



Seclusion and Restraint

Time for a Paradigm Shift

**A Follow Up Review of Seclusion and
Restraint Practices in New Zealand**

Dr Sharon Shalev



**NZ
Human
Rights.**

Te Kāhui Tika Tangata
Human Rights Commission

Whakatauki

Mai i mamaetanga o mua

Ka tipu te mamae o tenei ra

Mai i te mohiotanga o mua

Ko te maramatanga o te mamae

From the sorrows of the past, comes the pain of today.

In the wisdom of the past, is the understanding of the pain.



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Dr Sharon Shalev

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Commission, 2020

This report was commissioned by the New Zealand Human
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For any questions or comments, please contact:
Dr Sharon Shalev, Centre for Criminology, Oxford University, UK
Email: sharon.shalev@solitaryconfinement.org

Human Rights Commission

Level 7, AIG Building,
41 Shortland Street, Auckland
PO Box 6751, Wellesley Street
Tāmaki Makaurau Auckland 1141
Waea Telephone 09 309 0874

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Foreword

The Human Rights Commission invited Dr Sharon Shalev in 2016 to undertake a review of seclusion and restraint practices in New Zealand's places of detention. This was designed to provide an independent perspective on New Zealand's progress towards meeting its human rights obligations and where it needed to improve.

Dr Shalev undertook her initial review in co-operation with New Zealand's National Preventive Mechanism which consists of five organisations.

Four of these organisations are independent public sector watchdogs tasked with visiting and monitoring places of detention under the United Nations Optional Protocol to the Convention Against Torture (OPCAT): Chief Ombudsman, Children's Commissioner, Independent Police Conduct Authority and Inspector of Service Penal Establishments.

The Human Rights Commission is the fifth organisation and it is New Zealand's Central National Preventive Mechanism. In this capacity the Commission has several responsibilities, such as supporting the work of the other four organisations.

Dr Shalev's 2017 report, *Thinking Outside the Box?*, provided a clear pathway forward with a suite of thematic and specific recommendations for New Zealand's detaining agencies to implement. Following the release of her report, all agencies acknowledged Dr Shalev's recommendations. The Ministry of Health and Oranga Tamariki committed to implementing most, and the Department of Corrections committed to implementing some, of Dr Shalev's recommendations.

Follow-up reports are critical for ensuring the human rights standards the Government has committed to are worked towards and maintained. As New Zealand's Central National Preventive Mechanism under OPCAT, this is a fundamental concern of the Human Rights Commission.ⁱ

It has been the Commission's privilege to engage Dr Shalev to prepare this vital follow-up report which assesses the progress agencies have made in implementing the recommendations in *Thinking Outside the Box?*. It covers the period from the date *Thinking Outside the Box?* was published in 2017 to the period immediately preceding the COVID-19 pandemic in early 2020.

Dr Shalev's findings indicate that while there have been positive developments and strong commitments from the detaining agencies to reduce the use of seclusion, seclusion and restraint continue to be embedded in their practices.

i. See Association for the Prevention of Torture, written submission to the Australian Human Rights Commission Consultation, 21 July 2017 particularly 2. Coordination of the overall system at page 3

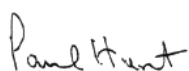
We know that the practices of seclusion and the use of restraints, particularly where they are used for prolonged periods, are inherently harmful. The impacts on the immediate and ongoing physical and mental health and well-being of those subjected to such practices are well documented. We also know that tangata whenua (indigenous people of New Zealand) are disproportionately subjected to seclusion and restraint, as are tamariki (children) and rangatahi (young people), wāhine (women) and tangata whāi kaha (disabled persons).

This has serious human rights and Te Tiriti implications. However, the remedial pathway is clear: the use of seclusion and restraint can and should be reduced, if not eliminated altogether. Proactive, preventive alternatives, based on human rights and Te Tiriti and focused on de-escalation and trauma-informed practice, must be at the forefront.

Dr Shalev has identified that meaningful change will require a paradigm shift in seclusion and restraint practices in places of detention in New Zealand. We urge the New Zealand Government to prioritise the work required to catalyse this paradigm shift.

We warmly thank Dr Shalev for the important human rights contribution she has made through *Thinking Outside the Box?* and this report. We acknowledge her efforts in collecting data against the unprecedented backdrop of the COVID-19 pandemic and the restrictions this caused. We appreciate the efforts of the detaining agencies that co-operated with Dr Shalev, especially in these difficult and evolving circumstances.

Finally, we take this opportunity to also warmly thank our partner organisations in New Zealand's National Preventive Mechanism for their indispensable work towards ensuring everyone deprived of their liberty is treated with respect.



Paul Hunt
Chief Commissioner
Te Amokapua



Paula Tesoriero MNZM
Disability Rights Commissioner
Kaihautū Tika Hauātanga



Saunoamaali'i Karanina Sumeo
Equal Employment Opportunities
Commissioner
Kaihautū Ōritenga Mahi



Meng Foon
Race Relations Commissioner
Kaihautū Whakawhanaungatanga-ā-lwi

Contents

Foreword	3
Acknowledgments	7
Executive summary	8
Introduction and general observations	10
1. Prisons	14
Background and key developments since 2016/17	14
The current use of segregation and restraint in prisons: key findings	15
• Frequency and length of segregation placements	15
• Who was housed in Segregation (Management, Separates and ISUs) and why?	16
• Material conditions and regime in segregation units	19
Restraints and the use of force	23
Key Recommendations for the Department of Corrections	25
2. Children's Care and Protection and Youth Justice facilities	26
Background and key developments since 2016/17	26
The current use of seclusion and restraint with children and young people: key findings	27
• Frequency and length of placements in Secure Care units	28
• Reasons for the use of Secure Care in Youth Justice and in Care & Protection facilities	31
• Material conditions and regime in Secure rooms in children and young people's facilities	32
Restraints and the use of force	35
Key recommendations for Oranga Tamariki	36
3. Health and Disability facilities	37
Background and key developments since 2016/17	38
The current use of seclusion in health and disability units: key findings	38
• Frequency and length of seclusion events	40
• Who was housed in seclusion rooms?	41
• Material conditions in seclusion units	44
The use of restraints	46
Key recommendations for the Ministry of Health and the DHBs	47
4. Police	48
Appendix 1: <i>Thinking outside the Box?</i> (2017) recommendations	49
Appendix 2: International human rights law on solitary confinement, seclusion and restraint	56
Appendix 3: New Zealand law and regulations on seclusion, segregation and restraint	71

List of figures

Figure 1:	Frequency and length of stays in segregation: 2019	10
Figure 2:	Segregation stays longer than 15 days: occurrences in 2019	16
Figure 3:	Ethnic makeup of New Zealand general population, prisons, segregation units, and longer segregation stays	17
Figure 4:	Ethnic groups representation in NZ general public; prisons; and different types of segregation	17
Figure 5:	Frequency and length of stays in a Youth Justice Facility's Secure Care unit: June – December 2019	29
Figure 6:	Frequency and length of stays in a Youth Justice Facility's Secure Care unit: 2016 and 2019 compared	29
Figure 7:	Frequency and length of stays in a Care and Protection Residence's Secure Care Unit August 2019 – January 2020	30
Figure 8:	Frequency and length of stays in a Care and Protection Residence's Secure Care unit: 2016 and 2019 compared	30
Figure 9:	Average number of seclusion events and seclusion hours 2016–2019 Health and Disability facilities	41
Figure 10:	Service users secluded October 2019 – March 2020 by ethnicity	42
Figure 11:	Seclusion events October 2019 – March 2020 by service user's ethnicity	42

Acknowledgments

I should like to express my sincere thanks to the Human Rights Commission (HRC) for inviting me to undertake this review. Too frequently, little is done to examine whether recommendations made in reports such as my 2017 review of seclusion and restraint practices in New Zealand, are met, and whether promises are acted on. Thanks are due to Jaimee Paenga, Legal Adviser, HRC, who worked alongside me on this project from the very start, and maintained her calm, competent composure throughout what can only be described as a highly unusual time. Many thanks also to Janet Anderson-Bidois, former Chief Legal Adviser, HRC, and to John Hancock who replaced her, for commissioning this report and working alongside me, and to Eleanor Vermunt, Legal Adviser, HRC, for her excellent briefings and papers. Finally, my thanks to Chief Human Rights Commissioner Paul Hunt, Disability Rights Commissioner Paula Tesoriero MNZM, Equal Employment Opportunities Commissioner, Dr Saunoamaali'i Karanina Sumeo and Race Relations Commissioner, Meng Foon, and Deputy Chief Executive Tricia Keelan, for supporting this work.

We invited a small number of civil society organisations to make informal submissions to this review. I am very grateful to: Amnesty International New Zealand; Balance Aotearoa; Barnardos; Health, Quality & Safety Commission; Wellington Howard League; Just Speak; Mental Health Foundation; People Against Prisons Aotearoa (PAPA); and Te Pou for their invaluable contributions. I look forward to continuing our work to improve conditions for those people who are held in closed institutions.

Thanks to the Office of the Children's Commissioner, and in particular to Tanya Jondahl, for accompanying us on a visit. Many thanks to the Office of the Ombudsman for their insightful comments and suggestions. Many thanks also to Matt Beattie, Principal Advisor at Oranga Tamariki, for ensuring that we were able to access all the information requested in a timely manner, and to Emma Roebuck, Patrick, and to Dolly and Wendy for their support.

Particular thanks to Julie Miller at the Department of Corrections for her open and helpful approach and for her efforts to respond to all our queries and requests, and to Valerie Shirley for doing the same when Julie left. Peter Johnston and Paula Thomson very helpfully pulled together the data requested: my thanks to them, and to Chief Inspector Janis Adair, and to Rebecca Gormley, Fiona Irving and Elaine Smit at the Office of Inspectorate, for generously sharing their time and expertise. Many thanks also to Waitemata DHB, Capital and Coast DHB, Mental Health and Addictions at the Ministry of Health, and to Mental Health, Addictions and Intellectual Disability Service for providing data and information on seclusion and restraint practices.

Last but not least, I am grateful to the many people who engaged with us during our visits – managers, staff, and, in particular, service users, for sharing their experiences and thoughts with us. It is my sincere hope that this report will serve to help improve their treatment and conditions.

Sharon Shalev

London, November 2020

Executive Summary

This report is a short follow-up of a 2017 review of seclusion and restraint practices in New Zealand (*Thinking Outside the Box?: A review of seclusion and restraint practices in New Zealand*), undertaken by Dr Sharon Shalev of the Centre for Criminology at the University of Oxford, at the invitation of the New Zealand Human Rights Commission.

There have been some positive developments since 2017, including a national effort to reduce the use of seclusion and restraint in health and disability facilities; an end to the use of 'tie down' beds in prisons and; a greater commitment to Māori culture and values in the care of children and young people by Oranga Tamariki.

The overall picture, however, is disappointing. In the three years since the review many of the issues highlighted in the 2017 report have not been addressed.

- Seclusion continues to be used too often, for too long, and not always with clear justification. That is the case with all agencies, and applies to children too: in one facility, for example, children were held in a Secure Room for over a week on 22 occasions in the six-month period examined.
- The use of seclusion remains disproportionately high with Māori and Pacific Peoples across the board. In women's prisons, for example, Māori women made up 78% of all stays in the most restrictive form of segregation ('Management units') in 2019.
- The data on the use of force and restraint also provides a cause for concern across settings. In health & disability facilities, for example, over a period of 6 months restraints were used 358 times, with 114 of these uses involving prone restraints, including several very lengthy holds – 1463 minutes in one case, 290, 125 and 100 minutes in others.

Many of the other issues identified in the 2017 review persist, including: risk averse policies and practices; impoverished regimes; austere material conditions and some un-fit for purpose accommodation; lack of individual autonomy; and over-reliance on staff availability and good will.

My recommendations accordingly focus on the same key themes as in 2017:

- Finding alternatives to Secure Rooms and similar separation practices for children and young people.
- Reducing both the use and length of seclusion and restraint;
- Exploring potential racial and gender bias in decision making on seclusion and segregation placements;
- Improving material conditions and access to meaningful human contact and activities in seclusion/segregation;
- Providing therapeutic environments for distressed individuals, and seeking alternatives to seclusion and restraint for them;
- Decommissioning facilities which are not fit for purpose.

Effective implementation of these recommendations must be underpinned by good quality and comprehensive data, which currently remains far too fragmented.

The central message of this report, though, is that a significant shift in the very way that detaining agencies think about the extreme tools of seclusion and restraint, is needed. Only then will a meaningful change be possible to achieve.

Introduction and general observations

In March 2020 I was invited by the New Zealand Human Rights Commission to conduct a short follow-up of my 2017 review of seclusion and restraint practices in New Zealand (*Thinking Outside the Box?: A review of seclusion and restraint practices in New Zealand*).

I was delighted to accept the invitation. Thematic reviews of this type do not always benefit from the opportunity of a full follow-up, and the Commission and I agreed that three years were about the right length of time for recommendations to be implemented, and for changes to be bedded in – or not.

Regrettably, the COVID pandemic broke out shortly before we were due to undertake field visits for the follow-up review, ruling out the option of visiting all the sites visited for the original report. This meant that the follow-up needed to be mostly paper based, although we were fortunate to manage visits in a number of prisons and in a secure care facility for children, which allowed us to see first-hand how things looked on the ground. This review also benefited from excellent submissions from a small number of civil society organisations whom we directly invited to comment on key developments since 2017.

