in circumstances which still constituted isolation and segregation from other patients and members of the wider community and the usual routines of the facility. These circumstances have been considered for the purpose of this review.

c. Seclusion and restraint: health effects and human rights standards

Solitary confinement typically involves three elements: social isolation and limited, if any, 'meaningful human contact' (as defined in Mandela Rule 44); monotonous physical environment, offering reduced access to sensory stimulation; and, increased institutional control of all aspects of the individual's daily life, affording them limited personal autonomy. As social beings, each of these elements is potentially damaging to us. Together, they create a toxic mix which has been shown by studies dating back to the 19th century to adversely affect the health and wellbeing of those subjected to it. The reported psychological effects of solitary confinement range from acute to chronic and include anxiety, panic, chronic depression, rage, poor impulse control, cognitive disturbances including poor concentration and confused thought processes, perceptual distortions including depersonalisation and hallucinations, paranoia and psychosis.⁴ Studies have demonstrated physiological symptoms and effects too, including migraine headaches, heart palpitations, back and other joint pains, gastro-intestinal and genito-urinary problems, excessive sweating, insomnia, deterioration of eyesight, lethargy, dizziness, weakness and profound fatigue, feeling cold, poor appetite, weight loss, diarrhoea, tremulousness and aggravation of pre-existing medical problems.⁵ Emerging research in the field of neuroscience demonstrates that solitary confinement disrupts brain activity, potentially leading to changes in the structure of the brain.⁶ Rates of self-harm

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- 4 Shalev, S. (2008) *A Sourcebook on Solitary Confinement*, Mannheim Centre for Criminology: London; Grassian S. (2006) Psychiatric effects of solitary confinement. *Journal of Law and Policy*, 22:325–383; Haney C. (2003) Mental health issues in longterm solitary and supermax confinement. *Crime & Delinquency*, 49(1):124–156.
- 5 Shalev, S. (2014). 'Solitary Confinement as a Prison Health Issue'. In: Enggist, S., Moller, L., Galea, G. and Udsen, C., (Eds.) *Prisons and Health: a World Health Organisation (WHO) guide to the essentials in prison health* (2nd edition), Copenhagen: WHO Regional Office Europe. pp27-35; Grassian S. (2006) Psychiatric effects of solitary confinement. *Journal of Law and Policy*, 22:325–383.
- 6 Pappas, S. (2012) Mystery of How Social Isolation Messes with Brain Solved. *Life Science*, September 13, 2012.

and suicide, which are anyway higher in prison than they are in the general population, are even higher in solitary confinement units.⁷

If solitary confinement can be damaging to those with no previous history of mental health issues, individuals with pre-existing mental illness are at a particularly high risk of worsening psychiatric problems as a result of their isolation.⁸ Children and young people are also particularly vulnerable to the damaging effects of solitary confinement, as they are still in the process of developing physically, mentally and socially, and solitary confinement effectively 'freezes' their development.⁹

Not everyone will experience solitary confinement in the same way. Individual responses to the stresses of solitary confinement vary, "depending on the pre-morbid adjustment of the individual and the context, length and conditions of confinement. The experience of previous trauma will render the person more vulnerable, as will the involuntary nature of his/her solitary confinement and confinement that persists over a sustained period of time. Initial acute reactions may be followed by chronic symptoms if the regime of solitary confinement persists".¹⁰ Some of these reactions may subside once the person is no longer in solitary confinement, but some individuals will carry with them the damage caused by solitary confinement long after their release from solitary confinement. The damaging effects of solitary confinement are therefore best mitigated by avoiding the placement of people in isolation altogether. Where people are held in solitary confinement, this should be limited to a short and pre-defined time, during which they should be housed in decent conditions, have access to meaningful human contact and to purposeful activities, and be able to exercise some personal autonomy.

Following three decades of what seemed like an unstoppable expansion in the use of solitary confinement, especially in the United States, in recent years the practice has been attracting increasing international attention. Human Rights and professional bodies, both international and regional, begun focusing their attention on its uses and consequences, seeking ways to minimise and better

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- 7 Kaba, Fatos et al (2014) Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *American Journal of Public Health* 104.3 (2014): 442–447; Fazel S et al. (2011) Prison suicides in 12 countries: an ecological study of 861 suicides during 2003–2007. *Social Psychiatry Psychiatric Epidemiology*, 46:191–195.
 - 8 United Nations General Assembly, Report of the Special Rapporteur on Torture A/HRC/22/53 1 February 2013, par. 67-68. See also: Kupers T. (1999) *Prison madness: the mental health crisis behind bars and what we must do about it*. San Francisco: Jossey Bass; Reid W.H. (2000) Offenders with special needs. *Journal of Psychiatric Practice*, 6(5):280–283.
 - 9 American Civil Liberties Union (ACLU) (2013) *Alone and Afraid: Children Held in Solitary Confinement and Isolation in Juvenile Detention and Correctional Facilities*. ACLU: Washington DC.
 - 10 Shalev, S. (2014). 'Solitary Confinement as a Prison Health Issue'. In: Enggist, S., Moller, L., Galea, G. and Udsen, C., (Eds.) *Prisons and Health: a World Health Organisation (WHO) guide to the essentials in prison health* (2nd edition), Copenhagen: WHO Regional Office Europe. pp27-35.

regulate its use, and in some cases eliminate it altogether.¹¹

The use of restraint is similarly controversial, and the application of restraints is known to have significant adverse physiological effects on the individual. These effects and the risks associated with them are elevated by medical conditions such as asthma, obesity, intoxication and psychotropic medications, with the risk of death or injury appearing to be higher for children and adolescents.¹² In addition, people who have a history of abuse can experience restraint as a re-enactment of their original trauma (ibid.) Individuals who were restrained reported feeling a loss of their dignity and sense of autonomy.¹³ Staff also reported feeling demoralised following the application of restraint.¹⁴ The physiological risks associated with restraint include death (most commonly from asphyxiation), and physical injuries such as lesions, blood clots, sprains, and fractured bones (Mohr et al, ibid).

The emerging consensus regarding restraints is that their use can and should be reduced if not eliminated altogether, and a growing body of research over the past decade documents the development of a range of effective alternatives to the use of restraint and further undermines its use.¹⁵

The current international consensus on minimum standards for the treatment of prisoners and detainees and on what constitutes prohibited treatment, as well as the position on solitary confinement and restraints, are expressed in the revised (2015) UN Standard Minimum Rules on the Treatment of Prisoners (now renamed the 'Mandela Rules', hereafter 'the Rules').¹⁶ The Rules make it clear that solitary confinement can amount to cruel, inhuman or degrading treatment or punishment, especially for children and people with disabilities, including mental health issues. The Rules stipulate that:

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- 11 For a fuller discussion of the professional and human rights instruments relating to solitary confinement see *Sourcebook on Solitary Confinement* (cited above).
 - 12 Mohr, W.K., Petti, T.A., and Mohr, B.D. (2003), Adverse Effects Associated with Physical Restraint, 48 *Canadian Journal of Psychiatry* 5 (2003) at 330-337.
 - 13 Barnett, R., Stirling, C., Pandyan, A.D. (2012) A review of the scientific literature related to the adverse impact of physical restraint: gaining a clearer understanding of the physiological factors involved in cases of restraint-related death. *Med Sci Law*. 2012;52(3):137-42.; See also National Association of State Mental Health Program Directors Position Statement on Seclusion and Restraint. (<https://www.nasmhpd.org/content/position-statement-seclusion-and-restraint>), accessed 10 February 2017.
 - 14 Wynn, R. (2003). Staff's attitudes to the use of restraint and seclusion in a Norwegian university psychiatric hospital. *Nordic Journal of Psychiatry*, 57(6), 453-459.
 - 15 Haimowitz, S., Urff, J.D., Huckshorn, K. A. (2006) *Restraint and Seclusion – A Risk Management Guide*. National Association of State Mental Health Program Directors Report. Virginia. (Online: <https://www.power2u.org/downloads/R-5%20Risk%20Manag%20Guide%20Oct%2006.pdf>, accessed 10 February 2017); American Psychiatric Nurses Association (APNA) *Position Statement on Seclusion and Restraint* (<http://www.apna.org/i4a/pages/index.cfm?pageid=3728>), both accessed 10 February 2017.
 - 16 For a guide on interpretation of the revised Mandela Rules see: Penal Reform International and Human Rights Centre, University of Essex (2017) *Essex paper 3: Initial guidance on the interpretation and implementation of the UN Mandela Rules*. (<https://www.penalreform.org/resource/guidance-on-implementation-the-nelson-mandela-rules/>), accessed March 15, 2017.

Mandela Rule 43

1. In no circumstances may restrictions or disciplinary sanctions amount to torture or other cruel, inhuman or degrading treatment or punishment. The following practices, in particular, shall be prohibited:
 - (a) Indefinite solitary confinement;
 - (b) Prolonged solitary confinement;
 - (c) Placement of a prisoner in a dark or constantly lit cell;
 - (d) Corporal punishment or the reduction of a prisoner's diet or drinking water;
 - (e) Collective punishment.
2. Instruments of restraint shall never be applied as a sanction for disciplinary offences.
3. Disciplinary sanctions or restrictive measures shall not include the prohibition of family contact. The means of family contact may only be restricted for a limited time period and as strictly required for the maintenance of security and order.

Mandela Rule 44

For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days.

Mandela Rule 45

1. Solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority. It shall not be imposed by virtue of a prisoner's sentence.
2. The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice, continues to apply.

Addressing the use of instruments of restraint, the Rules stipulate that:

Mandela Rule 47

1. The use of chains, irons or other instruments of restraint which are inherently degrading or painful shall be prohibited.

2. Other instruments of restraint shall only be used when authorized by law and in the following circumstances:
 - (a) As a precaution against escape during a transfer, provided that they are removed when the prisoner appears before a judicial or administrative authority;
 - (b) By order of the prison director, if other methods of control fail, in order to prevent a prisoner from injuring himself or herself or others or from damaging property; in such instances, the director shall immediately alert the physician or other qualified healthcare professionals and report to the higher administrative authority.

Mandela Rule 48.1

When the imposition of instruments of restraint is authorized in accordance with paragraph 2 of rule 47, the following principles shall apply:

- (a) Instruments of restraint are to be imposed only when no lesser form of control would be effective to address the risks posed by unrestricted movement;
- (b) The method of restraint shall be the least intrusive method that is necessary and reasonably available to control the prisoner's movement, based on the level and nature of the risks posed;
- (c) Instruments of restraint shall be imposed only for the time period required, and they are to be removed as soon as possible after the risks posed by unrestricted movement are no longer present.

Mandela Rule 48.2

Instruments of restraint shall never be used on women during labour, during childbirth and immediately after childbirth.

Mandela Rule 49

The prison administration should seek access to, and provide training in the use of, control techniques that would obviate the need for the imposition of instruments of restraint or reduce their intrusiveness.

The Rules also reiterate that prisoners retain their basic rights and entitlements also in seclusion:

Mandela Rule 42

General living conditions addressed in these rules, including those related to light, ventilation, temperature, sanitation, nutrition, drinking water, access to open air and physical exercise, personal hygiene, health care and adequate personal space, shall apply to all prisoners without exception.

d. Key principles for the use of seclusion and instruments of restraint

Drawing on the Mandela Rules and on other international human rights law and professional guidance,¹⁷ I would set out the following key principles for assessing the use of solitary confinement:

- It must only be used to achieve a specific and well defined purpose; as a last resort when other avenues have been tried and failed; for a short a time as possible, and; in the least restrictive conditions possible.
- Where used, minimum requirements must be met and minimum standards adhered to (and preferably exceeded). Minimum entitlements include sufficient food, drinking water and health care,¹⁸ and daily access to at least 1 hour of fresh air and exercise, a telephone, and a shower. Material conditions of detention must also meet the minimum standards set in international instruments including those relating to natural and artificial light, ventilation and thermal comfort.
- Solitary confinement must not be indefinite or prolonged (longer than 15 days).
- Certain categories of people must be excluded from solitary confinement altogether, in particular children and young people, and people with disabilities, including mental health conditions.
- Decisions on the regime, material conditions and provisions that segregated people can access should be based on ongoing, individual risk and needs assessments; should ideally involve the individual concerned, and be taken by a multi-disciplinary team, and; be regularly and substantively reviewed by a different person to the one who authorised the initial placement.
- The institution's need to maintain good order or discipline in prison or to prevent patients from acting in a harmful manner in health and disability settings must never be at the expense of the individual's needs and right to be treated with respect for their inherent human dignity. The individual has a right not to be subjected to inhuman or degrading treatment or punishment. The burden is on the authorities to demonstrate that they have sought alternatives to seclusion/ restraint.¹⁹

17 See Appendix 3 for additional human rights texts and *A Sourcebook on Solitary Confinement* (2008) (cited above) for further discussion and referencing.

18 Due to time constraints, health-care provisions for secluded/segregated individuals were outside the scope of this review, but these should be looked at and assessed.

19 World Health Organisation (2005) *Resource on Mental Health and Human Rights*. WHO Europe: Copenhagen.

- Finally, safeguards must be in place. These include access to legal counsel and to monitoring bodies, rights of appeal, and a robust, confidential and accessible system for making complaints.

Similar principles apply to the use of restraints, namely that their use must be lawful, necessary and proportionate. Restraint must only be applied in cases of emergency, when all other options have been tried and failed. The least restrictive form of restraint possible must be used and then for the shortest time possible necessary to achieve the specific aim which its use seeks to achieve. Instruments of restraint must never be used as punishment, and the manner in which restraint is applied must not be degrading or painful. Some forms of restraint, including chains, irons and or other instruments of restraint which are inherently degrading or painful (Mandela Rule 47(1)) are prohibited altogether.

Using these principles to assess whether the establishments visited met international standards on conditions of confinement and treatment of individuals secluded in them, the following issues were examined for this review:

- What is the legal basis for using solitary confinement and restraint in each of the settings examined? (see Appendix 3)
- How many people spent time in solitary confinement, and for how long?
- When and why was solitary confinement used in practice? Was it used only as a last resort?
- What were the material conditions, daily regime and in-cell provisions in solitary confinement cells? Were minimum human rights standards met?
- Were individuals belonging to vulnerable groups, as defined in the Mandela Rules, found in solitary confinement units?
- How often were placements reviewed and by whom? Were reviews substantive?
- How often was restraint used? Was it used only as a last resort?
- Was a robust system enabling confidential complaints in place?

2.

Seclusion and restraint in New Zealand: findings from the data and visits

Summary of findings

Overall, data collected by the Ministry of Health and the Department of Corrections on the use of seclusion and restraint in New Zealand revealed a high use.²⁰ The data also clearly showed that ethnic minority groups, in particular Māori, were overrepresented in seclusion and segregation units.²¹ This was very concerning and needs to be investigated further. Some of the restraints which were used included forms of mechanical restraint which several jurisdictions, including England and Wales, no longer use. The use of restraint or tie-down beds in prisons and the use of restraint chairs in police custody was particularly concerning, and I was not convinced that these extreme forms of restraint were reserved as a last resort when all else had been tried and failed. Some of the long-term restrictive measures applied to a small but persistent number of people in health and disability facilities were also troubling. Management plans for these individuals appeared to be focused on variants of seclusion and restraint, rather than thinking outside the seclusion room, or 'the box', to use the old fashioned term for solitary confinement.

In prisons, the physical design and material conditions in the so-called 'At Risk units', where vulnerable prisoners were housed, were mostly identical to

20 Some of the data examined here is not regularly collated by detaining agencies and was put together especially for this report, using different data sets from different resources, and should accordingly be viewed with caution.