There have been some very positive developments in the three sectors this report covers – the Department of Corrections, the Ministry of Health and District Health Boards, and Oranga Tamariki – since the original review. It was good to learn that Corrections no longer used the ‘tie down’ beds, described in *Thinking Outside the Box?* (hereafter: TOTB) as ‘inherently degrading’. A greater focus on a mental health component has been introduced in prison Management and Intervention and Support units (ISUs, the successors of the ‘At Risk units’, also criticised in TOTB). This too was a welcome development, though, as discussed later, there was some evidence that the key focus in the ISUs remained the control and incapacitation of those deemed to be at risk, and they did not provide a therapeutic environment for people who were unwell. Some of the newly built facilities in the prison estate had improved physical conditions in segregation cells, though the choice of similar designs to those used in the past was, in my view, a missed opportunity.

The Health and Disability sector has also seen some positive developments. These include the launch of the Zero Seclusion project initiated and led jointly by Te Pou and the Health Quality and Safety Commission (HQSC); an increased use of sensory modulation spaces and techniques; refurbishment of existing facilities, including seclusion rooms and units, and plans for additional newly built, modern facilities. However, seclusion persisted in Health and Disability facilities, and at the time of this review some refurbishment plans were being delayed.

It was positive to note that the newly established Oranga Tamariki – Ministry for Children, which took over responsibility from the Department of Child, Youth and Family for the care of children and young people in state residences in 2017, is committed to greater incorporation of Māori culture and values in how children in care are treated. This commitment is also enshrined in law (Oranga Tamariki Act 1989, as amended in 2017), though it is early days to assess the degree to which this commitment is reflected in practices on the ground.

Corrections have similarly committed to greater focus on issues of race and ethnicity, for example, in its strategy document Hōkai Rangi: Ara Poutama Aotearoa Strategy: 2019-2024.¹ This, too, is very positive and welcome and, as the analysis in this report demonstrates, much needed. This focus could also benefit, in my view, from stronger Māori voices amongst Corrections' workforce, especially at the managerial levels and not only in cultural roles, but also in other areas of the prison, including the development of use of force policies and practices.

The overall picture, though, positive developments notwithstanding, was disappointing. With the exception of the Department of Corrections, detaining agencies were unable to produce comprehensive and up to date data on their use of seclusion and other forms of restraint on request. By and large data needed to be collected especially for this review, meaning long delays and data of varied quality.

Despite the apparent goodwill, an understanding of the undesirability of seclusion and restraint practices – and the availability of strong research and inspection reports to back this knowledge – not much appears to have changed on the ground. Many of the issues identified in *Thinking Outside the Box?* including an overuse of seclusion and restraint; risk averse policies and practices; poor record keeping; impoverished regimes; poor material conditions; lack of individual autonomy; and over-reliance on staff good will and availability, remained a concern.

Too many people continued to be held for too long in sparsely furnished rooms and cells, with limited access to fresh air and exercise, and with little access to meaningful human contact.

1. Available at: https://www.corrections.govt.nz/__data/assets/pdf_file/0003/38244/Hokai_Rangi_Strategy.pdf

Seclusion (or solitary confinement) continued to be disproportionately used with Māori and Pacific Peoples in Health and Disability facilities, in children and young people's care and protection and justice residences (where the practice is known as 'secure care'), and in prisons (where the practice is known as 'segregation').

Some positive developments notwithstanding, then, the first and clearest finding of this review is that seclusion and restraint practices were still very much in use in closed institutions across New Zealand, and that the documentation, reporting and analysis of data remain woefully lacking.

As a Submission by the Tumu Whakarae, the National Reference Group of Māori Health Strategy Managers within District Health Boards (DHBs), to the Government Inquiry into Mental Health and Addictions (2018)² noted, sedation, seclusion, criminalisation and incarceration are strategies of a flawed system. A significant shift was needed:

'There is a pressing need for effective dual diagnosis services for tangata whenua in the area of Mental Health and Addiction, including significant shifts in the justice system from a model of criminalisation and discrimination, to a Pae Ora paradigm that focuses on intervention, healing and recovery.' (p 30.)

I think that this is true across the board. This report demonstrates that, without a significant shift in the very way that detaining agencies *think* about the extreme tools of seclusion and restraint, a meaningful change will be impossible to achieve.

National Preventive Mechanisms (NPM) have a key role to play in helping agencies realise this paradigm shift through monitoring closed institutions, reporting practices which fall short of acceptable standards, and holding detaining agencies to account.

In general, this is something that New Zealand's NPM bodies do well, producing excellent work individually, though there may be more scope for collaborative work and information sharing between them. Levels of resourcing appeared to vary between the NPM bodies, inevitably leading to a variation in the scope of monitoring work which could be carried by each body. It is crucially important that all NPMs are empowered to carry out their important roles and are properly resourced to carry these out.

2. Tricia Keelan and Jodi Porter, Submission by the Tumu Whakarae, the National Reference Group of Māori Health Strategy Managers within District Health Boards (DHBs) to the Government Inquiry into Mental Health and Addictions (August 2018).

Regrettably, this review did not benefit from co-operation with the Police. It therefore does not examine the use of restraints by the Police, despite serious concerns about practices in Police custody suites in 2016/17.

The remainder of this report focuses on seclusion and restraint practices across prisons, health and disability facilities, and children and young people's residences. It examines current use and conditions and assesses the degree to which recommendations made in *Thinking Outside the Box?* and good practice guidance have been met in regard to seclusion and restraint practices in each. To avoid identification, all establishment names are anonymised, as are the gender and role of people interviewed, and the names of civil society organisations and arms-length bodies who made submissions to this review.

1. Prisons

Background and key developments since 2016/17

There was a clear, and very welcome shift in the Department of Corrections' willingness to engage more openly about solitary confinement (or 'segregation') practices. This review was afforded every possible assistance in accessing facilities and data, and our questions were answered openly. It is my sincere hope, and belief, that the increased transparency and willingness to engage will also translate into more openness and better practices on the ground.

The mandate of Corrections' Inspectorate, the body charged with prison inspections, investigating prisoner complaints and investigating deaths in custody, has widened since my last visit and, with the regular publication of inspection reports (even if partially redacted), the Inspectorate has become much more visible publicly. Though not a body operating under the Optional Protocol to the Convention against Torture ((OPCAT), see Appendix 2), the Inspectorate's work is guided, *inter alia*, by international principles and guidance. This was a welcome development.

Responding to our request for information on developments since the original review and the degree to which recommendations were met, the Department of Corrections highlighted a number of issues: On oversight of placement into and routes out of segregation, the Department pointed to a strengthened role for the Office of the Inspectorate.

In relation to At Risk Units, the Department pointed to initiatives on the back of the 'Transforming the Management of At-Risk Prisoners Review' to better assess mental health issues, guide placements and provide individualised care. They noted that this had been supported by the recruitment of more clinical staff and a significant mental health training programme for staff. The Corrections Amendment Act that came into effect in October 2019 had introduced a new regime for managing at risk prisoners, increasing opportunities for association and input from health professionals.

The Department noted that the recommendation to introduce food serveries was not considered appropriate. It noted though, that as I recommended, tie down beds had now been removed. It also pointed to improvements to the physical environment of Intervention and Support Units across the prison estate.

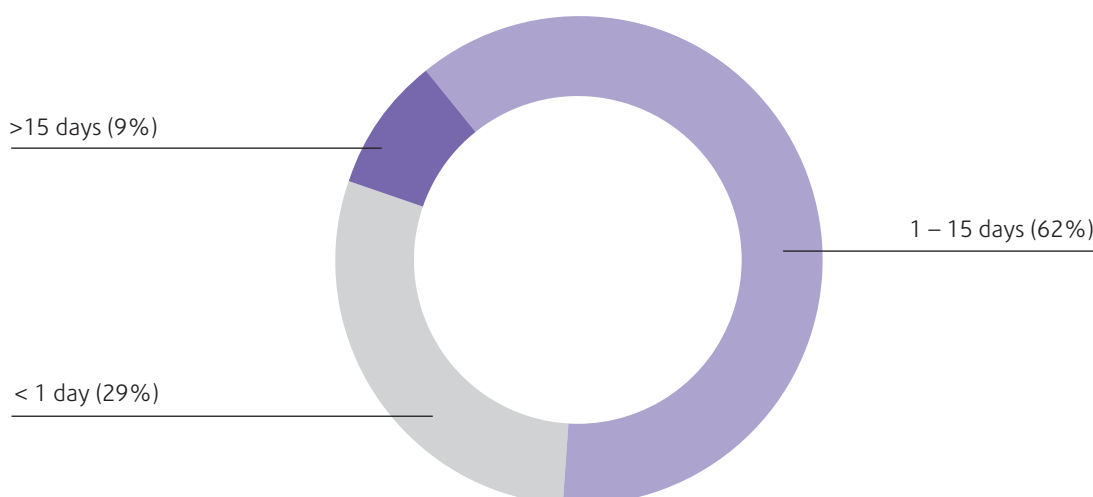
One civil society organisation pointed to several positive policy and legislative changes since 2017, which supported progress against recommendations made in *Thinking Outside the Box?*, (and in the Office of the Ombudsman's 2017 report, 'A Question of Restraint') including the ending the use of tie-down beds. In relation though to other issues raised in the review, it expressed concern about lack of progress, for example on early meal times, and inconsistencies in the documentation of segregation. Other areas of concern highlighted by submissions from civil society organisations included: mismatches between prisoner and unit classification; the impact of staffing levels on lock-up hours; prison transport; the impact of solitary confinement on older prisoners; and staff training on human rights.

The current use of segregation and restraint in prisons: key findings

Frequency and length of segregation placements

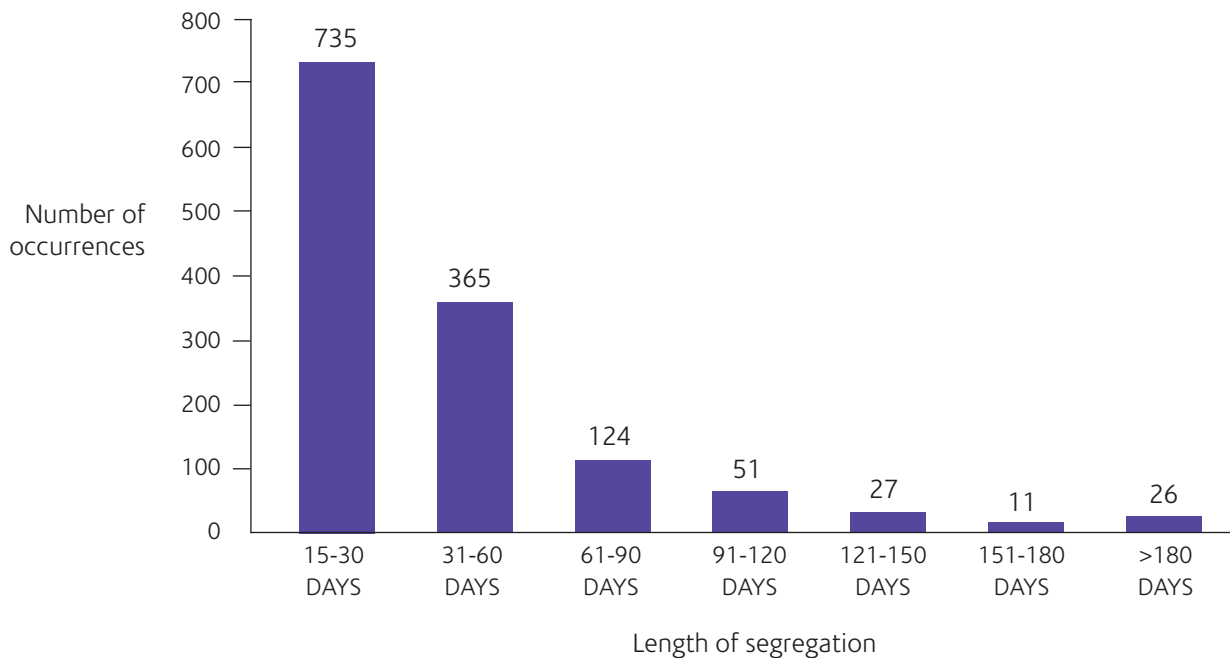
In the year to the end of December 2019, there were 15,225 recorded instances of segregation placements in New Zealand's prisons, compared to 16,370 placements in 2016. Close to 30% of the 2019 placements lasted less than a day. A total of 1,339 placements, or 9%, lasted longer than 15 days, the length of segregation stipulated in international human rights law as prolonged, as therefore potentially a form of prohibited treatment.

Figure 1: Frequency and length of stays in segregation: 2019



The 9% of segregations (N=1,339) lasting longer than 15 days varied in length, with the majority (55%) lasting up to 30 days, but some lasting longer than six months.

Figure 2: Segregation stays longer than 15 days: occurrences in 2019



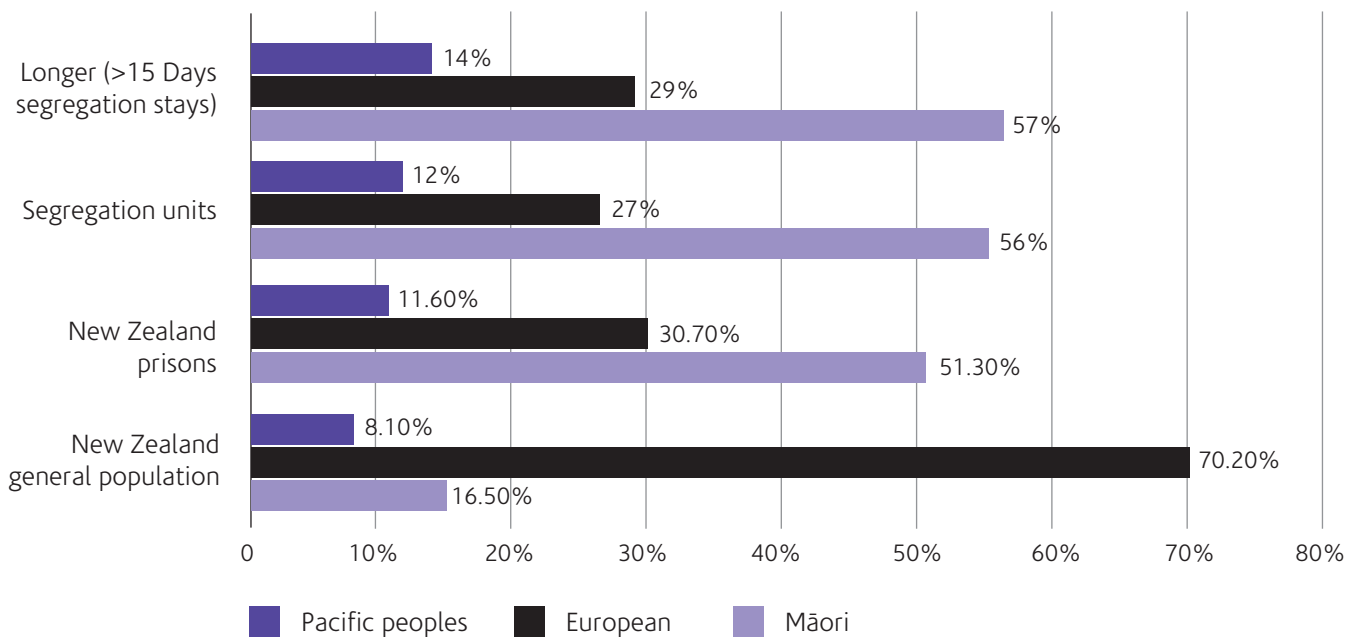
Compared to 2016, these numbers present a mixed picture: the overall number of segregation placement has gone down by 7.6% (from 16,370 in 2016 to 15,224 in 2019), but the number of longer segregation placements has risen marginally.

Who was housed in Segregation (Management, Separates and ISUs) and why?

Māori were more likely than their counterparts of European descent to spend longer periods in each type of segregated housing, and increasingly so in Management units. New Zealanders of European descent were less likely than Māori to be segregated at all, and when they were segregated, were more likely to spend time in an Intervention & Support Unit (ISU) than in a Management or Separates unit.

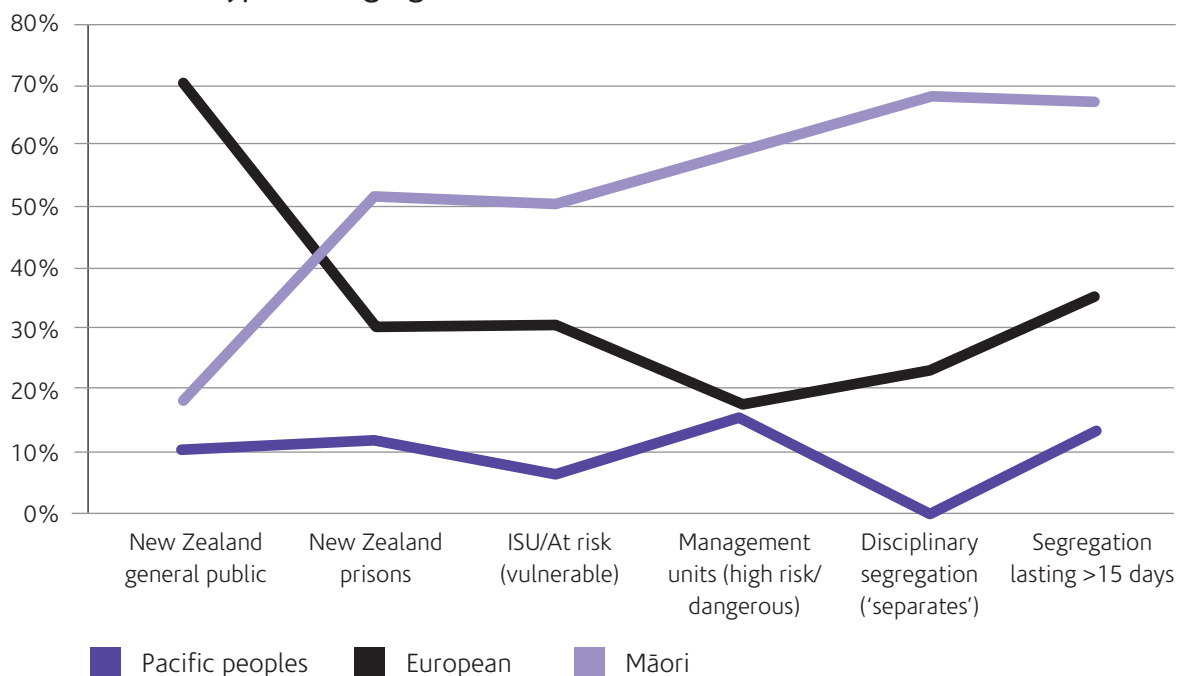
The disproportionate number of Māori and Pacific Peoples in the harsher forms of segregation may indicate, as observed in TOTB, that Māori and Pacific Peoples were more likely to be seen as dangerous, or high risk, and therefore requiring longer-term separation from their peers and tighter control in a Management Unit. New Zealanders of European descent on the other hand, may be more likely to be seen as vulnerable, rather than dangerous, and in need of the close observation and the clinical input offered (at least on paper) in an ISU.

Figure 3: Ethnic makeup of New Zealand general population, prisons, segregation units, and longer segregation stays



The discrepancy in the rate of segregation placements along racial lines is a very worrying observation which requires further analysis.

Figure 4: Ethnic groups representation in NZ general public; prisons; and different types of segregation



Women were segregated at a far higher rate than men: 255 instances per every 100 women prisoners, compared to 147 men per 100 (based on the number of prisoners at the end of December 2019). The number was even higher in the largest women's prison, where women were segregated 285 times per 100

prisoners. In fact, the rate of segregations in that particular prison was second only to that in the largest remand prison in the country, where men were segregated as many as **405 times per 100** prisoners.

A total of 139 segregation stays lasted longer than 15 days. Māori women were disproportionately represented in longer segregations, making up 59% of these stays; Pacific women 4.2% of longer segregations, and women of European descent 28.6%.

The gross overrepresentation of Māori women was even more pronounced in the most controlled segregation areas, **Management units**, where **Māori** made for **78% of all stays**. In Separates units (used for punishment) Māori women made for 65% of all stays, reducing to 45% in the more treatment orientated ISU. In one prison, all bar one of the New Zealanders of European descent who were segregated for longer than 15 days were housed in the ISU unit.

These discrepancies need to be explored as a matter of urgency, to determine whether decision making processes may be influenced by unconscious bias or other factors relating to gender and ethnicity.

As in 2016/17, reasons for the use of segregation were at times concerning, and it was not always clear from the paperwork why it was decided that segregation was the appropriate response. For example, one prisoner on remand who self-harmed told staff that they wanted to 'give themselves pain so that they can have a good sleep' and that they 'had no thoughts of killing themselves, but they haven't spoken to their family in a while and haven't received any mail, and it was too hard for them so they self-harmed'. The prisoner was nonetheless segregated in the prison's ISU. History does not relate whether this person received a telephone call or other means to communicate with their family, which would have potentially eased their distress, making the ISU placement unnecessary. Other examples included victims of bullying and violence in general population wings being rehoused in an ISU, while the perpetrators remained in the general population; people who were mentally very unwell and waiting for a hospital bed (in one case, for 4 months), and; a prisoner who was placed in an ISU because they were 'overweight, with poor hygiene, and couldn't fit anywhere else [in the prison]' (ISU staff).

There was also a large divergence between prisons in how, why and when segregated housing was used, and how long it was used for. Reasons for placement in Management Units varied from threats and breaking a window, to serious assaults and causing life changing injuries. ISUs / At Risk units were similarly used for anything from people who were extremely unwell to people who didn't want to mingle with others, to people detoxing.

Material conditions and regime in segregation units

There have been some positive changes since the original review took place. The 'silver cells' at Auckland Men's prison, described then as 'claustrophobic and not fit for purpose' (TOTB p 33) have been decommissioned. Physical conditions at the newly built Assessment Unit (formerly the Management Unit), also at Auckland Men's prison, were an improvement over the old unit. As well as self-contained cells equipped with a shower, a toilet/sink unit and a small individual exercise yard, the unit contained an audio-visual room, a room for programme provision (albeit with separating glass), and exercise yards where two men were sometimes allowed to exercise together, with two 'activity officers', for an hour weekly. Mostly, however, prisoners had little to do and could only spend very limited time outside their cell. An Intervention and Support Unit (ISU) had a beautiful new sensory garden built in one of the yards, but mental health staff had to make a special request for a prisoner to spend time in this garden, and it was not clear how long prisoners could spend in there.

Pockets of good practice notwithstanding, the key concerns over bleak environments, lack of privacy and impoverished segregation regimes remained, with the majority of segregated prisoners spending 23 hours a day inside their small cell. The number of times that in-cell toilets could be flushed continued to be limited, as was the length of showers. Not all cells had power points to enable

prisoners to watch television or listen to music. Some exercise equipment was added to yards in a number of prisons, but not to all.

The Intervention and Support Units (ISU), despite the name change, also continued to suffer similar issues – impoverished regimes and austere cells, with even fewer furnishings and personal belongings than those afforded to prisoners in Management Units, and with the added indignities of cardboard potties and tear-proof gowns. Some cells had no window and no access to natural light.

Other cells were constantly monitored by camera which covered all cell areas, including the toilet area, affording prisoners no privacy. Elsewhere, shower stalls were located in the centre of the unit, and only had stable doors, meaning that those using it were partially exposed to staff, other prisoners and anyone visiting the unit.



Windowless ISU cell.



Shower stalls in the ISU at a women's prison.



A cardboard potty and anti-ligature clothing and bedding for use at an ISU.

Some opportunities to explore different approaches to segregation were missed, in my opinion, and the design of some newly built facilities was lacking in imagination. For example, the NZ \$ 100 million project to construct 200 new remand and at-risk beds at Mount Eden Correctional Facility, a remand prison in Auckland, resulted in a segregation unit (ISU) the design of which is almost identical to that of the existing ISU, including the problematic internal yards and cells with no natural light.



A newly built cell.

Many of the prisoners we spoke to experienced their segregation as punitive and damaging. One person said: 'I've already been given my sentence from the judge – I don't need more on top of that'. Others accepted their placement: 'jail is jail', as another prisoner said – but thought that more should be done to allow them time outside their cell, and to enable more frequent and flexible use of the telephone to contact their families.

More generally, practices and policies lacked flexibility and were risk averse, for example regarding the number of people required to unlock a prisoner, what they could keep in their cells, or how often their cells should be searched. This sometimes led to arbitrary practices which were not always conducive to the prisoner's wellbeing or to good order and discipline in the prison.

Regimes remained basic, with segregated prisoners mostly receiving no more than their



A toilet in an outdoor exercise yard.

minimum entitlements (1 hour of exercise daily; 1 x 5-minute telephone call weekly; 1 x weekly 30-minute-long family visit (uncommon)). The key difference between the regime for prisoners on Directed Segregation and those on Directed Protective Custody (see Appendix 3) was that the latter could spend two hours, rather than one, outside their cell, and could spend longer on the phone.

With few exceptions, management plans for segregated prisoners were mostly generic and contained few avenues for prisoners to demonstrate good behaviour and progress out of segregation. As one prisoner put it: 'Management plans are used in the wrong way. What's not on there is automatically not allowed, no matter what'. People told us that they felt that bad behaviour was punished, but good behaviour was not rewarded, leaving them with little incentive or hope. As one person, a long-term resident of a segregation unit, said: *'there is no light at the end of my tunnel.'*

There were pockets of good practice, for example one young man segregated in a management unit was allowed to continue participating in a cultural programme which he was engaged with prior to his segregation, or prisoners in longer-term segregation in a management unit in another prison who could keep art materials in their cells. But the majority of prisoners spent the majority of their time locked up in their small cells with little to do. Furthermore, blanket policies were applied to all segregated prisoners (according to the 'type' of segregation), for example, handcuffing certain categories of prisoners whenever they are outside their cell; or daily cell searches, rather than according to the risk posed by and to individual prisoners.

By and large the staff we spoke to were familiar with prisoners in the segregation and ISU units, and relationships appeared, in most cases, reasonable if distant. But segregation units did not always employ the most experienced staff, and in some there was a high staff turnover, meaning that staff were less familiar with the units and the prisoners who resided in them.

ISUs benefited from greater mental health input, but other than a one-day 'Mental Health 101' workshop, staff, including those working in ISUs, received no formal mandatory specialist training. We were told that mental health staff in one ISU provided informal lunch-time training to custodial staff. This was good practice which could be replicated elsewhere, alongside increased formal mental health training for staff working in segregated units.

In TOTB I noted that evening meals were served too early. This remained the case in 2020 with some establishments serving dinner as early as 15:30. As previously noted, for those in segregation who couldn't afford to buy canteen goods or whose canteen rights had been revoked, this could mean a very long

stretch of time before breakfast was served at 8:00-8:30. It is worth noting that Corrections' own regulations stipulate that breakfast should be provided no more than 14 hours after the evening meal (Minimum Entitlements).³

In summary, many of the key issues around the use of segregation in prisons which were highlighted in *Thinking Outside the Box?* remained a concern, including:

- Segregation was overused and stays in segregation were too long;
- Overrepresentation of Māori and Pacific Peoples in segregation;
- Lack of clarity on placement in, and exit from, segregation units;
- Segregation cells not always used for their intended purpose;
- Segregation of vulnerable prisoners and high rates of self-harm in segregation;
- Impoverished regimes and little human contact;
- Austere material conditions and some un-fit for purpose accommodation;
- Lack of privacy and personal autonomy;
- Discretionary practices;
- Insufficient staff training.

Restraints and the use of force

According to data provided to this review by Corrections, during 2019 there were 1488 recorded uses of restraints in prisons (including pepper spray). The majority (1467) of these included the use of handcuffs for purposes other than escort. A head protector was used 5 times, and Spit Hoods were used 14 times.