21 For further discussion of disparities in mental health and strategies to reduce the use of seclusion for Māori see Te Pou's website: <http://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102>, and the Mental Health Foundation <https://www.mentalhealth.org.nz/>.

those in other solitary confinement units. Given that expert opinion²² and the Mandela Rule 45(2) explicitly prohibit the placement of prisoners with physical or mental disabilities in solitary confinement, it could be argued that these units, as they operated at the time of the visits, breached international standards by their very nature. The deprivation of social interaction which is inherent in all solitary confinement practices, was often made worse by the deprivation of other provisions which could have helped to mitigate the harmful effects of seclusion, including restrictions on family visits, in-room provisions such as books, hobby and craft materials or a TV set, and the generally very limited regimes. Review processes were not always robust, and some stays in restrictive conditions were far too long.²³

a. The prevalence of the use of seclusion and restraint in New Zealand

The prevalence of segregation and forms of restraint in Corrections

Segregation

The use of segregation in prisons across the country, according to data provided by the Department of Corrections, was high. In the year to 30 Nov 2016, there were **16,370** recorded instances of segregation in New Zealand. With an average prison population of 9,798 people, this equals 167.1 instances of segregation per 100 prisoners.

To put these numbers in context, in England and Wales the rate was 36.9 segregation instances per 100 prisoners,²⁴ meaning that, on average, New Zealand segregated prisoners over four times more often than England and Wales. This was a surprising finding, especially considering that the use of segregation in England and Wales itself was found to be high.²⁵

22 Including, inter alia, the UN Special Rapporteur on Torture (2011) and the Istanbul Statement on the Use and Effects of Solitary Confinement (2007).

23 It is worthwhile noting that many of the concerns raised in this report have been previously raised by, among others, the UN Subcommittee on the Prevention of Torture following their 2013 visit (see SPT report of 28 July 2014, UN DOC CAT/OP/NZL/1), and successive reports by New Zealand's NPM bodies, indicating slow progress.

24 Using the same definitions and measurements, in England and Wales, between 1/1-31/3/2014, there were 7,889 segregation events with an average total prison population of 85,509 (National Offenders Management data, cited in Shalev, S. and Edgar, K. (2015) *Deep Custody: segregation units and close supervision centres in England and Wales*, London: Prison Reform Trust p148). Note that, as with the New Zealand data, these segregation events included stays of less than 24 hours, usually while the prisoner was waiting for their adjudication hearing.

25 See discussion in Shalev & Edgar, *Deep Custody* (2015).

Of the 16,370 stays in segregation, 1,314, or 8 per cent lasted for 15 days or longer, the maximum duration stipulated in the Mandela Rules. This equates to 13.4 instances of segregation of 15 days or more per 100 prisoners.

Women were much more likely (69 per cent) than men to be segregated (269.4 instances per 100 women, compared to 159.7 instances per 100 men), and for longer times: 20.7 for instances of segregation lasting 15 days or longer per 100 prisoners for women, compared to 12.9 instances for men, (or a total of 138 instances for women and 1176 for men). By contrast, in England and Wales, there was little difference between men and women in the use of segregation: 38.1 instances per 100 of women, compared to 36.8 per 100 for men.

New Zealanders of non-European descent were much more likely to be segregated compared to their counterparts of European descent. Between May and October 2016, Māori and Pacific Islanders made up approximately 80 per cent of Directed Segregations (Management units and Disciplinary segregation). By comparison, New Zealanders of European descent accounted for a mere 15 per cent of prisoners in Directed Segregation. The picture was rather different in At Risk units, where the same ethnic groups made up approximately 54 per cent and New Zealanders of European descent made up 37 per cent of the population.²⁶

Taking all forms of segregation together, Māori and Pacific Islanders made up for approximately 62 per cent of those segregated, and New Zealanders of European descent made for 30 per cent of the segregated population. While these figures are almost identical to the representation of these groups in prison more generally (62 per cent and 32 per cent respectively), they are grossly disproportionate to Māori representation in New Zealand's population, where Europeans make for 69 per cent of the population, Māori make for 14.6 per cent, and Pacific Islanders make for 6.9 per cent of the population.

Forms of restraint

According to data provided to us by the Department of Corrections, in the six months May-October 2016, a total of 423 incidents involving the use of mechanical restraint were recorded, some involving the use of more than one form of restraint.

The recorded incidents primarily involved the use of handcuffs, but they also included five uses of a restraint bed; 9 uses of spit hoods; 16 uses of waist restraints, and; three uses of head protectors. This data needs to be approached

²⁶ Analysis of data provided to this review by Corrections, though the number of instances recorded compared to the total number of segregations instances set above suggests that these datasets are incomplete.



Restraint bed

with caution: we found a number of discrepancies in the recording of the type of restraint used, and some of the data did not align with data examined during visits. We are also unable to tell how long people could spend in restraint as the end time was not noted in the data provided to us, but looking at some of the case notes describing the incident it is clear that some people remained in restraint for a long time, sometimes for several hours and even days.²⁷

The prevalence of seclusion and restraint in health and disability settings

In its Annual Report for 2015, the Office of the Director of Mental Health reported that since the introduction of seclusion reduction policies in 2009, the total number of people secluded in adult inpatient services nationally had decreased by 30 per cent, and the total number of seclusion hours had decreased by 58 per cent. This is a substantial reduction, and the Ministry of Health and District Health Boards (DHBs) should be applauded for their continuing commitment to the reduction and eventual elimination of seclusion. But despite the Ministry's commitment and an overall reduction over the last few years, the Office of the Director of Mental Health's data revealed that in 2015 the rate of seclusion in adult mental health services remained high:²⁸

“Between 1 January and 31 December 2015, New Zealand adult mental health services (excluding forensic and other regional rehabilitation services) accommodated 7,545 people for a total of 198,525 bed nights.

27 For detailed examples of the use of restraints in Corrections and some case studies see the Chief Ombudsman OPCAT finding report, *A Question of Restraint*, 1 March 2017, online at: http://www.ombudsman.parliament.nz/system/paperclip/document_files/document_files/1885/original/a_question_of_restraint_march_2017.pdf?1488315220 (Accessed 15 March 2017).

28 Some limited comparative data on the use of seclusion internationally is available in: Steinert, T., Lepping, P., Bernhardsgrütter, R. et al. Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends. *Soc Psychiat Epidemiol* (2010) 45: 889. Online at: <http://www.imhcn.org/wp-content/uploads/2015/03/Lepping-2010-seclusion-3.pdf> (Accessed 15 March 2017).

Of these people, 754 (10 per cent) were secluded at some time during the reporting period.

People who were secluded were often secluded more than once (on average 2.2 times). Therefore, the number of seclusion events in adult inpatient services (1,668) was higher than the number of people secluded.

Across all inpatient services, including forensic, intellectual disability and youth services, 1001 people experienced at least one seclusion event. Of those secluded, 69 per cent were male and 31 per cent were female. The most common age group for those secluded was 20–24 years. A total of 121 young people (aged 19 years and under) were secluded during the 2015 year, in 289 seclusion events".²⁹

It should be noted that 72 per cent of seclusion events in 2015 lasted less than 24 hours (ibid.)

The prevalence of Secure Care Unit placements in Children and Young Persons' Care and Protection residences, and in Youth Justice residences

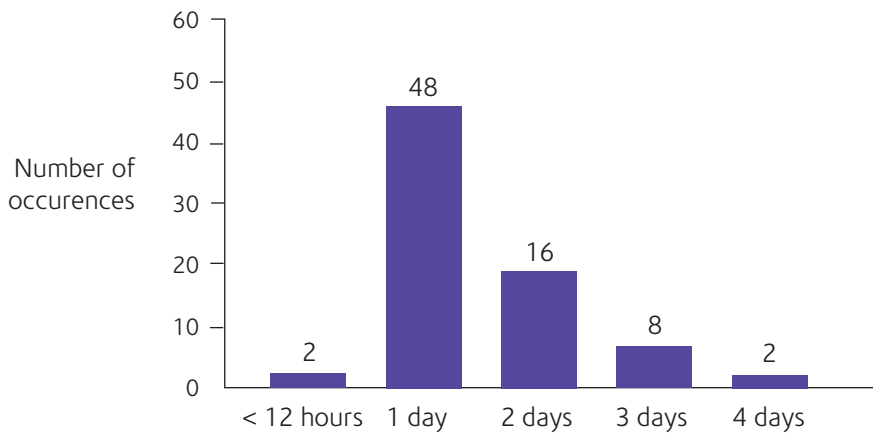
The data below is from the Secure Care Unit registers in the Children and Young Persons' Care and Protection residence and the Youth Justice residence visited.³⁰ As this data is not usually collected centrally, it was extracted especially for this report. Mechanical restraints are no longer used in Care and Protection residences or in Youth Justice residences. Instead, at the time of the visits residences used the Non-Violent Crisis Intervention (NVCi) system of personal restraint, and were planning to move to the Managing Aggression and Perceived Aggression (MAPA) which focuses more on de-escalation techniques. These were not examined in this report.

Data for Secure Care Unit stays in the Care and Protection residence indicated that between May and October 2016, twenty children spent time in the Secure Care Unit in the course of 76 different occurrences. The duration of stays was as follows:

29 The Office of the Director of Mental Health Annual Report for 2015, Seclusion data. We were unable to gather all the data needed for this review, and have therefore decided, for the sake of consistency, to focus on nationally recorded data instead.

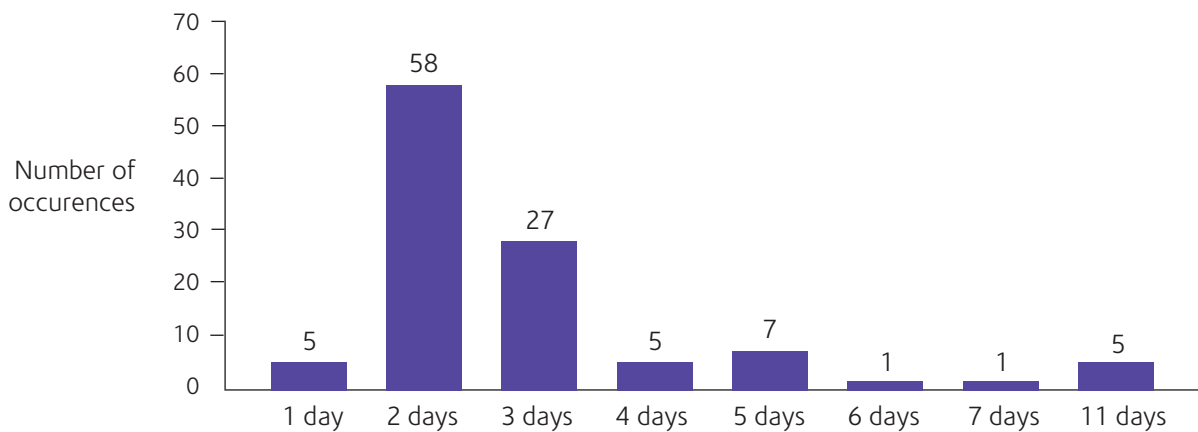
30 The term 'child' is used here to describe any person below the age of 18 (as defined in Article 1 of the UN Convention on the Right of the Child). This definition differs from that of New Zealand's Children, Young Persons and their Families Act 1989, which defines 'child' as 'any boy or girl under the age of 14' and a 'young person' as 'a boy or girl of or over the age of 14 years but under 17 years' (Section 2 of the Act). At the Care and Protection residence visited, at the time of the visit the youngest child was 11 years old, and the oldest was 15 years old.

Frequency and length of stay in a Care and Protection Residence's Secure Care Unit: May – October 2016



Seven of the twenty children housed in the Secure Care Unit had between 4 and 14 spells at the unit, together accounting for 54 of the occurrences. This finding is similar to findings on the use of solitary confinement in other contexts, demonstrating that people who experienced solitary confinement are more likely to experience it again (see for example the Office of the Director of Mental Health(2015) discussed above.)

Frequency and length of stay in Youth Justice Residence's Secure Care Unit: May – October 2016



Stays in the Secure unit in Te Puna Wai o Tuhinapo Youth Justice residence, tended to be longer. Between May and October 2016, 54 young people were housed in the Secure Care unit on 108 different occurrences, together spending 307 days in the Secure Care unit.

The prevalence of restraints in police custody

The majority of stays in police custody were short. Where stays were longer than 24 hours and the detainee spent the majority of the day in a single cell in separation from others, however, this constituted a form of solitary confinement.

Data on use of force and restraint in police custody units across the country was however collected on the Tactical Options Reporting (TOR) system. This data indicated the following for the six months May-October 2016 Restraints and Incapacitating Agents were used in a total of 144 incidents, as follows:

Tasers (6 times); Spit hoods (9 times); OC Spray (Pepper Spray) (9 times), Restraint chair (56 times) and Handcuffs.

Of the 56 uses of a restraint chair, 30 involved people detained for the purpose of mental health assessment (Code 1M) and 33 individuals were noted as 'attempted suicide' (Code 1X). The number of people with mental health issues amongst those subjected to the application of restraints was concerning and needs to be looked into in more detail as a matter of urgency.

Forty-nine per cent of all restraint incidents involved detainees of non-European ethnic origin (Māori, Pacific Islanders, Asian and African American). This, too, needs to be looked at in more detail.

b. The use of seclusion and restraints: concerns by institution type

Prisons, health and disability units, children and youth residences, and police custody suites, had issues unique to the populations which they were catering for. These are examined below.

Prisons

The Corrections Act 2004 stipulates that prisoners can be segregated for the security or good order of the prison (section 58(1)(a)); for the safety of another prisoner or person (section 58(1)(b)); for the purpose of voluntary protective custody (at the prisoner's request) (section 59(1)(a)); for the purpose of directed protective custody (non voluntary) (section 59(1)(b)); and for the purpose of medical oversight to assess or ensure the prisoner's physical or mental health. The Act (Sub part 4) also specifies when coercive powers including the use of force and restraints may be used.



At Risk cell

Depending on the reason for their segregation, prisoners could be housed in the prison's At Risk unit, in a Management Unit or in a punishment unit (sometimes called 'separates') or the 'pound' – an old fashioned term for a punishment block, essentially small, free standing, fenced and gated breeze block buildings, containing 3- 6 cells and shower stalls. These punishment blocks contained no office or other space for staff, as staff were not stationed in them, and we were told that they were only used when no other segregation cells were available.

Segregation cells³¹ – of all types – had an in-cell toilet/basin combination unit. Toilets were usually unscreened, and with two exceptions had no toilet seat or cover. Management units, which were designed for longer stays, often also had an in-cell shower, power point and a TV set, and some had an adjacent yard, with an electronic door which could be opened remotely, meaning that the prisoner could take their daily exercise without direct staff contact. At Risk cells were very similar to those in a Management unit, but with fewer furnishings and without an adjacent yard. Most At Risk units also had two or three 'round cells' or 'dry cells' which contained nothing at all other than a concrete slab with a thin mattress covered by tear-proof plastic, and a cardboard bedpan. Where the prison was in possession of a tie-down or restraint bed, it was usually located in the At Risk unit. Some At Risk cells had a glass front, and all were monitored by close circuit television.

Some of the issues and concerns around the use of segregation and restraint in the prisons visited, as identified in the course of visits, included:

Impoverished regimes and little contact with staff

Most of the segregation units visited were bleak, and lacked communal areas where congregated activities could take place.³²

31 Specifications for each cell type are listed in Part 6 ('Segregation of prisoners') and Schedule 6 of the Corrections Regulations 2005 (SR 2005/53).

32 Some of the good practice we observed in this regard is discussed further in the following section.

We observed very little movement and activity within the units, and opportunities for prisoners to engage with staff in a meaningful way or to undertake constructive activities were very limited.³³ We did not spend enough time in each unit to offer a considered comment on staff and prisoner relationships or to seek their view of each other. However, whilst we did not observe any adversarial interactions, with one notable exception (Christchurch Women's), the relationships that we did observe, appeared distant. A typical daily 'regime' included only access to a shower, telephone call and solitary exercise in a small, barren yard or cage, though there was a degree of staff discretion and some variation in practices. For example, women serving a disciplinary punishment in Christchurch Women's prison were offered no telephone calls, whereas men in Christchurch Men's, Auckland South and Mount Eden Management units could make one 5 minute telephone call daily, and At Risk prisoners in Auckland prison could enjoy up to 15 minutes daily. Management plans, which are meant to be tailored to the individual prisoner's needs and the challenges they present, lacked detail or individualized reintegration plans.