This number represents a substantial increase over 2016, where data provided by Corrections listed 423 uses of mechanical restraints over a six months period.

This is particularly concerning, as another key development since 2016 has been the wider availability of pepper spray as a tactical option. The Corrections Amendment Regulations (May 2017) allows corrections officers to carry pepper spray canisters as part of their daily duties.

"The officer may draw or use the pepper spray only against a prisoner and only if the officer has reasonable grounds for believing that the use of physical force is reasonably necessary for any of the purposes referred to in section 83(1) of the Act⁴." (Section C123(2))

3. Prison Operations Manual, F01.01 Minimum entitlement provisions https://www.corrections.govt.nz/resources/policy_and_legislation/Prison-Operations-Manual/Prisoner-finance-activities/F.01-Minimum-entitlements

Yet data provided to this review by Corrections suggests that rather than replacing physical force, pepper spray was used alongside other forms of restraint. In 2019 Pepper Spray was drawn, and discharged, 118 times, a small increase on the previous year (112). There was a very large disparity in the use of pepper spray across the prison estate, with Christchurch Men's and Auckland Women's prisons leading the way with 29 and 21 uses respectively.

An examination of data pertaining to the use of pepper spray across the prison estate demonstrated some instances of spray being drawn, but not used, thus used as a deterrent. It was not always clear, however, why it was deemed necessary to use such an extreme measure in the first place. On one occasion, for example, pepper spray was used against a prisoner who 'when told to settle down, became abusive and advanced towards staff'. In another, a prisoner who 'picked a book and threatened to throw it at staff', was pepper sprayed and, when they 'came at staff in an aggressive manner', was pepper-sprayed again.

Many of the recorded uses of pepper spray involved stopping fights between prisoners. Again, it is impossible to ascertain whether pepper spray was used as last resort in these instances but use of force footage indicated that this may not have always been the case. There was some suggestion from both staff and prisoners that pepper spray was now used instead of negotiation and de-escalation of volatile situations. As one person we spoke to, a prisoner, observed:

"Before pepper-spray they used to de-escalate, calm things down
Now you get pushed to a corner and you don't know what to do"

It should be noted that as well as being an unpleasant and potentially damaging to health for the person involved, the closed environment of prisons means that when one cell is being pepper sprayed, other cells are affected too. Prisoners have described having to resort to putting their head down the toilet in order to get fresh air when a neighbouring cell was gassed. One person said: "Your main thing is to try and breathe You start spewing, pleading with them [staff] to decontaminate us".

As well as examining national data on the use of force, we reviewed Use of Force (UoF) paperwork and incident footage in the prisons visited. It should be noted that although On Body Cameras are now mandatory in all prisons, the availability and quality of footage was variable. In a number of cases cameras were not turned on until after the event, if at all, and in others the view was obstructed. In other

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4. 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.

cases, there was video footage, but no sound, making it difficult to work out the chain of events leading to the UoF. It was not clear to me in some cases why force was deemed to be necessary or that its use followed good practice. For example, in one case a prisoner who refused to relocate from his cell was first pepper sprayed and then restrained, and when he complained that he couldn't breathe, the officer restraining him responded dismissively, 'yes you can'. In another case, a man's arm was broken during restraint, yet he was left in prone position until medical staff arrived. Such incidents are very concerning.

Key Recommendations for the Department of Corrections

- The large divergence between prisons in when and why segregation is used should be examined.
- Regime provisions in segregation need to be improved, including some flexibility in the use of individual exercise yards where these are attached to segregation cells; enabling more family visits and contact with friends and family, including more flexible use of telephones and audio-visual contact; providing more access to programmes and things to do.
- Cell cameras must exclude the toilet (and, where available, shower) area.
- The use of anti-ligature clothing and bedding should be reviewed and reconsidered.
- The disproportionate number of Māori and Pacific Peoples in segregation units needs to be investigated as a matter of urgency.
- Potential bias in decisions to segregate should be investigated.
- Segregation units should be staffed by experienced staff, well versed in de-escalating challenging situations.
- Staff working in segregated environments should receive specialist mental health training.
- Mealtimes should reflect those in wider society.
- Force should only be used when absolutely necessary, and only the least necessary force should be used (Section 83(1) of the Corrections Act should correspondingly change from 'reasonably necessary' to 'absolutely necessary').
- The value and benefit of On-Body-Camera for staff's own safety and integrity should be highlighted in staff training, and more emphasis placed on their correct use.
- The significant increase in the use of mechanical restraints, and pepper spray, needs to be investigated as a matter of urgency, including variation between prisons.

2. Children's Care and Protection and Youth Justice facilities

Background and key developments since 2016/17

A key development since 2016 has been the establishment of Oranga Tamariki, the Ministry for Children, in April 2017, taking over responsibility from the Child, Youth and Family department which operated within the Ministry for Social Development.

The Children, Young Persons and Their Families (Oranga Tamariki) Legislation Act 2017 raised the age under which young people can be subject to care and protection and youth justice interventions from 16 to 17, in line with New Zealand's international obligations under the Convention on the Rights of the Child. This broadens the cohort of children and young people who may be housed in youth justice residences.⁵

As noted in the introduction, Oranga Tamariki has committed to a greater focus on Māori values, practices and concepts, including principles of restorative justice and conflict resolution. These are all very welcome developments, as is the decision to move away from the current model to smaller, community-based residences. I hope that these residences will manage without a dedicated 'secure care room' and engage instead in alternative methods to resolve conflict and deal with troubled behaviour.

A key issue, noted in TOTB and repeated here, is that the seclusion of children and young people, by its very nature, runs contrary to international human rights law which completely prohibits its use with children under 18 years of age (see Appendix 2). The design, appearance and very purpose of 'secure care' units in the Department's Care and Protection and Youth Justice facilities would also appear to run contrary to principles of tikanga Māori, which Oranga Tamariki is committed to and which are enshrined in the Oranga Tamariki Act. Secure care rooms are, as one submission to this review commented: 'a potentially mana-stripping practice.'

5. Prior to the amendments, 17-year olds were treated as adults in the criminal justice system and could be sentenced to imprisonment in the youth wing of adult prisons. Young people in state care would also generally be discharged from state care and protection orders once they turned 16, unless they were in the guardianship of the state.

Oranga Tamariki expressed confidence that in general recommendations to all agencies in TOTB were being met in children's residences. It noted though that consideration of how the grievance procedure could be made more independent was ongoing and the continued need for IT investment to improve the ability to analyse incident records. Responding to specific recommendations on children's residences, the Ministry asserted that there was a reduction in use of force and secure care (though this was not borne out by the data). The Ministry also pointed to initiatives to find alternatives, for example the implementation of the restorative practice of Whakamana Tangata in youth justice residences.

A submission from one civil society organization noted the key importance of updating the Regulatory Framework for Residential Care in order to make it consistent with the UN Convention on the Rights of the Child. Whilst welcoming the options for change to the Regulatory Framework developed by Oranga Tamariki and opportunity to comment on these, it noted that no update had been provided since last year. The submission emphasised the need for a greater consistency of approach across residences, underpinned by universally applicable guidelines, and for more sharing of good practice.

The current use of seclusion and restraint with children and young people: key findings

There was little evidence that data collection and analysis improved since *Thinking Outside the Box?* was published. Pertinent data on the use of Secure rooms was still not collated centrally or recorded digitally. I was surprised to see that the Care and Protection unit we visited was still using large-format, pen-on-paper registers for the Secure unit.

Poor record keeping in Oranga Tamariki residences had also been commented on by the Children's Commissioner and the Office of the Chief Social Worker/Director Professional Practice⁶ who noted that, whilst some data recording has improved in some residences, this remained an area of concern.

As data on placements in Secure rooms was not collected and analysed centrally, the data analysed below had to be manually extracted especially for this report. The data provided to us by Oranga Tamariki on the use of Secure rooms in all its 4 Youth Justice residences and 4 Care and Protection residences,⁷ however,

6. See digest of annual facility reports for 2017: <https://www.orangatamariki.govt.nz/assets/Uploads/Publications/Residence-review-summaries/Korowai-Manaaki-2017-External-Summary.pdf>

7. According to data provided to this review by Oranga Tamariki, in the 6 months between June 1st and December 31st 2019, children and young people were placed 625 times in a Secure room in one of the four Youth Justice residences operated by OT, and 173 times in one of the four Care and Protection units it operates.

Figure 5: Frequency and length of stays in a Youth Justice Facility's Secure Care unit: June – December 2019

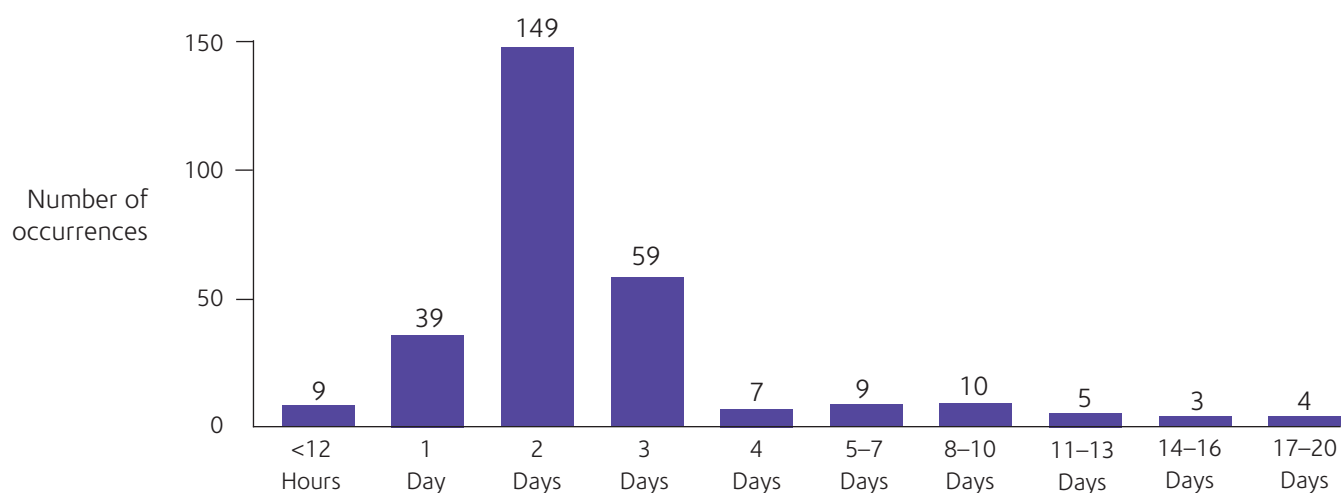
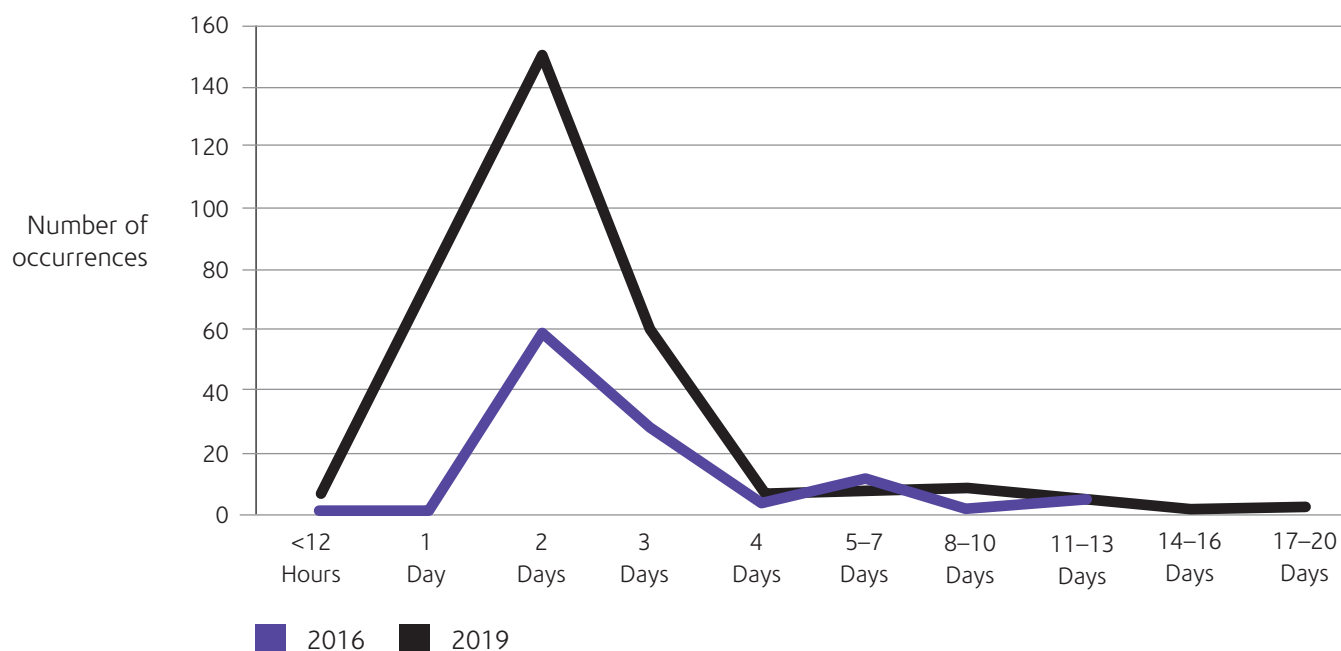


Figure 6: Frequency and length of stays in a Youth Justice Facility's Secure Care unit: 2016 and 2019 compared



Compared to 2016, then, the use of Secure Care rooms for children and young people in the Youth Justice residence we examined more than doubled: from 109 Secure Care stays over 6 months in 2016, up to 298 in 2019. It is positive to see a significant increase in the number of shorter stays of less than 12 hours, and less than a day, hinting at a more nuanced use of Secure for urgent cases. However, 2019 has also seen a significant increase in very long stays: in 2019 the number of incidents of children and young people spending 8 days or longer in Secure increased from none to 22, including 7 stays lasting longer than 2 weeks, the time set in the Nelson Mandela Rules as prolonged, and hence prohibited, solitary confinement (for adults – the Mandela Rules prohibit the use of solitary confinement with children, defined as younger than 18).

The use of Secure Care rooms in a Care and Protection Residence, June-December 2019

During the same time period (June-December 2019), 14 children aged 12 to 16 years old were placed in the Secure Care unit of a Care and Protection Residence a total of 70 times (compared to 20 children and a total of 76 occurrences in 2016). 62% of these children identified as New Zealand Māori.

Figure 7: Frequency and length of stays in a Care and Protection Residence's Secure Care Unit August 2019 – January 2020

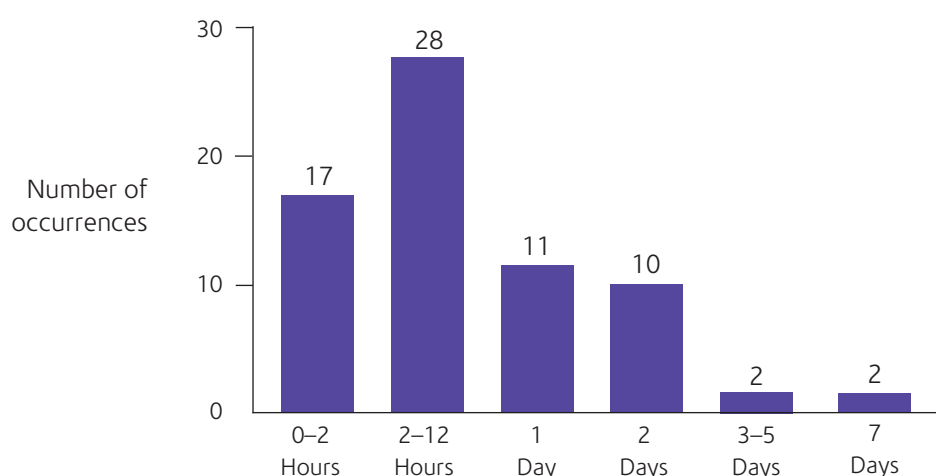
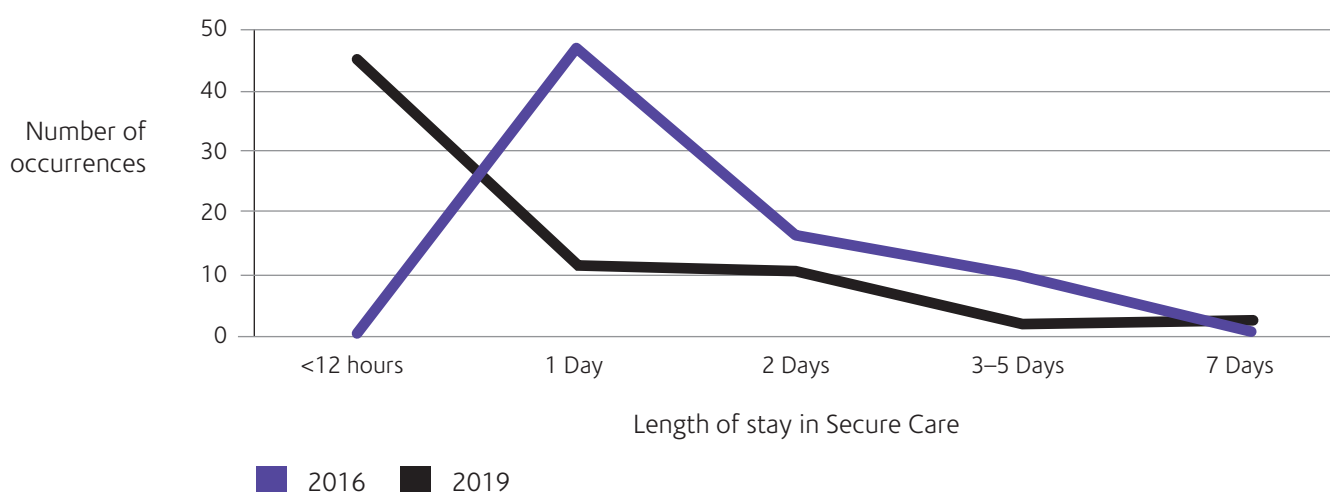


Figure 8: Frequency and length of stays in a Care and Protection residence's Secure Care unit: 2016 and 2019 compared



The Care and Protection residence saw a small reduction in the number of children spending time in a Secure room and the number of times they were placed there in 2019 compared to 2016: from 76 occurrences in 2016, down to 70 in 2019. Furthermore, a very substantial number of Secure stays were short – less than 12 hours. This was a very welcome development and indicates a more subtle use of this extreme tool.

Nonetheless and as noted earlier, too many children and young people were still spending too long in conditions which could adversely affect their health and wellbeing, retrigger traumatic events, and damage relationships in the residences. The evidence suggests that the potential for harm may even be worse for Māori children.

An Evidence Report on Therapeutic Residential Care prepared by Oranga Tamariki concluded that

‘Seclusion is not effective in reducing either the frequency or intensity of challenging behaviour with children and adolescents. Rather, seclusion has been shown to increase the risk of serious physical harm, and even death, with children. For children with trauma-related histories, the experience of seclusion is re-traumatising, making therapeutic goals more difficult to attain. Staff experience of seclusion is also negative, causing stress, psychological trauma, and spiritual trauma among Māori practitioners.

The use of seclusion can be significantly reduced, and even eliminated, through programmes that address staff management, and provide staff training in alternative methods of behavioural management for young people with challenging behaviours.’

(Oranga Tamariki (2020). *Therapeutic Residential Care: Evidence Brief*, Wellington, New Zealand: Oranga Tamariki – Ministry for Children. February 2020, at page 37).

I wholeheartedly agree with this analysis. As noted in *Thinking Outside the Box?* secluding children and young people is harmful to their health and wellbeing and can further traumatise them and damage their development and healing. It also runs contrary to international human rights law and principles of good practice.

Reasons for the use of Secure Care in Youth Justice facilities and in Care & Protection residences

The majority of Secure Care placements in the Youth Justice facility examined were recorded as ‘threats to assault’ or ‘threatening behaviour’. Preventing self-harm was cited as the reason for the placement of Secure Care in around 15% of placements. In many cases, several reasons were cited. For example, one 16-year-old was placed in Secure Care 17 different times in the course of 6 months, spending periods of 1-3 days each of these times for threats to self-harm, low mood and actual self-harm, and one period of 17 days for ‘making

sexual threats' towards two other children. One 17-year-old was placed in Secure Care 15 times over a period of 6 months, spending a total of 87 days in Secure, including one stay of 19 days for 'threatening to sexually assault a female member of staff', 14 days for 'inciting behaviour leading to group disorder', and 13 days for 'threats to harm himself and damage property'.

Recorded reasons for placing children in the Secure Care unit of a Care and Protection Residence included detoxing, absconding, low mood, 'threatening behaviour', 'distressed behaviour' and self-harm. Only a small minority of children appear to have actually done something, rather than make threats. The length of stay attached to each reasoning appeared almost random, and it was not entirely clear what the Secure placement was meant to achieve.

Secure rooms should not be used to accommodate children and young people who are mentally unwell and who self-harm. A distressed child should not be placed in conditions known to be stressful. This runs contrary not only to international human rights law, but also to common sense. It is interesting to note that since 2017 seclusion had not been practiced at the Barnardos run Te Poutama Arahi Rangatahi residence, and that all 'time-out' rooms in that unit had been re-purposed. This is a very positive step which demonstrates that it is possible to manage without the use of Secure rooms and other solitary-confinement like practices.

Material conditions and regime in Secure rooms in children and young people's facilities

Thinking Outside the Box? noted that the very existence of 'Secure rooms' for children and young people was contrary to international human rights law and good practice, and the drab conditions and prison-like appearance of Secure rooms. Since the original review took place in 2016, some improvements in the material conditions in Secure rooms took place: Secure rooms in both the Care & Protection and the Youth Justice facility examined in this report, were painted with murals, and a sensory modulation area had been added. However, despite the attempts at making Secure Care rooms more child-friendly, these rooms continued to resemble prison segregation cells, and the Secure Care unit's outdoor yard remained barren.



Secure Care unit yard in a Youth Justice facility.



Secure Care room in a Care and Protection residence.



Secure Care room with an observation panel in a Care and Protection residence.



Secure Care room in a Youth Justice facility.

The Children's Commissioner had noted in its 2017 annual State of Care report that material conditions in Secure units more generally remained institutionalised:

'In the secure units, even in care and protection residences, are prison-like and unwelcoming. They contain few furnishings and young people are not allowed to take personal belongings in with them.'

I repeat my observation that the prison-like environment in Secure Care rooms, where children and young people, often with previous trauma, are separated from their peers and where they need to sleep and attend to bodily needs in the same space, are degrading, harmful and, as previously suggested, inappropriate for housing children and young people.

It is my hope that many of these issues will be addressed in the new, community-based Care and Protection facilities.

There was some evidence of trauma informed work with children and young people in Secure rooms, but the good work was hampered, in my view, by the very traumatising nature of these rooms.

Evidence provided to us by Oranga Tamariki and reports from the Office of the Children's Commissioner's OPCAT inspections demonstrate some work in both Youth Justice and Care and Protection residences to work with children and young people to better understand their strengths and weaknesses and identify their triggers. These are welcome initiatives. However, the Daily Management Plans which were previously used (and highlighted as good practice in TOTB) were no longer completed daily, replaced instead with a one-page summary.



Secure Care unit corridor in a Youth Justice facility.

Restraints and the use of force

In 2019, Safe Tactical Approach and Response (STAR) replaced the Managing Actual and Potential Aggression (MAPA) approach in all Oranga Tamariki Youth Justice facilities. All staff now receive STAR training, which includes de-escalation techniques and physical holds, though the vast majority of the two-day programme focuses on physical holds and controls, and only one hour is dedicated to verbal de-escalation. The Children's Commissioner's OPCAT inspection reports indicate that physical restraints are now used less often, and that staff felt confident using STAR techniques.

It was not possible to speak to children and young people for this review. However, the Children's Commissioner's excellent 2019 insights report, 'A Hard Place to Be Happy: voices of children and young people in care and protection residences'⁸ provides children and young people's views and experiences of restraint:

"Children and young people told us being restrained is hard, and sometimes people are injured. We heard about carpet burns, sprained wrists and bruises. We also heard it can be frightening to see other people being restrained. Children and young people told us that, when staff are doing restraints, sometimes things go wrong and injuries can happen. One young person told us they were happy staff aren't allowed to take people to the ground anymore and that there are new restraint techniques. Others said staff still need more training around restraints. "I hate restraints ... they hurt me ... like, they grab the back of my shirt and ergghh! ... They hold me, and it hurts when they squeeze too hard." (Māori girl) "I don't like restraints 'cause some people do it hard. And, like, they don't mean to, but when [staff member] did my restraint, he left a huge bruise on my arm ... He was swearing at me and he told me I couldn't talk." (Māori young woman)

According to data provided to this review by Oranga Tamariki, in the six months to December 2019, there were 366 use of force incidents in its Youth Justice facilities, and 184 incidents in its Care and Protection residences. Oranga Tamariki were unable to provide this review with further information, including ethnicity and age of the children and young people against whom force was used, as these were not recorded.

8 Office of the Children's Commissioner (2019) 'A Hard Place to Be Happy: voices of children and young people in care and protection residences' (<https://www.occ.org.nz/assets/Uploads/HardPlaceToBeHappy-FINAL.pdf>)

Key recommendations for Oranga Tamariki

- Secure Care rooms are inappropriate for housing Children and Young People and their use should stop. Alternatives should be sought by the Ministry urgently.
- Distressed children and young people must not be placed in the stressful conditions of Secure Care rooms.
- Secure Care rooms should be better furnished, made more child friendly, and contain means for children and young people to occupy themselves whilst in the unit.
- Secure Care unit outdoor yards should include exercise equipment, a basketball hoop and other means for children and young people to physically exert themselves.
- Systems for electronically recording and analysing all uses of Secure Care rooms must be urgently developed and installed in all Oranga Tamariki residences. This should include data on ethnicity, age and other protected characteristics.
- The high number of use of force incidents in the Youth Justice facility examined needs to be analysed and addressed urgently.
- STAR training should place more focus on verbal de-escalation and less on physical holds and control.

3. Health and Disability facilities

Background and key developments since 2016/17

Since the publication of *Thinking Outside the Box?* efforts to reduce, and eventually eliminate, the use of seclusion in mental health, have intensified. There was a clear sense of a strong commitment to the goal of eliminating the use of seclusion by both the Ministry of Health (MoH) and the District Health Boards (DHBs). In December 2017 the Health Quality and Safety Commission (HQSC) and Te Pou announced that they would be collaborating on the *Pathways to Eliminate Seclusion by 2020* project. The 2017 annual report of the Office of the Director of Mental Health and Addiction Services for the Ministry of Health, published in 2019, stated support for these efforts and noted that “Seclusion should be an uncommon event, and services should use it only when there is an imminent risk of danger to the individual or others and no other safe and effective alternative is possible”.⁹

Locally, DHBs reported being actively engaged in the Zero Seclusion project, including the setting up of dedicated Zero Seclusion teams and a greater focus on the gathering and analysis of data on seclusion practices. This is a very welcome development.

In its submission to this review, one DHB emphasised their involvement in the Zero Seclusion Project, and the work of the Seclusion and Restraint Minimisation Committee as important drivers of positive change against TOTB’s recommendations. They noted, for example, a requirement for staff to undertake de-escalation training; the routine use of service user de-briefing after each seclusion event in most units; and better sharing of learning and good practice across DHBs.