Conditions in punishment blocks

The use of segregation as a disciplinary punishment ('cellular confinement') was fairly straightforward: a prisoner broke a prison rule, attended a disciplinary hearing and was given a punishment, which could include time in a segregation unit. Data from disciplinary hearings (or 'adjudications') indicated that most punishments involving segregation time were proportionate and relatively short. However, several of the prisons visited (including Christchurch Men's, Rimutaka,³⁴ Rolleston and Auckland Men's (Paremoremo)) also had a 'pound' unit which was sometimes used for housing prisoners serving cellular confinement. It was unclear whether these stays were appropriately recorded, and the 'pounds' visited felt very isolated. Of particular concern were night time arrangements in the 'pounds', as these units had no staff on site, but were instead supervised by 'rovers' who come throughout the night who could only open door flaps but not the doors themselves. This meant that if a prisoner self harmed or attempted suicide at night time, or indeed had another medical emergency (for example, a heart-attack), there was a reasonable chance that they would not be found for some time, and even then there would be further delay whilst the 'rover' called on other staff to make their way to the 'pound' so that the cell door could be

33 Prisoner-staff relationships and human interactions more generally are an important factor in mitigating the negative effects of solitary confinement (see Deep Custody, 2015, Chapter five).

34 We were pleased to learn from that, following our visit to Rimutaka prison, staff were instructed to "ensure that punishment cells are not used as a matter of course and if circumstances present themselves where they are being considered to be used authorisation needed to be sought from the prison's Director or Deputy Director" (email communication).

opened. At Rolleston prison and Auckland Men's, the night shift visited the pound only twice per night, whereas at Christchurch men's we were told that they came five times at night.

Other areas of concern included the three punishment cells at Christchurch Men's J Block which were of reasonable size, but the showers were located in the exercise yard and we were told that this had meant that in the winter those three cells could not be used. Finally, prisoners serving disciplinary punishments did not always receive minimum entitlements. Women serving Cell Confinement (CC) at Christchurch Women's, for example, could not receive any visits or make telephone calls and were only entitled to three showers a week. This may constitute a violation of their human rights, and it may also adversely affect the families, and in particular children, of these women.

Lack of clarity on placement in, and exit from, segregation units and inappropriate cells

The reasons for placements in Management units and At Risk units were not always clear, did not always correlate to the stated purpose of the units, and stays tended to be long. Although Management units were not meant to be punitive, the problems of bleak environment and impoverished regimes identified above were very much evident in them too. I was particularly concerned about use of the 'silver cells' – small cells made entirely of stainless steel (walls, bed slab, shelves, under-bed storage space, toilet), with a narrow and gridded glass pane overlooking a corridor – in Auckland Men's Management unit. These claustrophobic cells were not fit for purpose, particularly not for segregated men who had to spend the majority of the day in them. Also of concern was the use of a section of five grill-fronted cells in one of the general population blocks for the segregation of a mixture of Management and At Risk prisoners, some of whom were mentally very unwell, in some cases for many months. These cells were small and windowless, and, though prisoners housed in them could have more personal possessions than was usually the case in segregation, these cells were inappropriate for longer stays.

Segregation of vulnerable prisoners

The most concerning aspect of prison segregation practices were the At Risk units (ARUs), where those deemed to be the most vulnerable in the prison were housed, sometimes for long periods of time. ARUs appeared to be very similar to other segregation units (by whichever name) both in terms of the material conditions, and in terms of the impoverished regimes. But ARUs also had the added disadvantage of potentially degrading practices such as requiring all

prisoners housed in them to wear anti-tear gowns ('strip gowns') and use special bedding, or housing vulnerable individuals in glass-fronted cells with nothing in them. Key decisions were undertaken by custodial staff with limited clinical input into the identification of a prisoner as being at risk of self harm, and their management thereafter (for example, setting the frequency of their observation by staff).

The key focus in At Risk units appeared to be on having as little as possible inside the cell so to minimise prisoners' access to materials which they could use to harm themselves with. These 'situational controls' were not accompanied by the necessary accompanying work with the individual on addressing the underlying issues which led to their placement there. Furthermore, in a number of the At Risk units, some of the few in-cell fixtures were not ligature resistant or tamper proof, meaning that they could be used for self-harm, making these cells unsafe. This was extremely concerning and defeats the sole stated purpose of At Risk units- to provide a safe environment for individuals who were at high risk of self-harm.

In short, the appearance, conditions and regime in most of the At Risk units we visited were as impoverished and stark as those in punitive segregation units and units for the management of difficult prisoners. Since segregation is a known risk factor for self harm and suicide,³⁵ it follows that the people at risk of such behaviour should not be segregated. This practice also goes against international human rights law standards which call on states to altogether exclude people who are mentally unwell from segregation (see for example the Istanbul Statement, the Mandela Rules and UN Special Rapporteur on Torture reports), and with current trends to ban altogether the use of solitary confinement for people with mental illness (for example in the US).

Units and cells not always used for their intended purpose

Some people were housed in At Risk or Management units because cells there were accessible to people with disabilities , or because they were newly imprisoned and very anxious, because they needed medical supervision following a medical procedure, or because of other purposes which may be legitimate, but are not stipulated in the prison rules and do not warrant the strict conditions in these units. This was particularly prevalent in the female estate. To illustrate, at the time of our visit, occupants in one At Risk unit included the following: two cells were used for women in wheelchairs simply

35 See for example: Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., Venters, H. (2014). Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *American Journal of Public Health*, 104(3), 442–447. <http://doi.org/10.2105/AJPH.2013.301742>; Shalev 2008.

because "there's no other suitable (i.e. accessible) place for them in the prison" (Officer). Three women were there because this was their first time in prison and they were scared. One woman was ready to go to the General Population but there was no bed for her, "so we need to wait for one. But if we need her bed here, she'll go to Management" (Officer). At the same unit, 'soft cells' (i.e. 'round cells' or 'strip cells'³⁶) and cells at the Separates unit were sometimes used inappropriately as an overflow of women from the ARU. We were also told, in several prisons, that prisoners awaiting transfer to a forensic unit would usually be segregated until a bed became available for them, sometimes for many months.

Discretionary practices

As well as blanket policies which were applied also when there was no obvious rationale for their application (discussed in the following section), there was a high degree of staff discretion and it was not always clear how or why decisions were made on how to manage units, when to allow or disallow certain goods and services to secluded people (from books, art materials, TV sets, curtains and strip gowns through to time out of cell, showers, food items and coffee), or adopt practices such as strip searches (in some segregation units prisoners were strip searched upon placement whereas in others they were not).

Meal times too early

With one exception (Rolleston prison) meals were served much too early, with most facilities serving dinner as early as 15:30. These timings were inappropriate for adults, and the very long gap between the evening meal and the morning meal (8:00-8:30) meant that some individuals, in particular those who did not have access to canteen goods (either because they had no money to purchase them or because their disciplinary punishment included a loss of canteen purchases), could remain hungry.

Food was served to segregated prisoners through a hatch / flap in their cell door, and had to be consumed inside the cell, often in close proximity to an open (cover-less) toilet. This was bad practice and unpleasant for everyone, but potentially particularly problematic for Māori prisoners.³⁷

36 These are essentially barren cells with nothing but a concrete slab and a mattress. Some have no sharp corners, hence the term 'round'. Round cells (also called 'strip cells') are typically monitored by CCTV and some also have a glass wall, or large glass windows to facilitate observation of the prisoner.

37 I have been informed by the Human Rights Commission's Cultural Advisor that this practice is particularly problematic from a cultural perspective, as in Māori culture food occupies a specially sacred place and the area where it is prepared, and the area where it is consumed, must be kept strictly separate to avoid and danger of cross contamination.

We also observed a noticeable variation in the quality and quantity of food served in the facilities we visited despite standardised menus now being offered throughout the prison estate. In most At Risk units food was served in paper plates and with cardboard cutlery as a matter of policy, and in some prisoners were only offered finger food, regardless of their individual risks and needs.

Health and disability units

The physical place where patients and residents in health and disability units could be held in separation from others is called Seclusion. Section 71 of the Mental Health (Compulsory Assessment and Treatment) Act 1993 sets out the conditions that apply when a mental health patient is placed in Seclusion. Additional safeguards are listed in Appendix 3. These include a requirement that Seclusion only be used where, and for as long as, it is necessary for the care and treatment of the patient, or the protection of other patients. Section 60 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 stipulates that a care recipient may be placed in seclusion to prevent them from endangering their own health or safety or that of others and /or where the care and wellbeing of other persons would be seriously compromised.

Some of the issues around the use of seclusion and segregation practices in health and disability units included:

The official objective of reducing seclusion was not always accepted by front line-staff

While the Ministry of Health and the DHBs' high-level commitment to the reduction and eventual elimination of seclusion was clear, the necessary change of mindset was not always evident on the ground, with some patients (or 'clients') spending much of their time in seclusion and/or restraint and some staff fearing that reduction in the use of seclusion and restraints would endanger their safety. There also appeared to be some tension over the more ambitious aim of eliminating the use of seclusion altogether. As staff in one of the units visited put it:

'I'd like to see us not use seclusion at all, but to do that we'll need more staff/ if you don't [provide more staff] staff will feel unsupported, no matter what the evidence says'. (Clinical Lead)

'I agree. I don't like seclusion. It has no therapeutic value. It's an intervention to stop violence. From my perspective, the culture is still swayed towards staff safety. Fear is a big factor' (Nursing lead).

Seclusion rooms were not always used for their intended purpose

Seclusion rooms were not always used for their intended purpose. Asked about the purpose of seclusion a mental health nurse in another unit said: 'we don't view seclusion as a particularly therapeutic tool. It's a management issue'. Another nurse conceded that: 'it's about the circumstances of the person, but also about what's happening on the unit at the time'. In one of the units visited, all three available cells (two 'designated' seclusion cells and one used for overflow) were occupied by people who were 'transitioning and here to sleep'. In another unit, only one of five rooms was officially designated as a seclusion room, but all were identical in appearance and of the four which were occupied at the time of our visit, all appeared to be used for the purpose of keeping individuals separated from others: one man was 'transitioning' back to the main unit, another was a very long term patient who had a bedroom in this unit as well as in the main unit, a third patient, a woman, had been at the unit for over two months because of 'inappropriate behaviour', and the fourth patient 'sleeps here because there is no room for him in the main unit'. This was not good practice. In yet another unit we were told that placements in the low stimulus area were "usually driven by perceived dangerousness; actual assault on staff; overstimulation; risk of escape and overcrowding". Overcrowding is not a justifiable reason for locking up a patient in a small, barren room with no personal belongings for days on end, nor is it provided for under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (section 71(2)).



Seclusion room in a health and disability unit

Stark physical environment and lack of patient control over their environment

In all units visited, seclusion rooms resembled prison segregation cells, and were mostly barren other than a mattress and bedding. In many of the units visited patients had little control over their environment – for example light switches and blind controls were located outside the room and could not be operated by them. Where some control was given to service users, for example, allowing residents of one health and disability unit

to choose the colour scheme for seclusion or de-escalation rooms, some of the colour choices made (for example, deep purple) may not be ideal for an area set aside for calming down and de-escalation purposes. Units were mostly in a reasonable state of repair (indeed, two were recently refurbished), but the ICU at Te Whare Ahuru (Hutt Valley DHB) could do with an update.

Lack of personal belongings and things to do

Most seclusion rooms had none of the patient's personal belongings, and patients were offered very few, if any, activities, typically no more than a short time in a barren outdoor yard or in a so-called 'day room' containing a table, a chair and a TV set behind a protective screen. This was contrary to MOH guidelines (2010) proposing that giving patients access to personal belongings and things to occupy themselves with was a desirable practice. Many practices were discretionary. Asked if patients could have a book in one mental health unit, the nurse replied that: "it depends on the client. It's unusual to give them too much property. If someone is able to concentrate on reading a book, they would most likely be out [of seclusion]".

Insufficiently detailed recording

The statistical data for restraint incidents did not record the reason for use of restraints. Furthermore, incidents involving the use of restraint were not collated and analysed nationally.

Children and Young Persons' Care and Protection residences and Youth Justice residences

The physical space where children could be held in separation from other children in a care and protection residence is called a Secure Care unit. Section 368 of the Children, Young Persons and their Families Act 1989 stipulates that a child or a young person may be placed in the Secure Care unit of a residence only if such placement is necessary (a) to prevent the child or young person absconding from the residence or (b) to prevent the child or young person from behaving in a manner likely to cause physical harm to that child or young person or to any other person.

Some of the issues around the use of seclusion in Children and Young People's Care and Protection and Youth Justice residences included:

Children and young people were held in separation from others

My key concern with both types of facilities visited was the very fact that they had a 'Secure Care' unit where children and young people could be held in separation from others, even if for relatively short periods. As previously noted, international human rights law and principles of good practice call for a complete prohibition on the use of solitary confinement with children.

Insufficient safeguards

I was also concerned to find that the call-bell system in the Secure Care unit in the care and protection residence was not working. Not only was this a serious failing, it also pointed to wider issues: insufficient safeguards; overreliance on staff availability (previously discussed); acceptance of unacceptable situations (e.g. a child having to wave their hands in the air or bang on a door to attract attention); and for the different monitoring bodies who visited the unit but did not observe this shortcoming.

Drab conditions and prison-like appearance

Secure Care unit rooms in both facilities were barren and drab, with nothing to distinguish them from prison segregation cells in adult prisons. The Secure Care unit in the care and protection residence also had two 'timeout' rooms which contained nothing but a concrete slab. In the youth justice residence, the 'timeout' rooms were adjacent to the general units, but they, too, contained nothing other than a slab and had no call bell, and I was concerned to hear that these rooms are sometimes used as bedrooms. Rooms had no curtains and in the Youth Justice residence, young people could not access pencils inside their rooms.



A Secure unit room in a Children's care and protection residence

We were told that the reason for this was to prevent them from 'tagging' or drawing graffiti in the room, but this also meant that they were unable to, for example, do homework or write when they were inside their room. This seemed counterproductive and unnecessarily harsh.

Police custody suites

Police custody suites mostly accommodated detainees for relatively short periods lasting from a few hours and up to 48 hours,³⁸ but this time was mostly spent alone with nothing to do in an empty cell containing a metal toilet/basin combination unit or, if a person was in a 'high-risk cell', only a cardboard urinal. The use of restraints in police custody is regulated under section 41 of the Crimes Act 1961. Some of the issues identified included:

Insufficient kit

In both units visited we were told that the policy was not to give detainees more than one blanket – in Wellington Police custody suite we were told that this was the case because they did not have enough kit, and in Manukau police suite, where there was no shortage of kit, we were told that this is to ensure that there are always enough clean blankets ready for use. Bearing in mind the problem of poor temperature control in Wellington police (discussed later), this was problematic. Also in Wellington, detainees were provided with pillows which were, as one officer commented, "plastic and not very nice, and in short supply".

No clear minimum entitlements

No clear minimum requirements were set for the provision of exercise, shower, telephone calls, visits, in-cell provisions including books, and so on.³⁹ "They have a right to speak to a lawyer, anything beyond that is at our discretion" (Officer). Another officer explained that "Over the weekend I try to give them showers, but there is no guarantee. We will provide soap and towels".

Inappropriate conditions and Wellington police custody suite

Conditions in Wellington custody suite were more generally inappropriate. The entire suite was located underground, so that there were no windows anywhere. There was no yard. Cells had ligature proof furniture including sprinklers, but they were covered in graffiti and extremely institutional in feel. Ventilation and temperature control were poor. Cells were self contained with a toilet and a basin with drinking water, but otherwise they had nothing in them, and no activities were offered. The unit also had an 'association room' where

38 It is worth noting though that some custody suites were used as an overflow to house remanded prisoners. This was inappropriate and had meant that detainees could not access even very basic provisions such as outdoor exercise and were effectively held in conditions of strict solitary confinement.