The DHB recognised that, nonetheless, more remained to be done to understand variation in practice across DHBs and noted that it was still the case that no guidance had been issued by the Ministry of Health on minimum entitlements for patients service users held in seclusion, as recommended in TOTB.

9. Ministry of Health. 2019. Office of the Director of Mental Health and Addiction Services: Annual Report 2017. Wellington: Ministry of Health, at p 44

Another DHB highlighted the very low use of seclusion in its forensic units and the decommissioning of two seclusion rooms since the original report. It too highlighted its engagement in the Zero Seclusion Project and the forthcoming creation of a Reducing and Preventing the Use of Restrictive Practices Group to share learning and support improvement, underpinned by a policy document.

The DHB noted that funding had now been approved for the re-build of one of the units, further improving the quality of accommodation. They emphasised that all seclusion rooms are designed for that purpose, with call bells available to all service users, though noted that in most cases service users do not have control over lighting or temperature.

Finally, it noted the co-design approach they had taken within the Zero Seclusion Project, seeking to involve staff, service users and their whanau (though unsuccessfully with this latter group), and pointed to a regular inter-agency meeting, including the police and emergency staff, to support the greater cross-sector collaboration which I recommended in TOTB.

In its submission to this review one Civil Society Organisation similarly pointed to the Government's commitment to repeal and review the Mental Health Act, consultation on updated Guidelines to the Act, and the Health Quality and Safety Commission's quality and improvement programme to reduce seclusion and restraint, as positive developments. It also noted, however, the importance of establishing a clear legislative timetable; that aspirations for zero seclusion needed to have real weight behind them to drive change and; that there was still much work to be done, particularly for Māori. It noted that whilst section 7.1 of the Ministry's seclusion guidance had been amended, as recommended in TOTB, section 7.2 remained unchanged.

Another Civil Society Organisation expressed concern that despite positive intentions to eliminate seclusion, its use was again increasing, whilst noting a lack of consistency in the recording and reporting of data. Other submissions re-iterated these concerns and the goal of zero seclusion was in practice dependent on legislative change subject to an uncertain timescale.

The current use of seclusion in health and disability facilities: key findings

One of the key recommendations made in TOTB was for data on the use of seclusion to be more fully recorded and analysed. Since the original review took place, some good protocols on data collection and analysis developed as part of the wider project to reduce the use of seclusion in health and disability

facilities. MHAIDS, for example, have dedicated and enthusiastic local teams to lead seclusion reduction efforts and monitor its use. However, the length of time it took the Ministry of Health (MoH) to produce very basic data on the extent of the use of seclusion, the duration of seclusion events and the key characteristics of those secluded, indicates that much work is yet to be done.

This review's ability to assess the use of seclusion and restraint across health and disability facilities was limited by lack of timely access to national information and data from the Ministry of Health. Doubtless, this was in part because of COVID-19, which had meant that MoH personnel were under particular pressure, and everything else had to take a back seat. However, we were unable to obtain information from the Ministry despite repeated requests, also long after the initial lockdown period had ended. It took five months, from March to August, to receive any information, and then the information received was partial. I believe that the difficulty in obtaining information from the MoH was also at least in part due to difficulty in gathering the relevant information – which was worrying in itself, as good data keeping is key to any successful change. Other bodies have also noted the serious shortcoming associated with data collection and analysis by the Ministry, so the problem would appear to be a wider one.

When we finally received the Ministry's response to our request for data and information on changes and developments since 2017, it stated that:

“Clinicians must record the duration and circumstances of each episode of seclusion in a register that must be available for district inspectors to review....

Seclusion must be reported to the Ministry of Health via a national mental health and addiction database ('PRIMHD').

Statistics on the use of seclusion are published annually by the Ministry of Health in the Office of the Director of Mental Health Annual Reports. All reports are available online.”

Whilst all this is true, of course, this response overlooks the difficulties cited as reasons for the inability to provide this review with the basic data on the use of seclusion, and the fact that – at the time of writing (November 2020), the latest report published by the MoH was the 2017 annual report, published as late as February 2019.

The MoH noted that part of the problem lies with the different definitions and measurements used by the DHBs. Considering the immense investment in strategies to eliminate the use of seclusion, it would appear reasonable for a standardised definition and measurements to be in place by now.¹⁰

It also seems to me that some of the seclusion indicators for which data is available, for example “seclusion hours per 100k Population”, appear to be of very limited utility for understanding how and when seclusion is used.

I would note that good data is absolutely essential if any meaningful change is to be achieved. I would also suggest that transparency is a critical element for achieving any change. I was concerned about the quality of the data and responsiveness in our interactions with the Ministry of Health.

Frequency and length of seclusion events

Despite the stated intentions and best efforts of many individuals and bodies, and funding to facilitate efforts to reduce and eventually eliminate the use of seclusion in mental health, the overall picture from data and submissions provided to this review was one of persisting use, disproportionately with Māori and Pacific Peoples service users.

Space does not allow detailed examination or discussion of why seclusion and restraint practices persist despite efforts to limit and eventually eradicate them. Institutional change is difficult to achieve, and staffing pressures undoubtedly make change even more difficult.

As noted above, the lack of reliable data made it difficult to assess changes since the original review, but data from the national KPI dashboard¹¹ demonstrated that the goal of eliminating the use of seclusion and restraint in health and disability facilities had not yet been met.

Between 2016/17, when the initial review took place and 2018/19, the average number of seclusion events per person rose from 2.12 to 2.86 seclusion events per person (Dashboard data). On a positive note, the average length of seclusion events slightly reduced, but remained over two days.

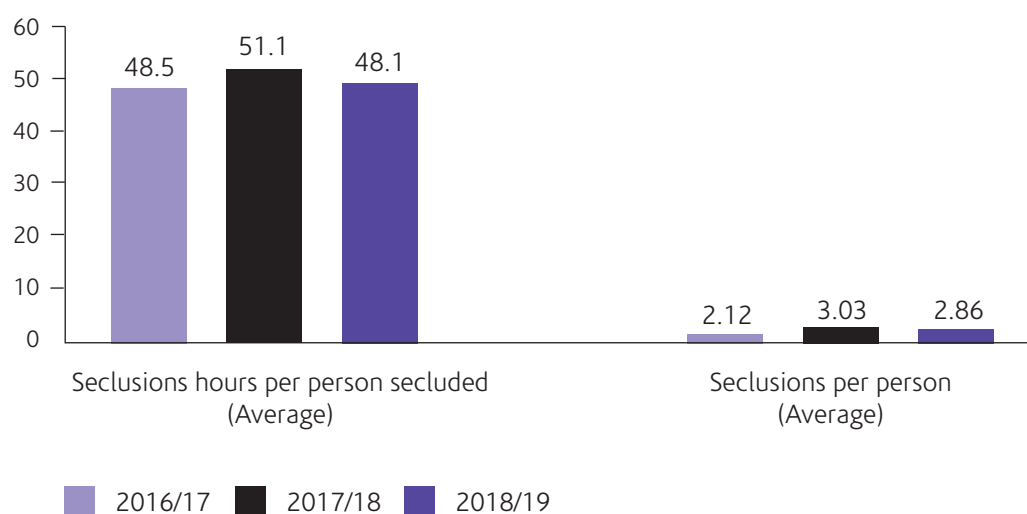
10. Seclusion is defined as: ‘Where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit’. New Zealand Standards. Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. Ministry of Health. 2008.

Personal restraint is when a service provider(s) uses their own body to limit a service user’s normal freedom of movement. New Zealand Standards. Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. Ministry of Health. 2008.

Environmental restraint is where a service provider(s) intentionally restricts a service users’ normal access to their environment, for example where a service users’ normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as wheelchair) denied. Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. Ministry of Health. 2008.

11. The New Zealand Mental Health and Addictions KPI Programme (KPI Programme)

**Figure 9: Average number of seclusion events and seclusion hours 2016–2019
Health and Disability facilities**



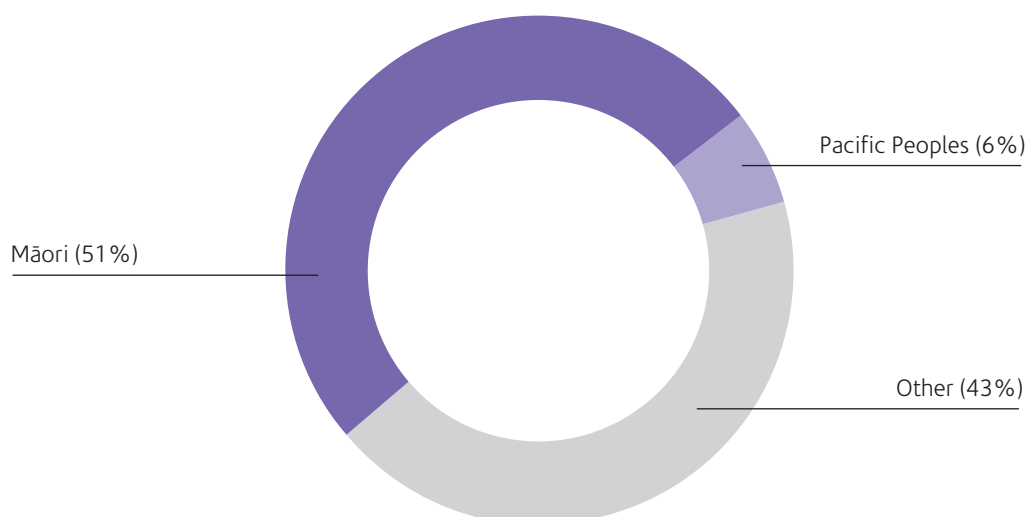
Some stays were significantly longer – one man of Pacific descent had spent 10 days in seclusion in one forensic unit, and two Māori men had spent 7 and 14 days each in one acute inpatient psychiatric unit. The Ombudsman reported the case of one man who was secluded in the High Care Secure Lounge of the Forensic Inpatient ward at Waikato hospital for close to three months following an assault on a member of staff. He stated “I consider the justification for continuing seclusion over a period of over 16 weeks was not established. The seclusion documentation regularly described a service user who did not demonstrate an imminent risk to the safety of others. I consider prolonged seclusion in these circumstances was degrading treatment and a breach of Article 16 of the Convention against Torture.” (Ombudsman, Puna Awhi-rua Forensic Inpatient Ward, Waikato Hospital ,2020, p11).

I concur with the Ombudsman’s observations. Seclusion must only be used as a very short-term emergency measure, not as a longer-term solution for more challenging service users, or lack of more appropriate beds or staff shortages.

Who was housed in seclusion rooms?

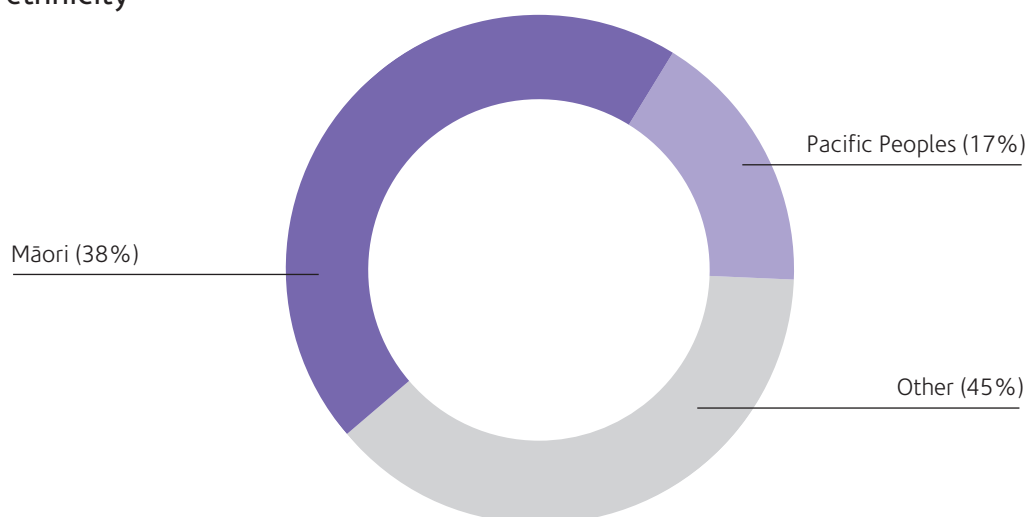
According to Ministry of Health data, of the 589 service users secluded in the 6 months to March 2020 across the country, 406 were men, and 183 were women. Together, they were secluded for a total of 3,106 times. Māori remained grossly over-represented in seclusion units. In the six months to March 2020, Māori made up 51 % of the total number of people secluded in Health and Disability facilities. Pacific Peoples made up 6%.

Figure 10: Service users secluded October 2019 – March 2020 by ethnicity



Interestingly, while Pacific Peoples accounted for 6% of service users who were secluded, they accounted for as many as 17% of all seclusion events, indicating a high number of repeated seclusions.

Figure 11: Seclusion events October 2019 – March 2020 by service user's ethnicity



There was significant variation in the use of seclusion across the four different regions. In one DHB, a total of 17 service users were secluded over a six months period, while in another DHB, 56 individual service users (including in in-patient disability facilities, rehabilitation units, adolescent inpatient service and youth secure forensic unit) were secluded 581 times, together spending 5,059 seclusion hours. As many as 48% of these service users were Māori, and 12.5% were Pacific Peoples.

Seclusion is meant to only be used when necessary for the care or treatment of the service user, or for the protection of other service users. However, one of the issues highlighted in TOTB was that seclusion rooms were not always used for their intended purposes, but instead were used as overflow bedrooms when the wards / units were over capacity, or as longer-term housing for individuals who are perceived as high need or challenging.