39 The 'People in Police Detention' policy manual stipulates that telephone calls and visits be provided if practicable, but this is not a requirement. Showers are guaranteed after 24 hours but we were told during the site visits that this does not always happen in practice when custody suites are full.

detainees could spend time together during designated times, but the room was essentially a concrete space fitted with concrete tables and chairs, and an open (but screened) toilet. Four cells were designated for self-harming detainees. These cells were on camera, and were painted in light pink. The women's shower in the custody suite had stable doors which were inappropriate as they afforded no privacy, especially considering that they were located inside the custody suite. People identified as very vulnerable will be placed on constant watch with someone sitting outside their cell all the time. One officer explained that: "We try to get someone from a company [that does constant watches] but if it's an emergency it will be one of us, in which case we will sit outside the cell but as we are not mental health trained we will not engage". The policy of not engaging with detainees on constant watch needed to be reconsidered.

The custody suite in Manukau was much newer and in a better state of repair than the Wellington custody suite. A joint project with local artists resulted in nine out of the 41 cells in the custody suite being painted using original, colourful designs. The custody suite also contained five 'high risk' cells for detainees deemed to be at high risk of self-harm which only contained a concrete slab with a mattress and, two of which were 'dry cells' containing nothing at all.

Lack of privacy

Detainees could be strip searched provided the appropriate authorisation was obtained. Strip searches took part in a special holding areas which were more private than the cells – but were still covered by CCTV.



Restraint chair

Use of instruments of restraint and poor record keeping

No records were kept of when and why high risk custody cells were used, and the start and end time of the application of restraints (which were recorded) were not prominently displayed in the paperwork.

Both of the custody suites visited had a restraint chair at their disposal, and used it not infrequently (see section on prevalence). Incidents involving the use of the restraint chair were recorded on the Tactical Options Reporting

(TOR) system and provided a good level of detail about events leading to their use. However, on closer examination of a sample of incident reports, it was not always indicated on the form that de-escalation and less restrictive options were attempted first and it was not always clear why the most restrictive form of restraint, in particular the restraint chair, were selected in preference to other forms. In this context it should be noted that the UN Committee Against Torture (CAT) has recommended that the use of restraint chairs be abolished altogether as “their use almost invariably leads to breaches of article 16 of the Convention.”⁴⁰

c. The use of seclusion and restraint in New Zealand: common issues and concerns

In addition to the more specific findings relating to individual facilities discussed above, a number of common themes were evident across several types of institutions. These are addressed in the following paragraphs.

Seclusion and restraints were not always used as emergency last resort tools for the shortest time possible.

The reasons for placing any one individual in seclusion/segregation, or restraining them, were not always clear, nor was it clear that alternative, less restrictive options were explored first. Distressed behaviours were sometimes interpreted as aggressive ones, and responded to as such. A number of prisons and health and disability units across the country housed individuals who were subjected to very long periods in seclusion and/or restraint. Not only were solitary confinement and restraint not reserved as last resort short-term options in these cases, but they appeared to have become the default position and were applied for prolonged times with no clear end in sight.

Examples include a man who had been held in isolative, segregated conditions in a long-term health and disability unit for over six years, two men at another health and disability unit, both also kept in similar conditions for over six years and one of whom was also restrained in a body belt, and a self-harming prisoner who had been restrained in a tie down bed for over a month as part of a ‘behavioural management plan’. For the individuals concerned, prolonged seclusion and /or restraint (and often both) had thus become a chronic state rather than an emergency short term response to an acute situation. Decisions

40 UN Committee against Torture, for example, 23rd and 24th Sessions, *Report of the Committee against Torture: Consideration of reports submitted by States Parties under article 19 of the Convention: United States of America*, May 2000, A/55/44, para. 180(c). Article 16(1) of the CAT reads: “Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1”.

to prolong their seclusion and/or the application of restraint did not appear to be subjected to ongoing, robust external review, and it was not clear if, how and when their seclusion could be terminated. I was concerned to note that discussions of what the future held for these individuals appeared to focus on how to 'do' the seclusion/ restraint better, or differently – build a better seclusion area, a new living quarter, or design a new restraint belt. But there appeared to be very little by way of thinking about an entirely different solution to the perceived challenges that these individuals presented (for example that they self harm or that they are unpredictable).

In this context, it should also be noted that this would appear to violate principles established by the Committee on the Rights of Persons with Disabilities' (CRPD):⁴¹

Throughout all the reviews of State party reports, the Committee has established that it is contrary to article 14 to allow for the detention of persons with disabilities based on the perceived danger of persons to themselves or to others. **The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty** (emphasis added).

Stark physical environments and impoverished regimes in seclusion, secure care and segregation units

The vast majority of the seclusion rooms and segregation cells we visited- in mental health and intellectual disability facilities, in children and young persons' residences and in prisons- were stark in appearance and feel and contained few furnishings and personal belongings. With one exception, where cells/rooms had a toilet, this was a metal toilet/basin combination unit with no toilet seat or cover. Overall, there was little to distinguish between conditions in a seclusion room in a secure mental health unit, which is meant to provide a therapeutic environment and a place of healing for people who are unwell, and those in a prison segregation unit, a place of punishment for prisoners who broke a prison rule, or indeed in a children's care and protection residence where vulnerable children are housed. The prison-like environment was particularly concerning in secure care units for children, many of whom are highly likely to have suffered previous trauma and disruption. Children could spend up to three days in these cells.

41 Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities. Adopted during the Committee's 14th session, held in September 2015. Geneva: September 2015

In prisons, At Risk units also housed very vulnerable people in what can only be described as austere and basic conditions, under constant observation through a CCTV system, all of which could potentially contribute to their distress. The individuals confined in these units were only offered a very basic regime with little or no access to educational or vocational training and limited access to recreational activities. Exercise yards were barren and small, and most units had either very limited communal space for congregated activities or, in the majority of places, no communal space at all.

Outdoor areas in most of the places visited also tended to small and barren. In one mental health unit there was no equipment in the yard and patients were not provided with a ball or other ways to work out in the yard. The seclusion area in another mental health unit had a caged yard, and in another it was an outdoor small barren concrete space, covered with mesh. Yard walls in another mental health unit visited were covered with graffiti, some of which was quite offensive. The length of stay in the yard varied- there were no fixed minimum or maximum times in mental health facilities. One very long-term (six years) resident in a health and disability unit, could not access a yard daily as he was deemed to be too strong and unpredictable to mingle with others. "We try to give him weekly access but realistically he probably only gets it once a month" (Staff). This, of course, is unacceptable.

In prisons, a number of yards were also covered in graffiti, and with few exceptions all were small and mostly barren. For example, at Christchurch men's ARU, one 'yard' was an internal room with no equipment. The 'yards' adjacent to cells on the lower tier of Mount Eden's Management Unit were essentially barren internal rooms which offered neither natural light nor fresh air.⁴²

Access to basic fixtures and provisions was not always not guaranteed

In all types of institutions visited, basic necessities were not always provided including, for example, access to drinking water, natural light and means of communicating with staff whilst isolated.

No in-room drinking water

Seclusion rooms/cells in several of the facilities visited did not have access to drinking water. Rooms in the Secure Care Unit in the children's care and protection residence had a basin, but we were told that the water was not suitable for drinking. 'Round cells' at Auckland Men's and Rimutaka prisons also had no running drinking water. Instead, prisoners were provided with

⁴² It should be noted that we were told by staff that prisoners from the lower tier could access exercise yards in the upper tier during their allotted exercise period.

paper cups filled with water during meal times or “on request” (Officer). The situation was similar in health and disability facilities. In one mental health unit we were told that when someone wanted water, they could press the call button and “we will bring it [water] over, no problem”. In another unit we were told that “we bring through three 250 ml cups every time we enter, to replenish them”. In yet another mental health unit we were told that clients could ask for more water by pressing a call button.

Call bells not installed or not functioning

I was concerned to find that seclusion rooms in several health and disability units and in the Time Out room in the Secure Care Unit at the Youth Justice residence, had no call bell or other means for patients and residents to alert staff. We were told that an intercom system stayed on whenever the rooms were occupied, but it could be turned off by staff: “the intercom system will stay on so that we can hear them, but if someone rumbles on, we can turn it off” (Mental Health nurse). In the Youth Justice’s ‘Time Out’ room, the young person would have to “bang on the door” to get attention (staff). Rooms in the Secure Care Unit in the children’s Care and Protection residence did have a call bells, but worryingly, they did not work and we were told that the system “hasn’t worked for years”. A child wanting attention, we were told, would have to “wave their hands in the air to draw our attention ” (staff). We were told that rooms had microphones connected to an intercom system which stayed on whenever the unit was occupied, but there was some confusion during our visit as to how the system operated and it did not appear to be regularly used.



Internal exercise yard

Limited control of immediate environment

In several of the health and disability units the light switches and blinds for each room could only be controlled from the outside. In the At Risk unit at Christchurch men's prison light switches were similarly outside the cell, and blue lights stayed on all night. At Rolleston prison, lights in 'Pound' units were controlled from the outside only. This was also the case at Auckland prison and Auckland South's At Risk units, though at Auckland South we were told that prisoners could use the call bell and ask for lights to be turned on or off at any time they wanted.

Poor temperature control

Temperature control was poor in a number of the institutions visited. For example, the de-escalation rooms at Te Whare Ahuru (Hutt Valley DHB) were too hot, whereas the air conditioning in one of the rooms in the Secure Care Unit at the Youth Justice residence was set on too low a temperature on the day of our visit, making the room very cold. The custody suite at Wellington police station, which was located underground, tended, according to officers working there, to get very cold in winter and very hot in summer. This was the case despite there being a forced air ducting system in place with sensors designed to keep temperatures within an appropriate range

Lack of privacy

Most high-risk cells in the facilities visited were continuously monitored by close-circuit cameras which covered the entire cell/room area, including the toilet, affording detainees no privacy. Examples include the ARU cells in Christchurch Men's and Christchurch Women's, and the Police custody suite in Wellington.

Lack of individual autonomy and over-reliance on the goodwill and availability of staff in the provision of basic necessities

Where these were not available in their room, access to a number of basic provisions (discussed above) was dependent on the goodwill of staff/officers/nurses. Some examples include: providing drinking water to prisoners, patients and young people who did not have access to it inside their cell/room ; responding to the hand signals of a distressed child in a Secure Care cell (as the call bell didn't work); escorting a patient to the toilet as their seclusion room/ segregation cell is not equipped with one (as was the case in seclusion room in many health and disability units and prison 'soft' and 'round' cells); providing ARU prisoners with toilet paper "as needed" (Auckland Men's); relying on prison staff to override the mechanism which only allowed for 10 or 15 or, in one

prison, only 3 flushes of the toilet daily (depending on the prison – note also inconsistency)⁴³; and relying on police or prison officers to be able and available to give a detainee their asthma inhaler when they had an asthma attack, as inhalers could not be kept in the cell (including at Auckland Women’s ARU, Auckland Men’s, and Wellington Police).

Whilst not doubting the goodwill of staff, they cannot always be available to assist and it is important to have structures and procedures in place to ensure that, to use the examples above, everyone can always access basic necessities such as drinking water and are able to alert someone in cases of emergency or distress or indeed if they need to use the toilet at night when their rooms are locked. In this respect I also note the practice of locking up patients in their bedroom at night in mental health facilities, a practice which, using the Ministry of Health’s own definition, would constitute ‘seclusion’.

Risk aversion and staff safety taking precedence

There were indications of a high level of risk aversion in the units visited, resulting in staff safety taking too much precedence over patients’ and prisoners’ comfort and rights. There appeared to be greater focus on control of individuals than on their treatment, and an anticipation of disruptive behaviour, especially in the case of a number of longer term mental health patients whose behaviours were perceived as wilful rather than distressed. In one or two cases, the management of patients appeared to have a punitive element.⁴⁴ Though some staff concerns over their own safety were of course legitimate, these needed to be considered and weighed against the individual’s needs and wellbeing, and solitary confinement must not be continued indefinitely.

Blanket restrictive policies applied

A number of standard procedures and practices which applied to all those segregated or secluded appeared unnecessarily restrictive and, when applied to those who did not require them for health or safety reasons, also unnecessarily punitive. Examples included: requiring all At Risk prisoners to wear strip gowns

43 A mechanism to limit the number of time a prisoner could flush their toilet appeared to be the norm in the prisons visited for this review. I should note that I have not encountered a similar mechanism in any of the many solitary confinement units I have visited over the years, including those in the so-called ‘supermax’ prisons in the US. Instead, most prisons have a mechanism which allows them to turn off the water supply to cells if prisoners attempt to flood their cells.

44 In some cases extreme risk aversion led to what can only be described as excessively punitive treatment, for example the management plan for one young woman who was a prolific self harmer, made use of her hearing aid and access to family visits dependent on her behaviour and compliance. We were told that this is because, in the past, she swallowed the batteries from her hearing aid, but this effectively meant that her disability was used as a tool, and we were not clear how, with two to three members of staff with her at all times, such action was practically possible.

(variously also called 'stitch gowns' or 'anti-rip gowns' – knee-length smocks made from thick, tear-proof materials), and providing them with finger food only, as was the case in several units; not permitting all women in an At Risk unit to wear a bra; requiring all patients arriving to one mental health unit from court or from prison to be placed in mechanical restraint (body belt/ cuff on side); searching all prisoners returning to their cell, even if just from the Day Room in one women's prison; strip searching all women who were serving disciplinary punishment (Cellular Confinement) in another, and; not allowing young people to have pencils in the Secure Care room. While some of these may be necessary for a short time, for a specific individual, they must not be applied as a matter of course to everyone.

Written records: some duplicates, little electronic recording and variable quality assurance

Stays in solitary confinement units across the different detention contexts were not consistently recorded, and where they were recorded, this was sometimes done manually in old fashioned large-format paper registers. Across detaining agencies, some data was recorded several times in different registers.

These inconsistencies made reviewing the data for trends, equalities and other issues of potential concern much more difficult and time consuming than necessary. This is partially evidenced also by the length of time it took to provide this review with some of the data requested.

Paperwork and case files related to individuals was of variable quality, sometimes even within the same institution, with examples of both excellent, detailed notes and notes, completed in illegible handwriting with signatures missing, across the different detention contexts. Where paper files (rather than electronic one) were kept, they were sometimes disorganised, making it difficult to access pertinent information and share information between shifts. In one mental health unit, for example, the paperwork examined was mostly of reasonable quality with detailed notes, mostly completed by nurses, but some notes were illegible, and there appeared to be some inconsistency in regime and provisions for two patients: one had a detailed management plan and access to various professionals, including an Occupational Therapist and a social worker, whereas the other patient had none. The Seclusion Authorisation Form for another patient listed a whole array of reasons for their seclusion including: requests to be secluded; homicidal; safety of self; and, needs low stimulus, making it difficult to judge the need for seclusion in that particular individual's case.

Management Plans in both mental health and prison settings were often laconic and brief, setting generic targets such as 'improve behaviour' or 'not engage in self-harm'. In prisons, the prisoner's signature was missing on several of the management plans examined, and prisoners did not always get a copy of their management plan, which seemed to defeat the point of having one. In contrast, Individual Behaviour Management Plans for Young People completed daily by Secure Care Unit staff at the Youth Justice facility visited were of excellent quality – see section on Good Practice.

The use of restraint by the police was recorded electronically on the Tactical Options Reporting (TOR). The small sample of individual incident reports involving the use of restraint chairs examined were completed to a good standard and included a detailed account of events.

Limited confidential access to written complaint mechanisms

The health and disability facilities visited provided residents with access to a telephone and free-phone numbers for District Inspectors and the Health and Disability Commissioners were either displayed on the wall or provided to residents as part of an information pack. Prisoners were similarly able to access the Inspector of Corrections and the Ombudsman's office and their telephone numbers were prominently displayed by the telephones, often in the exercise yard or 'day room'. However, with the exception of children and youth residences, which were equipped with confidential complaints boxes, seclusion areas in most of the health and disability units, prisons and police custody suites visited had no complaint boxes where people could deposit a complaint in a confidential manner. Instead, anyone wanting to make a complaint had to first ask staff for the relevant form and then hand it to them for further action. This was not good practice. Easily accessible confidential complaints boxes are a necessary adjunct to any phone based complaint avenues, and this access must be safeguarded. Where these were available for us to review, we found that the quality and promptness of responses to complaints received were variable as were processes of quality assurance.

d. Good practice examples

Though the general issues of concern identified above were present in many (and, in some cases, all) of the units visited, there were also pockets of good practice. What follows are good practice examples observed in either one or a number of the units visited (but not in all or even most), joined together to paint a picture of what good practice looks like in a solitary confinement unit.⁴⁵ These good practice examples can be used by the different detaining agencies as learning points for improving current practices.

People are provided with good information on unit routines and expectations on arrival

In one health and disability unit, newly arrived patients arriving to the de-escalation unit received a welcome pack with toiletries, a pen, a notebook, information on daily routines and activities available in the unit and an information booklet on the complaints system, peer support and so on (Te Whare o Matairangi). Newly arrived residents at Haumietiketike Intellectual Disability Secure Inpatient unit were also provided with 'housekeeping guidelines' setting out expectations and the unit's daily routines, as well as illustrated guidance on making complaints. The Mason clinic provided families of patients with a good information booklet on what to expect. Women segregated in Auckland Women's Management and Separates units were provided with an induction booklet containing detailed information on unit rules, routines, and on the women's entitlements.

Beds are kept for patients/prisoners in their sending unit

In a number of units (though not all), where patients were secluded, the bedroom they were originally allocated in the general units was kept for them (Te Whare o Matairangi). This was also the case in a number of prisons where the stay in segregation (usually to serve a disciplinary punishment) was expected to be short, and where the prisoner was currently residing in a forensic facility. Keeping the person's original bedroom / cell for them during their seclusion reasserts an expectation that seclusion is a short, temporary state of affairs, and it also ensures that patients/prisoners do not spend longer than necessary away from the general population solely because no beds are available for them back there. Staff at the ARU in Christchurch Women's went a step further and checked on women once they were back in the general population. This was excellent practice.

⁴⁵ Additional good practice examples and advice on strategies to reduce the use of seclusion and restraint can be found on Te Pou's excellent website. Though specific to mental health settings, these can be adapted to other detention settings: <http://www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102>



Decorated exercise yard

Cells/rooms offer a safe and healthy physical environment and sufficient provisions

A good segregation cell or seclusion room should be clean; in a good state of repair; have a window with a view, which can be opened for ventilation; good fixtures and provisions, and; allow individuals a degree of control of their immediate environment. Exercise yards and outdoor areas should be of a good size, offer some protection from the elements, contain exercise equipment, a sitting area and some greenery.⁴⁶

None of the units we saw offered all these elements, but many offered one aspect or another. This was a good start, but more needed to be done. Cells in the Management Unit in Auckland South prison had good fixtures and provisions including a couple of power points, a kettle, a television, and ample storage space. Prisoners were provided with a writing pad, pen and envelope on arrival, and could access art supplies with a manager's approval. Secluded patients at Te Whare o Matairangi mental health unit could operate their own window blinds, and the Tawhirimatea Rehabilitation unit was spotlessly clean. One of the long-term residents in Haumatiketike unit had a bedroom, an activities room, and a vegetable patch. Cells in the Management unit at Auckland Women's prison were of good size and well furnished, with a window looking out to some trees and

⁴⁶ For recommended design features and minimum size requirements see: International Committee of the Red Cross (ICRC): *Water, Sanitation, Hygiene and Habitat in Prisons*, ICRC, Geneva <https://www.icrc.org/eng/assets/files/publications/icrc-002-4083.pdf>; UNOPS (2015) *Technical Guidance for Prison Planning: Technical and operational considerations based on the Standard Minimum Rules for the Treatment of Prisoners*; UNOPS HQ Copenhagen, Denmark https://www.unops.org/SiteCollectionDocuments/Publications/TechnicalGuidance_PrisonPlanning_2015.pdf



Decorated police cell

grass, a separate shower and toilet with a modesty screen, and an in-cell power point. Cell call bells were checked every week, and the exercise yard had a stationary bike and a basketball hoop. The exercise yard in the Management unit in Rimutaka prison similarly had some fixed exercise equipment, and toilets had a modesty screen. The At Risk unit at Christchurch Women's had a small garden which women could enjoy during their out of cell time. The unit's walls were beautifully decorated with murals painted by a former resident of the unit. Doors to the individual yard attached to cells on the top tier of the Management Unit at Mount Eden Correctional Facility remained open throughout the day, enabling detainees to spend as much time there as they wished. The exercise yard in the Secure Care unit at Te Puna Wai o Tuhinapo Youth residence was large, had a basketball hoop and overlooked some trees and greenery. The custody suite at Manakau police included nine cells which were painted by local artists using themes they chose, following a competition judged by the Justice Minister. The resulting wall painted art really brightened up the unit and sent a positive message to both detainees and staff. Also at Manukau, detainees could borrow a book from a small selection of books held by custody staff.

Individuals are able to engage in varied daily regime activities

Whilst most of the facilities visited only offered very limited regimes for segregated / secluded people, there were some positive efforts to engage people in some form of activity. At the Mason Clinic, the default position was for secluded people to come out of their room and eat their meals by a table. This allowed the patient to spend some time outside their small rooms and engage, and presented staff a good opportunity to interact with them and assess how

they functioned in a normalised situation. Children in the Secure Care Unit in Epuni Care and Protection Residence remained outside of their seclusion room between 8:00-20:00 every day, during which they were expected to follow a daily timetable which included educational, recreational, and house-keeping activities as well as time on the yard or engagement with staff. Where possible, women at the At Risk unit at Auckland Women's could associate with others (of the same legal status) in the Day Room which was brightly painted and equipped with a television, books and a selection of board games.

Progression out of segregated environments is supported by multidisciplinary work and family involvement

There was a degree of multidisciplinary work in most of the prisons visited, especially in reviewing the segregation of At Risk prisoners. These reviews typically involved custodial staff, health and mental health staff, occupational therapists and representatives from the community mental health facility. For example, weekly meetings were held to discuss prisoners with complex needs at Auckland Men's, which included mental health, education and custodial staff, as well as representatives from the Mason Clinic. Similarly, weekly High Risk Assessment Team (HRAT) meetings which included Mason Clinic staff, psychology, site nurses, site doctors, social worker and unit staff meet once a to discuss all the women at the At Risk unit in Auckland Women's prison. Christchurch Men's also had good multidisciplinary work with monthly Complex Case Meetings to discuss all ARU residents and long-term segregated prisoners. All the women at the At Risk unit in Christchurch Women's prison were assessed daily by a multidisciplinary team which included nursing staff, senior custodial staff, unit staff and the prisoner herself. Segregation review hearings in Auckland South prison similarly included the prisoner himself as well as a cultural representative, mental health practitioner and custodial staff.

In one Health and Disability Unit (Haumietiketike) family members were invited to participate in six monthly reviews, which also included the patient's care team, occupational therapist, psychology and psychiatry. This, and in particular the involvement of the patient's family, was excellent practice.

Staff know the individuals in their care

With one notable exception, staff in all the facilities we visited demonstrated good knowledge of the individuals in their care, though, as noted earlier, staff-detainee relationships appeared to be distant. Segregation and seclusion units in most of the prisons and health and disability facilities had display boards listing all the individuals who were in the unit at the time, with varying degrees of detail. In most cases, boards were appropriately displayed out of general view

and included information about the individual's age, legal status, needs and preferences, for example whether they had any special dietary or health needs, the date of their arrival at the unit and their review dates, and the name of their personal officer or nurse. A good quality board also helped with staff handover and ensured that key information about the individual was passed on.

Individualised work with prisoners / patients/ residents is taking place to address their needs and challenges

As well as a Management Plan, prisoners at Auckland South's Separation and Reintegration Unit (SRU) set out their goals and plan to achieve them in the 'Prison Support Plan' - a compact of sorts, signed by the prisoner and by staff. At Risk unit staff at Christchurch Women's kept a separate file on each of the women in the unit, where all the observations, risk assessment and daily interview notes were held. Staff in both Epuni Children and Young Persons' Care and Protection residence and Te Puna Wai o Tuhinapo Youth Justice residence clearly knew the children in their care very well, and efforts were made to get to the bottom of the events which led the child to the Secure Care Unit. These attempts included the young person's perspective and understanding of their role in these events. This meant that time in the unit could be used in a productive way rather than being an entirely wasted, or 'dead time'. Children placed in the Secure Care Unit at the Children and Young Persons' Care and Protection residence had daily management plans drawn up, which included triggers, targets and issues. Children housed in the Secure Care Unit were also required to complete progressive workbooks addressing the event/s which led to their placement there, and how they might manage their own return to the open unit, which was very good practice. Individual Behaviour Management Plans for Young People completed daily by Secure Care Unit staff at Te Puna Wai o Tuhinapo Youth Justice residence were also of excellent quality, and included relevant, detailed observations and targets for young people.

Use of force and restraints is minimal, regularly reviewed, and staff are up to date with their training

Force should only be used as little as possible, when other alternatives had been tried and failed. Where force is used, it is crucially important for staff involved and Management to review the incident and learn lessons for it. Arrangements for reviewing use of force incidents in most of the facilities visited were of reasonable quality, and of excellent quality at Mount Eden Correctional Facility. The majority (but not all) of permanent staff in both mental health facilities and prisons were up to date with their use of force / 'Calm and Restraint' training.

An easily accessible system of complaints is in place

Both health and disability facilities and prisons provided freephone numbers and reasonable access to a telephone for contacting the District Inspectors and the Health and Disability Commissioners or the Inspector of Corrections and the Ombudsman's office respectively. Patients, prisoners and residents could also access a form for making a written complaint in all the facilities visits, though confidential complaint boxes were only provided in the Children and Young Persons' Care and Protection residence and in the Youth Justice residence visited.⁴⁷ Complaint procedures were explained in an easy to understand language which included illustrations to facilitate the needs of people with learning difficulties.

47 We were informed, however, that in some residences children and young people had to ask for the complaint form.

3.

Recommendations

The right of prisoners, patients, detainees and residents to be treated fairly and with respect for their human dignity, and not to be subjected to torture and other cruel, inhuman or degrading treatment or punishment, does not end at the doors of seclusion rooms and segregation cells.

To all detaining agencies

- Force and all forms of restraint, including seclusion or segregation, must only be used when absolutely necessary, as last resort and for as short a time as possible. Decisions to use seclusion or restraint should be based on an individualised and proportionate risk-needs based approach, and be regularly reviewed.
- Minimum standards for decent living conditions and essential provisions as set out in the Mandela Rules and other human rights instruments must always be met. Specifically, cells and rooms must be of a reasonable size, clean, safe, well ventilated, well lit and temperature controlled. Basic requirements regarding access to fresh air and exercise, food and drinking water must always be adhered to across all detention contexts.
- Internal rooms cannot be considered an appropriate substitute to an outdoor exercise yard; access to fresh air and natural light should be provided in all the institutions which do not currently provide it.
- All cells/rooms must be equipped with a means of attracting the attention of staff, and these must be regularly checked to ensure that they are in good working order.
- Measures to enable detainees and patients to exercise more personal autonomy inside their solitary cells should be implemented. Examples include removing restrictions on the use of the toilet flush in prisons or control of light switches and room blinds in health and disability facilities.
- Facilities which are not fit for purpose should be decommissioned as soon as practicable. These include the Wellington police custody suite; the 'silver cells' in Auckland Men's Management Unit, and the Free standing 'pound' units in all prisons.⁴⁸
- Confidential and accessible complaint mechanisms must be closely safeguarded in all places of detention, and even more so in units where people are separated from others and thus potentially more vulnerable to mistreatment. All prisoners, detainees, patients and residents should have unlimited and unmonitored access to written complaints forms and means to submit these in a confidential manner, ideally using a secure complaints

48 We were pleased to hear from the Department of Corrections, following the drafting of this report, that a decision had been taken to decommission the 'silver cells' on 1 March 2017. This is a very welcome development. We were also pleased to learn that the 'pound' cells were now under active review and rarely used in the interim.

box which can only be accessed by a nominated member of staff, preferably someone who is not part of the treatment or custody team. People with disabilities and anyone who may have difficulties in accessing the complaints system should be provided with assistance to enable them to do so.

- Oversight mechanisms need to be strengthened, in particular with regard to placement in, and ways out of, seclusion and segregation units. These should be made proportionally more exacting as time in seclusion/segregation progresses. In the case of the 'chronic' stays in solitary confinement (in prisons and in health and disability settings), a national multidisciplinary oversight body which includes expertise from outside the detaining agencies, should be considered.
- Data on the use of seclusion/segregation/secure care units and the application of restraints should be recorded more fully and analysed for trends and protected characteristics such as age, gender and ethnic origin. The apparent overrepresentation of ethnic minorities, in particular Māori, in seclusion and segregation units in prisons and health and disability units should be investigated further as a matter of urgency.⁴⁹ Similarly, the apparent overrepresentation of women in prison segregation units needs to be investigated and addressed.
- Records should clearly and prominently: indicate the reason for the placement in solitary confinement or the application of restraint; the start and end times of the application of seclusion or restraint; record efforts to use less restrictive practices, and; record any injuries sustained in the process (to both detainees and staff), and any other interventions and observations regarding the person.⁵⁰
- Detaining authorities should consider cross-sectoral collaboration aimed at the reduction of seclusion and restraint practices, sharing learning and good practice identified across other detention contexts. For example, the Ministry of Health's seclusion reduction policies could be adapted to the prison context, and the Department of Corrections' Minimum Entitlements could be adapted for use in health and disability units and in police custody suites.

49 As noted earlier, Te Pou, the Mental Health Foundation and others are already engaged in work to analyse discrepancies in the use of seclusion across DHBs and the over-representation of Māori in seclusion, and to develop culturally sensitive alternatives. Such strategies could be expanded and adjusted to other detention contexts.

50 These and other recording requirements are helpfully listed in NZS8134.2.2: 2008 Standard 2.3 Criteria 2.3.4 of the Restraint Minimisation and Safe Practice Standard (2008), and could be adapted from health and disability settings to other detention contexts.

- Future research should seek the views and experiences of service users- patients, prisoners and residents- during their time in seclusion, segregation, or restraint. For example, did they experience their treatment as good and caring, or as degrading and punitive? Which aspects of their confinement did they find most difficult to deal with? What could be done to improve these experiences? Similarly, more work needs to be done to understand staff perceptions and concerns about the potential consequences of reducing and eventually eliminating seclusion practices. While these concerns must not take precedence over patients', prisoners' and residents' health and wellbeing, they do need to be acknowledged and addressed.

To the Ministry of Health /District Health Boards

- The Ministry of Health and individual DHBs should be applauded for their commitment to policies aimed at the reduction, and eventual elimination, of seclusion. This commitment must be supported by a reassertion of why seclusion needs to be minimised in the first place: i.e. because it is damaging, inappropriate, not conducive to the therapeutic relationship between the patient and their care givers, and because it has no therapeutic value. This can be done through further training which may also help to address staff concerns about policies to eliminate the use of seclusion.
- The physical environment of seclusion units and rooms needs to be improved. 'Low stimulus' need not mean barren and drab. Basic furniture can and should be introduced to rooms, especially where patients may spend longer than a few hours in seclusion. This can be special 'safe furniture' designed from tamper-proof materials aimed specifically for high risk patients. Patients should be allowed to keep some personal belongings and provided with something to do inside seclusion rooms.
- Call bells should always be located inside the room so that the patient always has means of communicating with staff. Light switches and blind controls should be located inside seclusion rooms unless there are compelling and temporary reasons not to do so. Mechanisms which enable staff to override patients' control can be installed to allay any safety concerns. This will help to normalise the environment and will afford the patient/client a degree of control over their environment.
- All regular seclusion rooms should have drinking water. Where water is not provided, better arrangements for providing it need to be made to ensure

ongoing access to drinking water without requiring the detained individual to have to ask for it or already stretched staff to provide it on request.