Reports by monitoring bodies indicate that seclusion rooms continue to be used, alongside other rooms and areas, for purposes outside their designation, in a practice described by unit staff as 'sleep overs'.

Reporting on so-called 'sleep overs' in one forensic inpatient ward, the Ombudsman stated that he considers these to be in breach of Article 16 of the UN Convention Against Torture (the prohibition against torture and inhuman or degrading treatment). I concur and join the Ombudsman's call for such practices to cease.

It was illuminating that the New Zealand Nurses Organisation Mental Health Nurse Section (MHNS) National Committee felt compelled to issue a public statement issued by the New Zealand Nurses Organisation Mental Health Nurse Section (MHNS) National Committee in response to critical reports by the Ombudsman, hinting at some of the complexities around seclusion reduction policies:

"Seclusion rooms have been used as accommodation because of over occupancy and over-crowding. Mental health nurses make difficult choices every day in terms of either admitting service users when units are over capacity or declining them, which may result in unsafe conditions in the community. Mental health staff are criticised when they discharge service users too soon and criticised when they do not create space for service users in acute need.

Mental health nurses have been concerned about staffing levels – both in numbers and levels of expertise.

Mental health nurses have been concerned about violence and the provision of sufficient well-trained staff, in-patient and community facilities with safe environments to appropriately respond to challenging and complex situations. They have been asking for provision of safe environments conducive to delivering safe and therapeutic care.

Mental health nurses have been concerned about access to acute services, the lack of acute care beds and the resourcing of services for people with high and complex needs and people presenting with co-existing serious mental illness and substance disorders – especially methamphetamine and alcohol. There is no flexibility in the

health system to find temporary beds elsewhere – sometimes there is no option other than an open seclusion room.”¹²

One must not underestimate the strains and challenges of an overcrowded and understaffed system. However, locking up service users who are unwell in the barren, austere seclusion rooms for hours, days or weeks is not an acceptable solution for staffing and budgeting problems. It can also mask the extent of the use of de facto seclusion.

Material conditions in seclusion units

In TOTB I recommended that: the physical environment of seclusion units and rooms be improved; service users be allowed to keep some personal belongings and provided with something to do in seclusion, and; that yards be equipped with exercise equipment.

Whilst the COVID pandemic had meant that we were unable to visit Health and Disability units ourselves, reports by monitoring bodies and submissions to this review indicate that, some new build and refurbishment work notwithstanding, many of the problems identified in *Thinking Outside the Box?* persisted in these units, including:

- Stark environment with limited or no natural light and no fresh air;
- Furnishings comprising of no more than a bed base and a mattress, often just a mattress;
- No means to tell the passing of time of day or date (clock/ calendar);
- Windows without curtains or, conversely, with blinds that are kept shut and are not working;
- Seclusion rooms have no toilets. Instead, service users need to use cardboard bedpans for urinating and defecating;
- No access to running water.

Another issue highlighted in several reports was lack of privacy in seclusion rooms, with service users potentially having to attend to their bodily needs in full sight of unit staff.¹³

12. Response To The Chief Ombudsman's OPCAT Report Press Release: New Zealand Nurses Organisation, 28 August 2020. <https://www.scoop.co.nz/stories/GE2008/S00170/response-to-the-chief-ombudsmans-opcat-report.htm>

13. See for example a series of OPACT inspection reports on visits to Health and Disability facilities by the Office of the Ombudsman between September 2019 and March 2020, available on the Ombudsman's website: <https://www.ombudsman.parliament.nz/resources?f%5B0%5D=category%3A1993>



Seclusion room mattress and anti-ligature clothing and bedding in a Health & Disability unit.



Seclusion room with regular bedding in a Health & Disability unit.



Courtyard in the seclusion area of a Health & Disability unit.

Such arrangements are degrading and may breach the UN Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

It is regrettable that these issues, highlighted in *Thinking Outside the Box?* and numerous other reports, had not yet been addressed. In TOTB I also noted that lack of basic provisions, including running water and a toilet, inside seclusion rooms, had meant that service users needed to rely on already-stretched staff to provide basics such as drinking water or access to a toilet. Our recommendation to ensure that service users have ongoing access to these basic necessities does not appear to have been met. In its submission to this follow-up review one DHB asserted that:

“All low stimulus areas have access to secure outdoor spaces. Refreshments are offered to service users during regular room entries (minimum of two-hourly).

All rooms are air-conditioned with temperature being controlled centrally and adjusted automatically to help ensure it stays within the optimal range... Staff provide blankets if needed during cold weather and fans during the warmer weather.” (DHB)

With regard to access to a toilet, the DHB noted that some of seclusion units have en suite rooms and others

“...have toilets in the near vicinity. Wherever possible, these are made accessible to service users in seclusion. If there are concerns re risk, a toilet pan/urinal is made available to people.”

These responses again fail to account for the de-facto conditions in many mental health and disability units, namely overcrowding and staff shortages. These mean that no matter how well-intentioned seclusion staff are, providing service users with toilet access or water on request in a timely manner is likely to stretch them beyond capacity. Access to basics should be ongoing and not dependent on staff goodwill and availability.

The use of restraints

The Ministry of Health informed this review that data on restraint use was not currently collected, but plans were underway to introduce national reporting. I look forward to hearing more about national reporting as it evolves. Good record keeping, as noted earlier, is crucial for any meaningful change to take place.

Although this review did not benefit from nationwide data on the use of restraints, however, it might be useful to examine the use of restraint by one DHB by way of illustration. The data examined below was provided to this review by the DHB.

Between September 2019 and February 2020 restraints were used 358 times. More than half of these uses were with female service users, and 42% were Māori service users. The majority of restraint uses involved personal holds, but close to a third (114) of the uses involved prone restraints, where the person is held chest down, including several very lengthy holds – 1463 minutes in one case, 290, 100 and 125 minutes in others. These, clearly, are incredibly long times, especially considering that because of the health risks associated with prone restraints, international good practice suggests that they should only be used in exceptional, emergency situations.

Key recommendations for the Ministry of Health and the DHBs

- More effort needs to be directed at finding and agreeing a standardised measurement and national recording of seclusion events across the different health and disability services.
- Physical conditions in all seclusion rooms must adhere to minimum standards regarding room size, ventilation, lighting and temperature.
- Service users should have ongoing direct access to drinking water, toilet facilities, and sufficient clothing and bedding, without need for staff intervention.
- Secluded service users should have access to fresh air and the opportunity to exercise.
- All uses of locked seclusion rooms and areas which the service user cannot freely exit must be recorded as seclusion events.
- Seclusion rooms must not be used as regular bedrooms.
- Record keeping and data analysis must be improved nationally.
- More work needs to be done to understand some of the barriers to achieving a sustained reduction in seclusion events. In particular, it may be worth exploring the views and concerns of different staff groups about seclusion reduction policies.
- More work needs to be done to understand the divergence in use of restraints across DHBs and their use with Māori and Pacific Peoples in particular.

4. Police

The Police failed to provide this follow up review, despite repeated requests, with the information sought in a timely manner and in a format which allowed for ready analysis.

Regrettably, this means that I am unable to assess if and how recommendations made in 2017 (see appendix 1) had been acted upon by the Police.

I am concerned by the inability to follow-up on Police custody suites and the use of restraints by the Police, and by the lack of accountability and transparency that suggests. Ultimately, this may be prejudicial to ensuring that those in Police care are treated with respect to their inherent dignity.

Appendix 1: *Thinking outside the Box?* (2017) recommendations

All agencies: 2017 recommendations

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|----|--|
| G1 | 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. |
| G2 | 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. |
| G3 | 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. |
| G4 | 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. |
| G5 | 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. |
| G6 | 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. |
| G7 | 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 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. |

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- G 8** 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.
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- G 9** 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. Similarly, the apparent overrepresentation of women in prison segregation units needs to be investigated and addressed.
-
- G 10** 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.
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- G 11** 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.
-
- G 12** 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.
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Ministry of Health/DHBs: 2017 recommendations

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- H1** 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.
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- H2** 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.
-
- H3** 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.
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- H4** 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.
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- H5** 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.
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- H6** 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.
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H7	Consideration should also be given to the amendment of sections 7.1 and 7.2 of the Ministry's Seclusion Guidelines (52) 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.
H8	More work should be carried out to better understand the variation in practice between the different DHBs.
Department of Corrections: 2017 recommendations	
C1	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.
C2	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.
C3	The Corrections Act allows for basic regime provisions, for example education, visits, and telephone calls, to be denied to people serving a disciplinary punishment. This runs contrary to international human rights law and should be amended. Basic provisions must always be provided.
C4	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.
C5	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).

C6	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.
C7	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 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.
C8	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. 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.
C9	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.
C10	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.

Ministry of Social Development (Child, Youth and Family): 2017 recommendations

Y1	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.
Y2	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.
Y3	Where the Secure Care Unit is used, children and young people should be allowed to have some personal belongings with them including the means to study and/or do some writing.
Y4	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.

Police: 2017 recommendations

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| P1 | 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. |
| P2 | 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. |
| P3 | 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. |
| P4 | 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. |
| P5 | 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. |
| P6 | 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. |
| P7 | 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. |
| P8 | 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. |
| P9 | 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. |

National Preventive Mechanism: 2017 recommendations

- NPM1** The bodies who make up New Zealand's National Preventive 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.
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- NPM2** NPM members should consider the adoption of a joint approach to monitoring the use of seclusion and restraint across their different areas of responsibility and promoting an agenda of reducing, and eventually eliminating, the use of seclusion and restraint across the board, in line with current international thinking.
-
- NPM3** All NPM members should consider making their monitoring reports public.
-
- NPM4** 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.
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Appendix 2: International human rights law on solitary confinement, seclusion and restraint

Compiled by Eleanor Vermunt, Legal Adviser,
New Zealand Human Rights Commission

International treaties

International Covenant on Civil and Political Rights (ICCPR)

Adopted in 1966 and ratified by New Zealand in 1978

- **Article 7:** “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.”
- **Article 4(2)** established this as a non-derogable peremptory norm, which means that States can never derogate from it, even in times of a public emergency.
- **Article 10.1:** “All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.”
- **Article 10.3:** “The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation.”

Juveniles

- **Article 10(2)(b):** “Accused juvenile persons shall be separated from adults and brought as speedily as possible for adjudication.”
- **Article 10(3):** “... Juvenile offenders shall be segregated from adults and be accorded treatment appropriate to their age and legal status.”
- **Article 14(4):** “In the case of juvenile persons, the procedure shall be such as will take account of their age and the desirability of promoting their rehabilitation.”

Convention against Torture and other Cruel, Inhuman or Degrading Treatment (CAT)

Adopted in 1984 and ratified by New Zealand in 1989

- **Article 1.1:** "For the purposes 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 a 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, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."
- **Article 2.1:** "Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction."
- **Article 16(1):** "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 I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity... ."

Optional Protocol to the Convention Against Torture (OPCAT)

- **Article 1:** "The objective of the present Protocol is to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment."
- **Article 2.1:** "A Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of the Committee against Torture (hereinafter referred to as the Subcommittee on Prevention) shall be established and shall carry out the functions laid down in the present Protocol."
- **Article 4.1:** "Each State Party shall allow visits, in accordance with the present Protocol, by the mechanisms referred to in articles 2 and 3 to any place under its jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (hereinafter referred to as places of detention). These visits shall be undertaken with a view to

strengthening, if necessary, the protection of these persons against torture and other cruel, inhuman or degrading treatment or punishment.”

- **Article 17:** “Each State Party shall maintain, designate or establish, at the latest one year after the entry into force of the present Protocol or of its ratification or accession, one or several independent national preventive mechanisms for the prevention of torture at the domestic level. Mechanisms established by decentralized units may be designated as national preventive mechanisms for the purposes of the present Protocol if they are in conformity with its provisions.”

Convention on the Rights of the Child (CRC)

Adopted in 1989 and ratified by New Zealand in 1993

- **Article 37:** “(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment... (c) Every child deprived of liberty 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... .”

Convention on the Rights of Persons with Disabilities (CRPD)

Adopted in 2008 and ratified by New Zealand in 2008

- **Article 2:** “reasonable accommodation” is defined 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.”
- **Article 12.4:** “States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law.”
- **Article 13.2:** “In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.”
- **Article 15:** “1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. ... 2. States Parties shall 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.”

Non-binding instruments

Universal Declaration of Human Rights (1948)

- **Article 5:** “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”

United Nations Declaration on the Rights of Indigenous Peoples (2007)

- **Article 7 1:** “Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person.”

United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules)

First adopted in 1957 and revised and unanimously adopted as the Nelson Mandela Rules in 2015

- **Rule 1:** “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.”¹⁴

Solitary confinement

- **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;”
- **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.”
- **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.

14. The centrality of the Mandela Rules is reflected in New Zealand through section 5 of the Corrections Act 2004, which 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;...”

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."

- **Rule 46:** "1. Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff."

Restraint

- **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 health-care professionals and report to the higher administrative authority."
- **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. (d) Instruments of restraint shall never be used on women during labour, during childbirth and immediately after childbirth."
- **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."

United Nations Rules for the Protection of Juveniles Deprived of their Liberty 1990 (Havana Rules)

- **Rule 67:** "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."

Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment (1988) G.A. Res. 43/173, at 6, U.N. Doc. A/RES/43/173 (9 December 1988)

- **Principle 1:** "All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person."
- **Principle 6:** "No person under any form of detention or imprisonment shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. No circumstance whatever may be invoked as a justification for torture or other cruel, inhuman or degrading treatment or punishment. The term 'cruel, inhuman or degrading treatment or punishment' should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time."
- **Principle 15:** "Notwithstanding the exceptions... communication of the detained or imprisoned person with the outside world, and in particular his family or counsel, shall not be denied for more than a matter of days."