- Outdoor yards should be made more accommodating and contain, as a minimum, somewhere for the patient to sit down, and ideally also stationary exercise equipment.
- The Ministry should consider the introduction of 'Minimum Entitlements' for patients in a seclusion unit, including exercise time, access to a shower, a telephone, and family visits, similar to those issued by the Department of Corrections.⁵¹ This would enhance consistency throughout the system and, importantly, it would help to ensure that secluded individuals are able to access basic provisions which may also help to mitigate the harms of seclusion.
- Consideration should also be given to the amendment of sections 7.1 and 7.2 of the Ministry's Seclusion Guidelines⁵² which may result in the unintended consequence of prolonging stays in seclusion and reducing time out of room. The requirement in Section 7.1 for three clinicians to authorise the termination of seclusion may lead to a delay in such termination due to lack of appropriate staff, whereas the stipulation in section 7.2 that where the patient has been out of seclusion for longer than an hour their seclusion would be deemed to have ended, may inadvertently lead to staff reluctance to allow secluded patients spend longer than an hour outside their rooms, because doing so would trigger a new seclusion event with its associated paperwork. Fresh air, exercise and engagement with staff are key elements in mitigating the adverse effects of solitary confinement and as such should be encouraged, for as long as possible. The guidelines should reiterate that this is the case.
- More work should be carried out to better understand the variation in practice between the different DHBs.

51 Department of Corrections, Prison Operations Manual, section F.01 Minimum Entitlements. http://www.corrections.govt.nz/resources/policy_and_legislation/Prison-Operations-Manual/Prisoner-finance-activities/F.html

52 Ministry of Health. 2010. Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health. February 2010. The Guidelines stipulate that:

7.1 If the goals for seclusion have been achieved, a decision to end seclusion should be taken by two suitably qualified clinicians, in agreement with the responsible clinician. If the decision is made to end seclusion after hours, the delegated authority must be notified at an appropriate time.

7.2 Each episode of seclusion is deemed to have ended if the patient leaves the conditions of seclusion without expectation of return, and in any case, is deemed to have ended if the patient has been out of seclusion for more than one hour. The purpose of this is to allow a short period of evaluation out of seclusion.

To the Department of Corrections

- Individual prisons and the Department more widely need to ensure that At Risk units are not merely another form of segregation. Prisoners in these units should be offered some form of a daily regime, and health staff should be more involved with prisoners in the units, and work with them to address the issues which resulted in their placement at the unit.
- Efforts to prevent self harm should include assurance that cells are safe and free of ligature points. We observed unsafe cells with broken fittings which could be used for self harm and potential ligature points in At Risk units. This was unacceptable. As well as ensuring that the physical environment is safe, efforts should also include offering those considered to be at risk an individualised programme of treatment and support.
- The Corrections Act allows for basic regime provisions, for example education, visits, and telephone calls, to be denied to people serving a disciplinary punishment.⁵³ This runs contrary to international human rights law and should be amended. Basic provisions must always be provided.
- In my view, restraint beds are inherently degrading, and there is no justification for their continued use in prison settings. This extreme form of restraint should be removed from the menu of options available in prisons, just as it has been in health and disability settings.
- Mental health staff should engage more closely with segregated prisoners, and ensure that these prisoners are closely monitored for signs of deterioration (cf. Mandela Rule 46, requiring health staff to pay particular attention to the health needs of segregated prisoners).
- All prison staff working in Management units, At Risk units and any other unit where prisoners are segregated, should receive regular mental health awareness training. This will help them to recognise warning signs of distress and deteriorating mental health of segregated prisoners, and to better manage prisoners who are experiencing such difficulties.
- Prison managers should consider the introduction of food serveries in Management and Separates units, and enabling prisoners to leave their cell to collect their food tray from the servery. This will allow the prisoner

⁵³ Department of Corrections, *Prison Operations Manual*, section F.O1.02 Prisoners denied minimum entitlements. http://www.corrections.govt.nz/resources/policy_and_legislation/Prison-Operations-Manual/Prisoner-finance-activities/F.html

another short time outside their cell, and a degree of control over this one activity. Serveries could be staffed by prisoners from the unit, providing them with an opportunity to demonstrate improved behaviour and staff with an opportunity to assess their behaviour and ability to appropriately engage with one another.

- The Department must ensure that all forms of segregation and restraint are appropriately documented in an electronic register which is regularly quality assured and examined for trends, issues, and protected characteristics including ethnic origin, disability, age and gender. Monitoring should be done on the institutional and national levels.⁵⁴ Registers should also include a clear indication of when the segregation or the restraint had been applied and when they ended, as well as a clear summary of why it was deemed necessary to use segregation or restraint in any one case.
- Segregation documentation / forms should be less cumbersome and more focused, and review mechanisms must be strengthened to ensure that placements in a segregation unit are regularly and robustly reviewed. All documentation must be regularly quality assured for compliance with procedures and guidelines.
- The Department should consider replicating the Ministry of Health's 'seclusion reporting template', which requires documentation of alternative measures attempted, events, reasons for seclusion and so on.

To the Ministry of Social Development (Child, Youth and Family)

- Secure Care unit rooms, as observed on visits, were inappropriate for housing children and young people in a Care and Protection residence or in a Youth Justice residence. The Ministry should consider alternatives.
- All rooms where children and young people can spend any length of time locked up (including 'time out' rooms) should be equipped, as a minimum, with call bells or other means for the young person to communicate with staff, and these should be checked regularly to ensure that they are in good working order.
- Where the Secure Care Unit is used, children and young people should be

⁵⁴ In England and Wales all prisons are now required to complete a monthly record of their use of segregation to the Deputy Director of Custody as well as a quarterly review of their use of force and segregation. See PSO 1700 (Segregation) <https://www.justice.gov.uk/offenders/psos>

allowed to have some personal belongings with them including the means to study and/or do some writing.

- The 'time out' rooms at the youth justice residence are identical to Secure Care rooms and should be identified as such. These rooms must not be used as overflow due to shortage of beds.

To the police

- Though it is only intended for short stays, the physical environment in the custody suite at Wellington police meant that it was not fit for purpose, and should be decommissioned as soon as possible. Until that time, cell walls should be cleared of graffiti, ventilation and temperature control improved, and internal practice changes put in place as per the recommendations below, to ensure that minimum standards are met for all detainees.
- Detainees should be offered, as a minimum, a shower and an opportunity to get one hour of fresh air and exercise each day, and an opportunity to make a personal telephone call. Detainees should also be offered reading and writing materials, appropriate to their needs and abilities.
- Detainees should be provided with a sufficient quantity of clean bedding, including a sufficient number of blankets to keep them warm. Where necessary, these can be tear-proof.
- The number of people with mental health issues amongst those subjected to the application of restraints and the apparent prevalence of the use of restraints with people of ethnic minority groups need to be looked into in more detail as a matter of urgency.
- Restraint chairs are inherently degrading and their use could be considered to breach the prohibition against cruel and inhuman or degrading treatment or punishment. Their use should be abolished and alternative, less restrictive methods used.
- The use of force and the application of restraint should be proportionate to the risk or threat posed, and reserved as a last resort. If, as we were told, the use of more restrictive forms of restraint is symptomatic of difficulties dealing with detainees in crisis who require urgent psychiatric assistance, but this is not available, then the systemic reasons for this need to be urgently addressed by the relevant authorities. As a general rule, police cells are inappropriate

for the mentally unwell and the emphasis needs to be put on the provision of adequate facilities and services for them, rather than using police custody as a place of safety using police custody as a place of safety, just because it is there and there is an absence of anything more appropriate.

- Records of the use of restraints should include the use of high-risk (strip) cells, and clearly state the start and end time of the application of restraint and/or placement in a high-risk cell.
- Body searches must be carried out in private, and not conducted on the general CCTV feed which can be viewed by anyone in the control room.
- Police cells are inappropriate for longer stays and should only be used as overflow for housing remanded prisoners in exceptional circumstances. Where stays are longer, conditions and access to activities need to be substantially enhanced.

To the NPMs

- The bodies who make up New Zealand's National Preventative Mechanism are crucial for ensuring that all those deprived of their liberty are treated with respect for their human dignity and free from torture and cruel, inhuman or degrading treatment or punishment. As such, they have a particularly important role to play in monitoring places of detention. Nowhere is this role more important than in the most hidden part of all places of detention, namely, solitary confinement units. Training on monitoring places of detention should be better coordinated and harmonised. All NPM bodies should have refresher training in how to monitor places of detention.
- NPM members should consider the adoption of a joint approach to monitoring the use of seclusion and restraint across their different areas of responsibility⁵⁵ and promoting an agenda of reducing, and eventually eliminating, the use of seclusion and restraint across the board, in line with current international thinking.
- All NPM members should consider making their monitoring reports public.

55 For one example of a successful joint approach see the UK NPM's *Annual Report* for 2014/15 (section on solitary confinement). Online at: <http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2015/12/NPM-Annual-Report-2014-15-web.pdf>, and the UK NPM's *Guidance: Isolation in Detention*, January 2017. Online at: <http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2017/02/NPM-Isolation-Guidance-FINAL.pdf>

- Further work is needed to better understand the views and experiences of those subjected to seclusion or the application of restraint and those of staff working in solitary confinement units, and their perceptions of each other. Further work is also needed to gain a better understanding of the apparent overrepresentation of Māori among secluded populations as well as cultural aspects of seclusion and restraint.

Appendix 1

Facilities visited

Wednesday 26 October

1. Tawhirimatea Inpatient Rehabilitation Service (Capital and Coast DHB at Kenepuru Hospital, Te Korowai Whariki)
2. Haumietiketike National Intellectual Disability Secure Inpatient Service (Capital and Coast DHB at Kenepuru Hospital, Te Korowai Whariki)

Thursday 27 October

3. Rimutaka Prison

Friday 28 October

4. Te Whare Ahuru Acute inpatient unit (Hutt Valley DHB)

Monday 31 October

5. Epuni Care and Protection residence

Tuesday 1 November

6. Te Whare o Matairangi Acute and Intensive Inpatient Services (Capital and Coast DHB at Wellington Hospital)
7. Wellington Police Custody unit

Wednesday 2 November

8. Christchurch Women's Prison
9. Rolleston Prison (short visit)

Thursday 3 November

10. Christchurch Men's Prison

Friday 4 November

11. Te Puna Wai ō Tuhinapo Youth Justice residence

Monday 7 November

12. Mason Clinic Regional Forensic Psychiatry Services (various units) (Waitemata DHB)
13. Auckland Region Women's Corrections Facility (short visit)

Tuesday 8 November

14. Auckland Prison (Paremoremo)

Wednesday 9 November

15. Auckland South Corrections Facility

Thursday 10 November

16. Mt Eden Corrections Facility

Friday 11 November

17. Manukau police custody suite

Appendix 2

International human rights law on solitary confinement and restraint

(compiled with the assistance of New Zealand Human Rights Commission staff)

It is well accepted that the absolute prohibition on torture and other forms of ill-treatment has the highest standing in customary law and is so fundamental it supersedes all other treaties and customary laws.

The absolute prohibition against torture is set out in the Universal Declaration of Human Rights (UDHR), which was adopted by the United Nations in 1948 following the horrors of World War II. Article 5 states that:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

This ban on torture and other ill-treatment has subsequently been incorporated into international and regional human rights treaties. New Zealand has ratified seven of the nine core international human rights treaties including the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture and other Cruel, Inhuman or Degrading Treatment (CAT).

Article 7 of the ICCPR states:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

This is one of the few absolute rights in the ICCPR. No restrictions are permitted. It is also a non-derogable right, which means that states can never derogate from it even in times of public emergency that threaten the life of the nation. The Human Rights Committee, the United Nations body that monitors the implementation of the ICCPR, has stipulated that use of prolonged solitary confinement may amount to a breach of Article 7 of the ICCPR.

Article 7 of the ICCPR is complemented by the positive requirements of Article 10(1) which states:

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person – the penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation.

The Human Rights Committee has interpreted Article 10 to mean that detainees may not be “subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons”.⁵⁶

The Convention against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (CAT) was adopted by the UN in 1984.

Article 1 of the CAT stipulates that:

For the purpose of this Convention, the term ‘torture’ means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person....

The Committee Against Torture, a body of experts charged with monitoring the implementation of the Convention, has recommended that the use of solitary confinement be abolished, particularly during pretrial detention, or at least that it should be strictly and specifically regulated by law. Solitary confinement, when used for punishment, cannot be justified for any reason. The Committee has stated the need to “strictly regulate the use of physical restraints in prisons, (...) juvenile prisons and detention centres for foreigners with a view to further minimizing its use in all establishments.”⁵⁷

The Optional Protocol to the Convention against Torture (OPCAT), to which New Zealand is also a party, is an international human rights treaty designed to strengthen the protection of people deprived of their liberty. The OPCAT does not set out additional standards or create new rights, but assists States to implement their existing obligations at international law to prevent torture and ill-treatment in places where people are deprived of their liberty. It embodies the idea that prevention of ill-treatment in places where people are deprived of their liberty can best be achieved by a system of independent and regular visits that monitor conditions and treatment.

OPCAT creates the Sub-Committee on the Prevention of Torture (SPT). The SPT has pointed out that prolonged solitary confinement may amount to an act of torture and other cruel, inhuman or degrading treatment or punishment. They recommended that solitary confinement should not be used in the case of

56 Human Rights Committee, General Comment 21, Article 10 (Forty-fourth session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 33 (1994)

57 Report of the UN Committee against Torture to the UN General Assembly – 47th/ 48th session, A/67/44, p47

minors or the mentally disabled. The SPT has also recommended that a medical officer should visit prisoners held in solitary confinement every day, on the understanding that such visits should be in the interests of the prisoners' health. Furthermore, prisoners held in solitary confinement for more than 12 hours should have access to fresh air for at least one hour each day and that beds and mattresses be available to all, including those in seclusion. Following their visit to New Zealand SPT said the use of physical restraints is legitimate only if lawful, necessary and proportionate.

The Special Rapporteur on Torture noted circumstances where the physical conditions and the application of solitary confinement can cause severe mental and physical pain or suffering, when used as a punishment, during pre-trial detention, indefinitely, prolonged, on juveniles or persons with mental disabilities, can amount to cruel, inhuman or degrading treatment or torture.⁵⁸ The Special Rapporteur had also made clear that "there can be no therapeutic justification for the prolonged use of restraints and that such use may constitute ill-treatment".⁵⁹

In addition to international human rights law, a considerable range of other rules and standards have been developed to safeguard the right of all people to protection against torture and other forms of ill-treatment. Although not of themselves legally binding, they represent agreed principles which should be adhered to by all States and can provide important guidance. Some of the key relevant provisions are discussed below.

The Nelson Mandela Rules

The Standard Minimum Rules for the Treatment of Prisoners were first adopted in 1957. In 2015 these rules were revised and adopted unanimously by the United Nations General Assembly as the Nelson Mandela Rules (Mandela Rules).

The Mandela Rules are non-binding.⁶⁰ Rather, they "set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management."⁶¹ Furthermore, the Rules are often regarded by states as

58 United Nations General Assembly, 2011. Interim report prepared by the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, in accordance with General Assembly resolution 65/205 (A/66/268). See also Human Rights Committee, general comment No. 20, HRI/GEN/1/Rev.9 (Vol. I).

59 Reports of the Special Rapporteur on torture: A/63/175, paras. 40, 47 and 48, and A/HRC/22/53, para. 63; and A/68/295, para. 58

60 The Rules explicitly state "the preliminary observations to the Nelson Mandela Rules, underscores the non-binding nature of the Rules, acknowledges the variety of Member States' legal frameworks, and in that regard recognizes that Member States may adapt the application of the Rules in accordance with their domestic legal frameworks, as appropriate, bearing in mind the spirit and purposes of the Rules;"

61 UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), Preliminary observation 1.

the primary source of standards relating to treatment in detention, and are the key framework used by monitoring and inspection mechanisms in assessing the treatment of prisoners. Rule 1 provides:

All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times.

The centrality of the Mandela Rules is reflected in New Zealand in the Corrections Act 2004. Section 5 of the Act sets out the purpose of the corrections system and makes explicit reference to the Mandela Rules. It states:

(1) The purpose of the corrections system is to improve public safety and contribute to the maintenance of a just society by –

...

*(b) providing for corrections facilities to be operated in accordance with rules set out in this Act and regulations made under this Act **that are based, amongst other matters, on the United Nations Standard Minimum Rules for the Treatment of Prisoners;***

[emphasis added]

The Rules cover aspects of life in prisons, such as accommodation, food, bathing, and exercise. Rule 13 provides accommodation “shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation.” Rule 14 specifies how the need for natural light and air. Rules 15 and 16 discuss sanitary and bathing requirements, installations must allow prisoners to go to the toilet in a clean and decent manner and at a minimum have a bath or shower once a week at a suitable temperature. In regards to food rule 22 states food is to be provided at the usual hours and be of adequate nutritional value. Under rule 23 a minimum of one hour exercise daily in the open air, weather dependent, is to be provided. Appropriate installations and equipment shall be provided.

Prisoners must be able to make complaints. These must be promptly dealt with and in a confidential manner if requested (Rule 57). Prison administrations are encouraged to use conflict prevention, mediation, and other alternative dispute mechanism, and if a prisoner is separated measures must be taken to alleviate the detrimental effects (Rule 38).

Solitary confinement

The Rules uphold that solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible, subject to independent review, and only pursuant to the authorisation by a competent authority. Rule 43 prohibits indefinite solitary confinement, being seclusion in excess of 15 consecutive days. Rule 45 provides solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. Rule 46 outlines the role of healthcare personnel including paying particular attention to those in seclusion and report to the prison director about any adverse effects of restrictive measures. They shall have the authority to review and recommend changes to the involuntary separation of a prisoner to ensure separation does not exacerbate the medical condition or mental or physical disability of the prisoner. In accordance with rule 35, the detained person must receive this information in plain language that he or she understands. This information must additionally be provided to any legal representative of the detained person.

Restraint

In regards to restraints, Rule 45 also prohibits the use of restraints as a sanction for disciplinary offences. Rule 47 prohibits the use of chains, irons or other instruments of restraint which are inherently degrading or painful. Other restraints shall only be used as a precaution against escape during transfer or to prevent a prisoner injuring themselves or other or damaging property and only if other methods have failed. These can only be used by the direction of the prison director and they shall immediately alert qualified health-care professionals and report to the higher administrative authority. Under Rule 48 when restraints are used they shall be the least intrusive method that is necessary and reasonably available to control the prisoner's movement and imposed only for the time required and removed when the risk is no longer present. Instruments of restraint shall never be used on women during labour, during childbirth, and immediately after childbirth.

Human rights standards designed for the protection of specific groups and individuals

The numerous treaties, statements, and rules that cover solitary confinement and restraints emphasis the serious nature of this practice and the very serious negative effects it can have. The standards and rules need to be adhered to in order to ensure the negative effects do not occur or are minimal. Recognising the particular vulnerability of individuals belonging to certain groups, a number of human rights standards specifically address the rights and needs of these individuals, including children, women, and people with disabilities.

Children

Children (aged under 18 years) are identified as being as particularly vulnerable to the ill effects of solitary confinement, for whom solitary confinement may constitute cruel, inhuman or degrading treatment. Human rights standards and international human rights bodies call for an end to the practice of isolating children. Rule 67 of the 1990 United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules) specifically states that:

All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement, or any other punishment that may compromise the physical or mental health of the juvenile concerned. The reduction of diet and the restriction or denial of contact with family members should be prohibited for any purpose.

The UN Special Rapporteur on Torture noted that:⁶²

United Nations treaty bodies consistently recommend that juvenile offenders, children or minors should not be subjected to solitary confinement (CAT/C/MAC/CO/4, para. 8; CAT/OP/PRY/1, para. 185; CRC/C/15/Add.151, para. 41; and CRC/C/15/Add.232, para. 36 (a)). Juveniles are often held in solitary confinement either as a disciplinary measure, or to separate them from the adult inmate population, as international human rights law prohibits the intermingling of juvenile and adult prison populations. Regrettably, solitary confinement as a form of punishment of juvenile detainees has been prevalent in States such as Jamaica (A/HRC/16/52/Add.3, para. 211), Paraguay (A/HRC/7/3/Add.3, appendix I, para. 46) and Papua New Guinea (A/HRC/16/52/Add.5, appendix). In regard to disciplinary measures, a report has indicated that solitary confinement does not reduce violence among juvenile offenders detained in the youth prison.

The United Nations Committee on the Rights of the Child, the body that monitors the implementation of the UN Convention on the Rights of the Child (CRC), stated that any disciplinary measure must be consistent with the inherent dignity of the juvenile and with Article 37 of the CRC.⁶³

Article 37 prohibits torture or other cruel, inhuman or degrading treatment or

62 United Nations General Assembly, Report of the Special Rapporteur on Torture A/HRC/22/53 1 February 2013

63 CRC/C/GC/10, 25 April 2007. (section 89). See for example United Nations Convention on the Rights of the Child Committee on the Rights of the Child, Concluding Observations on the combined third and fourth periodic reports of Luxembourg, adopted by the Committee at its sixty-fourth session (16 September–4 October 2013). Vienna: United Nations; October 29, 2013. Report No.: CRC/C/LUX/CO/3-4

punishment on children. Detention of a child must conform with the law and be used only as a measure of last resort and for the shortest appropriate period of time. Every child who is detained “shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.”

Both solitary confinement and restraint are directly addressed by the CRC in its General Comment No 10 (2007) on Children’s rights in juvenile justice, where the CRC reiterates that⁶⁴:

Restraint or force can be used only when the child poses an imminent threat of injury to him or herself or others, and only when all other means of control have been exhausted.

The use of restraint or force, including physical, mechanical and medical restraints, should be under close and direct control of a medical and/or psychological professional.

It must never be used as a means of punishment. Staff of the facility should receive training on the applicable standards and members of the staff who use restraint or force in violation of the rules and standards should be punished appropriately;

Any disciplinary measure must be consistent with upholding the inherent dignity of the juvenile and the fundamental objectives of institutional care; disciplinary measures in violation of article 37 of CRC must be strictly forbidden, including corporal punishment, placement in a dark cell, closed or solitary confinement, or any other punishment that may compromise the physical or mental health or well-being of the child concerned.

Persons with disabilities, including mental health issues

The negative effects of solitary confinement are particularly profound for those with mental health disabilities. Solitary confinement can result in the exacerbation of an issue, and at an extreme some engage in self-harm and even suicide.

The principle of ‘reasonable accommodation’ requires detaining agencies to appropriately modify the procedures and physical facilities of places of detention

64 CRC/C/GC/10, 25 April 2007. (section 89). see for example United Nations Convention on the Rights of the Child Committee on the Rights of the Child. Concluding observations on the combined third and fourth periodic reports of Luxembourg, adopted by the Committee at its sixty-fourth session (16 September–4 October 2013). Vienna: United Nations; October 29, 2013. Report No.: CRC/C/LUX/CO/3-4

to ensure that persons with disabilities, including mental disorders and other psychosocial disabilities, can enjoy or exercise their human rights on an equal basis with others. Article 2 of the Convention on the Rights of Persons with Disabilities defines “reasonable accommodation” as:

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

The Special Rapporteur on Torture has noted the denial or lack of reasonable accommodations for persons with disabilities may create detention and living conditions amounting to ill-treatment and torture.⁶⁵

The CRPD also reinforces the prohibition on torture and cruel, inhuman or degrading treatment or punishment. Article 15 requires States to “take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.”

The Subcommittee on the Prevention of Torture has said that solitary confinement must never be used in health care settings as it segregates persons with serious or acute illness and leaves them without constant attention and access to medical services. In regards to restraints, both physical or pharmacological, the SPT regards them as forms of deprivation of liberty and should be considered only as measures of last resort for safety reasons. Their use must be subject to a strict framework as there is a high potential for abuse. Restraints must never be used for convenience.⁶⁶

The UN Special Rapporteur on Torture further elaborates:⁶⁷

The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed

the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or

65 United Nations General Assembly, Interim Report of the Special Rapporteur on Torture A/63/174 28 July 2008

66 Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent, adopted at the 27th session of the SPT (16-20 November 2015), paras. 9- 10.

67 www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.

Therefore, the Special Rapporteur calls on all State Parties to

Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as narcoleptics, the use of restraint and solitary confinement, for both long- and short-term application.

Women

The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (known as “the Bangkok rules”) were adopted by the UN General Assembly in December 2010. The rules⁶⁸ were developed to supplement and complement, as appropriate the Standard Minimum Rules for the Treatment of Prisoners and the United Nations Standard Minimum Rules for Non-Custodial Measures (“the Tokyo rules”) in relation to the treatment of women prisoners and alternatives to prison for women offenders. The rules take into account the gender specific requirements of women prisoners, including those that arise through pregnancy and childcare.

Of relevance in the present context, rule 22 states that punishment by close confinement or disciplinary segregation shall not be applied to pregnant women, women with infants and breastfeeding mothers in prison. Rule 23 states that disciplinary sanctions for women prisoners shall not include a prohibition on family contact, especially with children. Rule 24 prohibits the use of instruments of restraint on women in labour, during birth and immediately after birth.

Rule 41 requires gender sensitive risk assessment and classification of prisoners to take into account the generally lower risk posed by women prisoners to

68 <http://www.ohchr.org/Documents/ProfessionalInterest/BangkokRules.pdf>

others as well as the harmful effects that high security measures and increased isolation can have on women prisoners. Other rules, including 6 and 16, cover requirements related to gender specific health care and mental health care assessment and treatment.

Uncharged and untried detainees

Provisions of the Mandela Rules as discussed above apply to all prisoners and detainees, including people held in police custody, be it prior to being charged or as untried detainees. Of particular relevance is Rule 42:

General living conditions addressed in these rules, including those related to light, ventilation, temperature, sanitation, nutrition, drinking water, access to open air and physical exercise, personal hygiene, health care and adequate personal space, shall apply to all prisoners without exception.

Part II, section C of the Mandela Rules addresses untried detainees specifically and includes some of the following provisions:

Untried prisoners shall be kept separate from convicted prisoners, and young untried prisoners shall be kept separate from adults and shall in principle be detained in separate institutions (Rule 112); Untried prisoners shall sleep singly in separate rooms, with the reservation of different local custom in respect of the climate (Rule 113);

An untried prisoner shall be allowed to wear his or her own clothing if it is clean and suitable (Rule 115); An untried prisoner shall be allowed to procure at his or her own expense or at the expense of a third party such books, news papers, writing material and other means of occupation as are compatible with the interests of the administration of justice and the security and good order of the institution (Rule 117).

Appendix 3

The legal and administrative framework for the use of seclusion, segregation and restraint in New Zealand

(compiled by New Zealand Human Rights Commission staff)

Much of New Zealand's domestic law incorporates the international human rights standards.

The long title of the New Zealand Bill of Rights Act (NZBORA) states that it is "An Act to affirm, protect, and promote human rights and fundamental freedoms in New Zealand, and to affirm New Zealand's commitment to the International Covenant on Civil and Political Rights". Under section 9 of NZBORA every person has the right not to be tortured or ill-treated. Section 23(5) protects the right of every individual in custody to be treated with "humanity and with respect for the inherent dignity of the person".

The Crimes of Torture Act 1989 (COTA) enables New Zealand to meet its international obligations under the UN Convention Against Torture. This Act makes it a criminal offence for a public official or person acting in an official capacity to commit an act of torture, or to aid, incite, abet or procure an act of torture. Law enforcement officers and Corrections officers are included within the statutory definition of a "public official" for the purposes of the legislation. COTA defines an "act of torture" as including any act or omission by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for purposes such as obtaining information or a confession, punishing that person or coercing or intimidating them, or for reasons based on discrimination of any kind

Under the Crimes Act 1961 anyone who "has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty to provide that person with necessaries and to take reasonable steps to protect that person from injury." (Crimes Act s 151). A 'vulnerable person' is defined as "a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person." (Crimes Act s 2). Anyone who fails to discharge this legal duty may be held criminally responsible if, in the circumstances, the omission is "a major departure from the standard of care expected of a reasonable person to whom that legal duty applies." (Crimes Act s 150A(2)).

These laws apply to people detained in all types of detention facilities. Other legislation applies more specifically to particular types of detention environments and facilities, and to practices within them, including the segregation and seclusion practices and the use of restraints.

Prisons

The Corrections Act 2004 establishes New Zealand's corrections system, and is administered by the Department of Corrections.

The Corrections Act uses the term 'segregation', and defines it as an event where "[t]he opportunity of a prisoner to associate with other prisoners may be restricted or denied in accordance with sections 58 to 60" (Corrections Act s 57). The Corrections Act provides for the segregation of prisoners for the purpose of security, good order or safety (Corrections Act s 58), protective custody (Corrections Act s 59), or medical oversight (Corrections Act s 60).⁶⁹

Security, good order, or safety

A prisoner may be placed in segregation if the prison manager is of the opinion the security or good order of the prison would otherwise be endangered or prejudiced, or the safety of another prisoner or another person would otherwise be endangered.⁷⁰ If a prisoner is segregated in this way, they must be given the reasons for their segregation in writing and the chief executive of the Department of Corrections must be promptly informed. The decision to segregate someone may be revoked at any time by the chief executive or a Visiting Justice (Corrections Act s 58(3)(b)), and it must be revoked by the prison manager if there ceases to be any justification for continuing to restrict or deny the opportunity of the prisoner to associate with other prisoners (Corrections Act s 58(3)(a)). A decision to segregate expires after 14 days unless the chief executive directs for it to continue, in which case the decision must be reviewed by the chief executive at least every month (Corrections Act sections 58(3)(c) and 58(3)(d)(i)). It then expires after three months unless renewed by a Visiting Justice, who must then review it in intervals of not more than three months (Corrections Act sections 58(3)(d)(ii) and 58(3)(e)).

Protective custody

The prison manager may direct that the opportunity of a prisoner to associate with other prisoners be restricted or denied if a prisoner requests this and the manager considers that it is in the best interests of the prisoner, or if the prison

69 Corrections Act 2004 (<http://www.legislation.govt.nz/act/public/2004/0050/latest/DLM294849.html>)

70 S 58 Corrections Act

manager is satisfied that the safety of the prisoner has been put at risk by another person; and there is no reasonable way to ensure the safety of the prisoner other than by giving that direction. (Corrections Act s 59(1)). A prisoner asking to be segregated must give consent in writing and can withdraw consent at any time (Corrections Act s 59(2)(a)). If the prison manager has decided that the prisoner is at risk, the segregation may continue and the decision must be given promptly in writing to the prisoner, and the chief executive informed ((Corrections Act s 59(3)). The direction to segregate must be revoked by the prison manager if there ceases to be any justification for continuing to restrict or deny the opportunity of the prisoner to associate with other prisoners (Corrections Act s 59(4)(a)). It may also be revoked, at any time, by the chief executive, and expires after 14 days unless, before it expires, the chief executive directs that it continue in force, in which case the decision must be reviewed by them at intervals of not more than 3 months (Corrections Act s 59(4)(b)-(d)).

Medical oversight

Segregation may also be ordered if the health centre manager of the prison recommends it to assess or ensure the prisoner's health (both physical and mental health, including the risk of self-harm). (Corrections Act s 60(1)). Again, this decision must be given promptly in writing and the chief executive must be informed (Corrections Act s 60(2)). This segregation continues until revoked by the prison manager or chief executive (Corrections Act s 60(3)). The prison manager may not revoke the segregation unless advised to do so by the health centre manager (Corrections Act s 60(4)). The health centre manager must ensure a registered health professional visits the prisoner at least once a day, or twice a day if the prisoner is at risk of self-harm (Corrections Act s 60(5)).

Corrections Regulations 2005

Regulations 53-64 ('Segregation of Prisoners') of the Corrections Regulations 2005 detail the day to day application of sections 58-61 of the Corrections Act. The Regulations state that prisoners in segregation "must be detained, so far as is practicable in the circumstances and if it is not inconsistent with the purposes of the segregation direction, under the same conditions as if he or she were not subject to a segregation direction."⁷¹

The Regulations further prescribe the standards of accommodation for each 'type' of segregation, and make specific provision for the treatment of segregated prisoners.⁷²

71 Regulation 62(1) of the Corrections Regulations (2005). <http://www.legislation.govt.nz/regulation/public/2005/0053/latest/DLM315417.html#DLM315897>

72 Regulations 57-64 of the Corrections Regulations (2005)

Restraint

The use of force, non lethal weapons and mechanical restraints is addressed in Sections 83-88 of the Corrections Act 2004, and regulations 118-129 of the Corrections Regulations 2005.

Section 83(1) of the Corrections Act stipulates that:

No officer or staff member may use physical force in dealing with any prisoner unless the officer or staff member has reasonable grounds for believing that the use of physical force is reasonably necessary (a) in self-defence, in the defence of another person, or to protect the prisoner from injury; or (b) in the case of an escape or attempted escape (including the recapture of any person who is fleeing after escape); or (c) in the case of an officer, (i) to prevent the prisoner from damaging any property; or (ii) in the case of active or passive resistance to a lawful order.

Only force which is “reasonably necessary in the circumstances” (Corrections Act s 83(2)) must be used, and may include non-lethal weapons and mechanical restraints (sections 85 and 83(3) respectively) .

Restraints must not be used for disciplinary purposes and must be used in a way that minimises harm and discomfort to the prisoner (Corrections Act s 87(4)). Mechanical restraints can only be used for more than 24 hours if authorised by the prison manager and in the opinion of a medical officer the restraints are necessary to protect the prisoner from self-harm (Corrections Act s 87(5)). This authorisation must be in writing, specify the type of restraint, specify the time, and include a record of the medical officer’s opinion section (Corrections Act s87(5A)).

The Corrections Regulations further specify the types of weapons and restraints, and conditions and restrictions, and reporting on their use. Restraints which can be used include hand-cuffs, tie-down beds, wrist bed restraints, torso restraints, head protectors, and spit hoods.⁷³ Regulations specify how these are to be used and not used, for example a waist restraint may only be used around a prisoner’s waist and in conjunction with handcuffs⁷⁴. Reports about the use of restraints must be made to the manager, and then to the chief executive and Visiting Justice. (Regulation 127)

73 Schedule 5 Corrections Regulations 2005

74 Schedule 5, clause 15A Corrections Regulations 2005

Health and disability facilities

Both the Mental Health (Compulsory Assessment and Treatment) Act 1993 (the Mental Health Act) and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act) provide authorised health and disability care providers with significant powers to detain and treat patients and care recipients on a compulsory basis.

The Mental Health Act

The Mental Health Act provides health care providers with the power to compulsorily detain and treat any individual who is determined to be “mentally disordered” as defined in the Act and is considered to constitute a danger to themselves or others.

Section 71 of the Mental Health Act sets out the conditions that apply when a mental health patient is placed in seclusion. These include a requirement that seclusion only be used where, and for as long as, it is necessary for the care and treatment of the patient, or the protection of other patients. Section 71(2) provides conditions for placing a patient in seclusion. These are:

- seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients
- a patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services
- except in an emergency, seclusion shall be used only with the authority of the responsible clinician
- in an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician
- the duration and circumstances of each episode of seclusion shall be recorded in the register.

Seclusion is not specifically defined in the Mental Health Act, however the New Zealand Health and Disability Service Standards⁷⁵ define seclusion as circumstances where “a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit”.⁷⁶

75 Section 9 of the Health and Disability Services (Safety) Act 2001 requires certified health and disability service providers to meet all relevant service standards when providing health and disability services.

76 NZS 8134.0:2008 p 30

The Mental Health Act does not contain specific provisions permitting the use of restraint. However, section 122B of the Mental Health Act permits the use of force in certain emergency situations and allows the use of “such force as may be reasonably necessary in the circumstances”. If force is used pursuant to this provision, then section 122B (4) requires that the circumstances in which the force was used must be recorded and a copy of the record must be given to the Director of Area Mental Health Services as soon as practicable.

The Intellectual Disability (Compulsory Care and Rehabilitation) Act

The Intellectual Disability (Compulsory Care and Rehabilitation) Act, similar to the Mental Health Act, provides the state with powers to deprive people with an intellectual disability of their liberty in certain circumstances where they have been charged with, or convicted of, an imprisonable offence.

Section 60 defines seclusion as the “placing of the care recipient without others in a room or other area that provides a safe environment for the care recipient throughout the care recipient’s stay in the room or area but does not allow the care recipient to leave without help.” A care recipient may be placed in seclusion to prevent them endangering the health or safety of the care recipient or of others and/or seriously compromising the care and well-being of other persons. (Section 60(2)) Seclusion must comply with guidelines and must be no longer than necessary to achieve the purpose of placing the person in seclusion (Section 60(3)).

Care recipients may be restrained to prevent them endangering the health or safety of the care recipient or of others or seriously damaging property or seriously compromising the care and well-being of the care recipient or of other care recipients. When a care recipient is restrained the following conditions apply:

- a person exercising the power of restraint may not use a greater degree of force, and may not restrain the care recipient for longer, than is required to achieve the purpose for which the care recipient is restrained
- a person exercising the power of restraint must comply with guidelines issued under section 148 that are relevant to the restraint of the care recipient
- in an emergency, a care recipient may be restrained by a person who, under a delegation given by the care recipient’s care manager, has immediate responsibility for the care recipient, but that person must immediately bring the case to the attention of the care manager
- the duration and circumstances of each episode of restraint must be recorded in a register kept in accordance with guidelines issued under section 148.

All service users under both these Acts have access to District Inspectors. District Inspectors are independent lawyers appointed to protect the rights of service users, investigate alleged breaches of these rights, address the concerns of family/whānau, and monitor service compliance with the Acts. District Inspectors have powers to conduct inquiries into suspected failings in a person's treatment or management of services. They report their activities to the Director of Mental Health and the Director IDDCR. The Ministry of Health issues guideline on the activities of District Inspectors The most recent were published in 2012.⁷⁷

Standards and Guidelines

Standards for the use of seclusion and restraint are set out in the Health and Disability Services (Restraint Minimisation and Safe Practices) Standards ⁷⁸(the Standards). The stated intent of the Standards is to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. The Standards also make it clear that restraint is not a treatment in itself, but is one of a number of strategies used by service providers to reduce or eliminate a clinical risk. Restraint should only be used in the context of ensuring, maintaining or enhancing the safety of the consumer, service providers or others.⁷⁹

The Ministry of Health has also issued guidelines on "Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992" (the Guidelines). The Guidelines reflect the developing focus on strategies to reduce, and eventually eliminate, the use of seclusion in mental health settings. Prefacing the Guidelines, the Director General of Mental Health affirmed the role of seclusion as a last resort and the Ministry's commitment to reducing seclusion:⁸⁰

"Seclusion may be legally implemented under the conditions set out in the Mental Health (Compulsory Assessment and Treatment) Act 1992, but only during situations in which other methods of clinical management cannot safely be used, or as a last resort when other interventions have been used without success. ... Seclusion should be used for as short a time as possible. The decision to seclude should be an uncommon event, subject to strict review ... These guidelines reflect an ongoing Ministry of Health commitment to promote a culture wherein, over time, seclusion usage by the mental health sector will gradually decrease. I endorse these guidelines."

77 <http://www.health.govt.nz/publication/guidelines-role-and-function-district-inspectors>

78 <http://www.health.govt.nz/system/files/documents/pages/81342-2008-nzs-health-and-disability-services-restraint-minimisation.pdf>

79 Ibid, page 5

80 Ministry of Health. 2010. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

The emphasis on the need for seclusion to be a tool of last resort, used only when other interventions have failed and for a short a time as possible, is very much in line with current thinking and international human rights law standards identified in this report. Much of the substantive work in this area has been led by Te Pou o te Whakaaro Nui (“Te Pou”) a national centre of evidence based workforce development for the mental health, addiction and disability sectors.

Child, Youth and Family residences

The Children, Young Persons and Their Families Act 1989 determines how the state intervenes to protect children from abuse and neglect, and to prevent and address child and youth offending, including the use of CYF residences.⁸¹

Seclusion is known as ‘secure care’.⁸² A child or young person may only be placed in secure care to prevent them from behaving in a manner likely to cause physical harm to themselves or someone else, or to prevent them from absconding from the residence. If a child or youth is placed in secure care notice must be given within 24 hours to their parent, guardian, or someone previously having care of that child, and their lawyer or youth advocate (court appointed-lawyer). This notice must specify the reasons why secure care is being used and include information on the right to apply for a review care and the procedure for doing this.

A child or youth cannot legally be in secure care for more than one day unless approval has been granted by the court. The chief executive may apply to a court for approval of continued detention. A registrar may authorise continued detention in secure care until the application is determined. The hearing of the application is to be held at the residence if practicable. The court may grant an approval authorising the continued detention of the child or young person in secure care. It is valid for 14 days, then it must be renewed. The child or youth, their parent or guardian, or their lawyer/youth advocate may apply for a review of the use of secure care at any time.

Regulations

The Children, Young Persons, and Their Families (Residential Care) Regulations 1996 provides further detail on the rights of children and young people in residences, and operational matters such as discipline, inspections, grievance procedures, secure care and records.⁸³

81 The Children, Young People and their Families Act (<http://www.legislation.govt.nz/act/public/1989/0024/latest/DLM147088.html>)

82 Sections 367-383A, Children, Young Persons and their Families Act 1989

83 The Children, Young People and their Families (Residential Care) Regulations 1996 <http://www.legislation.govt.nz/regulation/public/1996/0354/latest/DLM225697.html>

Corporal punishment and torture, cruelty, and inhuman, humiliating or degrading discipline and treatment are prohibited. The Children, Young Persons and Their Families (Residential Care) Regulations 1996 prohibits any member of staff of a residence from using physical force in dealing with a child or young person unless that member of staff has reasonable grounds for believing that the use of physical force is reasonably necessary in self-defence or defence of someone else, to protect the child, to prevent the child damaging property, prevent the child leaving, to secure the child in secure care, or for carrying out a search. The staff member must use no more force than is reasonably necessary in the circumstances, and only applied for as long as necessary to prevent an individual harming themselves or others.

A staff member at the residence must review daily whether a child should be kept in secure care. At this review the child is entitled to be present. A child or youth cannot be confined to their room between 8am and 8pm unless it is necessary because of illness, injury, extreme emotional disturbance, or in case of emergency. A child can be confined in their room between 5pm and 8pm to enforce a sanction under a specific behaviour management programme.

Police cells

New Zealand Police are provided with specific powers to use force under various enactments. These include powers under the Search and Surveillance Act 2012, the Policing Act 2008, the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Misuse of Drugs Act and many others.⁸⁴ Each piece of legislation sets out the extent of the powers that the Police have and the circumstances in which they may be exercised. In addition, the Crimes Act 1961 contains more general legal provisions that permit the police to use force in certain circumstances. For example, section 39 of the Crimes Act covers the degree of force that may be used when executing any sentence, warrant or process or making an arrest. Section 40 covers the force that may be used when preventing an escape from lawful custody.

Sections 41 and 48 of the Act are very wide and apply to “everyone” including (but not limited to) police officers. Section 41 of the Act stipulates that everyone is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide, or the commission of an offence which would be likely to cause immediate and serious injury to the person or property of any one, or in order to prevent any act being done which he or she believes, on reasonable grounds, would, if committed, amount to suicide or to any such offence. Section 48 of the Act states that “everyone is justified in using, in the defence of himself

84 A full list of enactments authorizing use of force are included in the Police Manual.

or another, such force as, in the circumstances as he believes them to be, it is reasonable to use.”

Section 62 of the Act makes any person authorized by law to use force, “criminally responsible for any excess, according to the nature and quality of the act that constitutes the excess.”

The use of restraints by police is not specifically provided for in legislation. The practices are covered by the general legislative provisions relating to use of force referred to above and the relevant sections of the Police Manual. The manual includes specific chapters on “People in Police Detention”, “Use of Force” and “Mechanical Restraints”. These chapters provide detailed guidance and set out the operational requirements. The “Mechanical Restraint” chapter states that restraints must be used safely and humanely, and not for the purpose of cruel, inhumane or degrading treatment or punishment. When considering whether to use mechanical restraints, officers are required to first carry out an operational threat assessment using the TENR tool. This requires an assessment of the threat (eg considering the person’s behaviour, whether he or she is under the influence of drugs or alcohol) , an assessment of the exposure (the safety of the person and others, factors that may elevate risk, such as mental health condition, age, weight) the necessity to act (assess threat and exposure and determine if it reasonable, necessary and proportionate to use a mechanical restraint) and then develop a response (ensuring that the use of the restraint is necessary and proportionate given the circumstances known at the time).

Those who are restrained must be subject to monitoring. The stipulated level of monitoring is dependent on the type of restraint. Particular attention must be given to the person’s airway clearance, respiration, skin colour, circulation, range of movement/discomfort, pressure areas, hydration, changes in the person’s state which could indicate a need to review their status, swelling of the body area adjacent to the mechanical restraint, and statements by the person in respect of their condition. There is a specific section in the “Mechanical Restraint” chapter on the risk of positional asphyxia. All mechanical restraints must be removed from a person as soon as it is believed that the need for using them ceases, and in some instances, time limits on their use apply.

Only mechanical restraints approved by the National Manager: Response and Operations can be used. These are currently limited to metal handcuffs, plastic handcuffs, waist restraint belt, vehicle leg restraint, restraint chairs, and spitting hoods. The manual contains a section on each restraint; photos of the restraint, how to apply them, risk factors when deciding to use the restraint, risk factors to the person being restrained, safety rules, and tactical considerations.

For mechanical restraints deemed intrusive (spitting hood, restraint chair, and a combination of either a rear wrist and ankle restraint, or a waist restraint belt and ankle restraint, linked by plastic ties) a supervisor's authority must be obtained before use.

Tactical Options Reporting (TOR) forms must be submitted when using a spitting hood, restraint chair, a combination of either a rear wrist and ankle restraint, or a waist restraint belt and ankle restraint, or when using pain compliance. Pain compliance is defined as "the direct and intentional use of force by a constable that causes pain to the subject, usually evidenced by the subject showing and/or verbalising pain." The use of these restraints must be recorded in the police officer's notebook and custody module along with the time the restraint was used and removed. TOR forms are reviewed by a supervisor and an Inspector. Once signed off, the TOR form is 'completed' and stored in the TOR database for research and analysis purposes.

A person restrained by a spitting hood, a restraint chair, or a combination of either a rear wrist and ankle restraint, or a waist restraint belt and ankle restraint linked by plastic ties, must not be in the restraint for more than two hours unless they have been assessed by a Police Medical Officer. If a Police Medical Officer is not available a registered health professional or ambulance officer is sufficient. A POL 705 Health and Safety Management Plan for Person in Custody must be completed.