Interpretation of rights on solitary confinement, seclusion and restraint by united nations treaty bodies and special rapporteurs

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/63/175 Annex (28 July 2008) (Manfred Nowak)

- “The use of solitary confinement should be absolutely prohibited in the following circumstances:
 - For death row and life-sentenced prisoners by virtue of their sentence.
 - For mentally ill prisoners.
 - For children under the age of 18.”
- “Furthermore, when isolation regimes are intentionally used to apply psychological pressure on prisoners, such practices become coercive and should be absolutely prohibited.”
- “As a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort.”

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/66/268 (5 August 2011) (Juan Mendez)

- “... the social isolation and sensory deprivation that is imposed by some States does, in some circumstances, amount to cruel, inhuman and degrading treatment and even torture.” [20]
- “...the Special Rapporteur defines solitary confinement as the physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day. Of particular concern to the Special Rapporteur is prolonged solitary confinement, which he defines as any period of solitary confinement in excess of 15 days... because at that point, according to the literature surveyed, some of the harmful psychological effects of isolation can become irreversible.”
- “...the longer the duration of solitary confinement or the greater the uncertainty regarding the length of time, the greater the risk of serious and irreparable harm to the inmate that may constitute cruel, inhuman or degrading treatment or punishment or even torture.” [58]
- “Solitary confinement, when used for the purpose of punishment, cannot be justified for any reason, precisely because it imposes severe mental pain and suffering beyond any reasonable retribution for criminal behaviour and

thus constitutes an act defined in article 1 or article 16 of the Convention against Torture, and a breach of article 7 of the International Covenant on Civil and Political Rights. This applies as well to situations in which solitary confinement is imposed as a result of a breach of prison discipline, as long as the pain and suffering experienced by the victim reaches the necessary severity.” [72]

- “Where the physical conditions of solitary confinement are so poor and the regime so strict that they lead to severe mental and physical pain or suffering of individuals who are subjected to the confinement, the conditions of solitary confinement amount to torture or to cruel and inhuman treatment as defined in articles 1 and 16 of the Convention, and constitute a breach of article 7 18 of the Covenant.” [74]
- “The use of solitary confinement can be accepted only in exceptional circumstances where its duration must be as short as possible and for a definite term that is properly announced and communicated.” [75]
- “...the Special Rapporteur concurs with the position taken by the Committee against Torture in its General Comment No. 20 that prolonged solitary confinement amounts to acts prohibited by article 7 of the Covenant, and consequently to an act as defined in article 1 or article 16 of the Convention. For these reasons... any imposition of solitary confinement beyond 15 days constitutes torture or cruel, inhuman or degrading treatment or punishment, depending on the circumstances.” [76]
- “[The Special Rapporteur] calls on the international community to... impose an absolute prohibition on solitary confinement exceeding 15 consecutive days.” [76]
- “Depending on the specific reason for its application, conditions, length, effects and other circumstances, solitary confinement can amount to a breach of article 7 of the International Covenant on Civil and Political Rights, and to an act defined in article 1 or article 16 of the Convention against Torture. In addition, the use of solitary confinement increases the risk that acts of torture and other cruel, inhuman or degrading treatment or punishment will go undetected and unchallenged.” [80]
- “The Special Rapporteur reiterates that solitary confinement should be used only in very exceptional circumstances, as a last resort, for as short a time as possible. He emphasizes that when solitary confinement is used in exceptional circumstances, minimum procedural safeguards must be followed. These safeguards reduce the chances that the use of solitary confinement will be arbitrary or excessive, as in the case of prolonged or indefinite confinement. They are all the more important in circumstances of detention where due

process protections are often limited, as in administrative immigration detention. Minimum procedural safeguards should be interpreted in a manner that provides the greatest possible protection of the rights of detained individuals.” [89]

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/68/295 (9 August 2013) (Juan Mendez)

- “Prison regimes of solitary confinement often cause mental and physical suffering or humiliation that amounts to cruel, inhuman or degrading treatment or punishment.” [60]
- “Solitary confinement should be imposed, if at all, in very exceptional circumstances, as a last resort, for as short a time as possible and with established safeguards in place after obtaining the authorization of the competent authority subject to independent review.” [60]

Human Rights Committee, General Comment 20, Article 7 (Forty-fourth session, 1992) Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 30, U.N. Doc. HRI/GEN/1/Rev.1 (1994)

- “The Committee notes that prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by article 7. ...” [6]

Human Rights standards for certain populations

Children and Youth

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Human Rights Council, U.N. Doc. A/HRC/28/68 (5 March 2015) (Juan Mendez)

“In accordance with views of the Committee against Torture, the Subcommittee on Prevention of Torture and the Committee on the Rights of the Child, the Special Rapporteur is of the view that the imposition of solitary confinement, of any duration, on children constitutes cruel, inhuman or degrading treatment or punishment or even torture.” [44]

- “With regard to conditions during detention, the Special Rapporteur calls upon all States: ... (d) To prohibit solitary confinement of any duration and for any purpose [for juveniles.]” [86(d)]

Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc. A/66/268 (5 August 2011) (Juan Mendez)

- “States should abolish the use of solitary confinement for juveniles Regarding disciplinary measures for juveniles, the Special Rapporteur recommends that States should take other measures that do not involve the use of solitary confinement. ...” [86]

Committee on the Rights of the Child, General Comment No 10 (2007) Children’s rights in juvenile justice, CRC/C/GC/10 (25 April 2007)

- “The Committee wishes to emphasize that, inter alia, the following principles and rules need to be observed in all cases of deprivation of liberty:
 - Children should be provided with a physical environment and accommodations which are in keeping with the rehabilitative aims of residential placement, and due regard must be given to their needs for privacy, sensory stimuli, opportunities to associate with their peers, and to participate in sports, physical exercise, in arts, and leisure time activities; ...
 - 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; ...”

Disabled people, including persons with mental illness

Report of the Special Rapporteur on the rights of persons with disabilities, U.N. Doc. A/HRC/40/54 (11 January 2019) (Catalina Devandas-Aguilar)

- “Deprivation of liberty as a result of diversion from the criminal justice system is also a common practice across jurisdictions (A/HRC/37/25). When

persons with intellectual or psychosocial disabilities have been deemed unfit to stand trial, or declared not responsible for their criminally relevant actions, they are usually diverted to a forensic facility or civil institutions. Frequently, in these facilities, they will have less access to procedural guarantees than others in the criminal justice system and be subjected to forced interventions, solitary confinement and restraint. In such facilities, they are also subject to stricter regimes, and have less access to recreational, educational and health services than those available in mainstream prisons, as well as fewer procedural guarantees. The criterion of “dangerousness” is usually used to assess the need for imposition of these security measures. Police and social services may also act as diversion agents and are in many cases entitled to initiate involuntary hospitalization.” [20]

- “Persons with disabilities deprived of their liberty are invariably placed into an extremely vulnerable position. They are at serious risk of sexual and physical violence, sterilization and human trafficking. They also experience a higher risk of being subjected to torture and inhuman and degrading treatment, including forced medication and electroshock, restraints and solitary confinement. They are even denied medical care and left to die. Moreover, persons with disabilities deprived of their liberty are often formally stripped of their legal capacity, without opportunities to challenge the deprivation of liberty, and in the long run invisible and forgotten by the wider community. Indeed, due to the mistaken belief that those practices are benevolent and well intentioned and do not constitute deprivation of liberty, the situation of persons with disabilities deprived of their liberty is hardly monitored by national preventive mechanisms or national human rights institutions.” [24]
- “Deprivation of liberty involves a more severe restriction on physical freedom than mere interference with liberty of movement. Individuals are deprived of their liberty when they are confined to a restricted space or placed in an institution or setting, not free to leave, and without free and informed consent. Examples of deprivation of liberty include police custody, pretrial detention, imprisonment after conviction, house arrest, administrative detention, involuntary hospitalization, and placement of children in institutional care. They also include certain further severe restrictions on liberty, for example, solitary confinement or the use of restraints.” [40]
- “The deprivation of liberty on the basis of impairment is a human rights violation on a massive scale. Persons with disabilities are systematically placed into institutions and psychiatric facilities, or detained at home and other community settings, based on the existence or presumption of having an impairment. They are also overrepresented in traditional places

of deprivation of liberty, such as prisons, immigration detention centres, juvenile detention facilities and children's residential institutions. In all these settings, they are exposed to additional human rights violations, such as forced treatment, seclusion and restraints." [85]

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/63/175 Annex (28 July 2008) (Manfred Nowak)

- "Persons with disabilities are often segregated from society in institutions, including prisons, social care centres, orphanages and mental health institutions. They are deprived of their liberty for long periods of time including what may amount to a lifelong experience, either against their will or without their free and informed consent. Inside these institutions, persons with disabilities are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence. The lack of reasonable accommodation in detention facilities may increase the risk of exposure to neglect, violence, abuse, torture and ill-treatment." [38]
- "The Special Rapporteur notes that under article 14, paragraph 2, of CRPD, States have the obligation to ensure that persons deprived of their liberty are entitled to "provision of reasonable accommodation". This implies an obligation to make appropriate modifications in the procedures and physical facilities of detention centres, including care institutions and hospitals, to ensure that persons with disabilities enjoy the same rights and fundamental freedoms as others, when such adjustments do not impose a disproportionate or undue burden. The denial or lack of reasonable accommodations for persons with disabilities may create detention and living conditions that amount to ill-treatment and torture." [54]
- "Within institutions, persons with disabilities are often held in seclusion or solitary confinement as a form of control or medical treatment, although this cannot be justified for therapeutic reasons, or as a form of punishment." [56]

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/68/295 (9 August 2013) (Juan Mendez)

- "...the [Standard Minimum] Rules should explicitly prohibit the imposition of solitary confinement of any duration for...persons with psychosocial disabilities or other disabilities or health conditions." [61]

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/HRC/22/53, Annex (1 February 2013) (Juan Mendez)

- “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 ... 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 degrading treatment ... 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.” [63]
- 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.” [89(c)]

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, CAT/OP/27/2 (26 January 2016)

- “Restraints, physical or pharmacological, are forms of deprivation of liberty and, subject to all safeguards and procedures applicable to the latter, should be considered only as measures of last resort for safety reasons. The State must take into account, however, that there is an inherently high potential for abuse of such restraints and as such these must be applied, if at all, within a strict framework that sets out the criteria and duration for their use, as well as procedures related to supervision, monitoring, review and appeal. Restraints must never be used for the convenience of staff, next of kin or others. Any restraint has to be recorded precisely and be subject to administrative accountability, including independent complaint mechanisms and judicial review.” [9]

- “Solitary confinement must never be used. It segregates persons with serious or acute illness and leaves them without constant attention and access to medical service. It should be differentiated from medical isolation. Medical isolation requires daily monitoring with the presence of trained medical staff and must not deprive the person of contact with others provided that proper precautions are taken. Any isolation has to be made for the shortest possible period of time, recorded precisely and be subject to administrative accountability, including independent complaint mechanisms and judicial review.” [10]

Committee on the Rights of Persons with Disabilities, observations on the Standard Minimum Rules for the Treatment of Prisoners (20 November 2013)

- “Detention conditions should never amount to creating increased suffering to inmates with disabilities. In no case should the disability entail added forms of suffering for persons under detention. To avoid this violation of law, priority should be given to the dignity of the individual and to the preservation of their autonomy in relation to the kind of disability he or she has.” [6]
- “On the issue of *solitary confinement* it should never be used on a person with disability, in particular with a psychosocial disability or if there is danger for the person’s health in general.” [12]

Women

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/68/295 (9 August 2013) (Juan Mendez)

- “... the [Standard Minimum] Rules should explicitly prohibit the imposition of solitary confinement of any duration for...pregnant women, women with infants and breastfeeding mothers” [61]

United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (2010) (The Bangkok Rules)

- **Rule 22:** “Punishment by close confinement or disciplinary segregation shall not be applied to pregnant women, women with infants and breastfeeding mothers in prison.”
- **Rule 23:** “Disciplinary sanctions for women prisoners shall not include a prohibition of family contact, especially with children.”
- **Rule 24:** “Instruments of restraint shall never be used on women during labour, during birth and immediately after birth.”
- **Rule 41:** “The gender-sensitive risk assessment and classification of prisoners shall:

- (a) Take into account the generally lower risk posed by women prisoners to others, as well as the particularly harmful effects that high-security measures and increased levels of isolation can have on women prisoners;
- (b) Enable essential information about women's backgrounds, such as violence they may have experienced, history of mental disability and substance abuse, as well as parental and other caretaking responsibilities, to be taken into account in the allocation and sentence planning process;
- (c) Ensure that women's sentence plans include rehabilitative programmes and services that match their gender-specific needs; ...
- (d) Ensure that those with mental health-care needs are housed in accommodation which is not restrictive, and at the lowest possible security level, and receive appropriate treatment, rather than being placed in higher security level facilities solely due to their mental health problems."

Uncharged and untried detainees

United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules)

- **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."
- **Rule 112:** "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 113:** "Untried prisoners shall sleep singly in separate rooms, with the reservation of different local custom in respect of the climate."
- **Rule 117:** "An untried prisoner shall be allowed to procure at his or her own expense or at the expense of a third party such books, newspapers, 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."

Appendix 3: New Zealand law and regulations on seclusion, segregation and restraint

Compiled by Eleanor Vermunt, Legal Adviser,
New Zealand Human Rights Commission

Provisions that apply to all forms of detention

New Zealand Bill of Rights Act 1990

- Long title: “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.”
- **Section 9:** “Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment.”
- **Section 23(5):** “Everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person.”

Crimes of Torture Act 1989

- **Section 2** defines an “act of torture” as “any act or omission by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person – (a) for such purposes as – (i) obtaining from that person or some other person information or a confession; or (ii) punishing that person for any act or omission for which that person or some other person is responsible or is suspected of being responsible; or (iii) intimidating or coercing that person or some other person; or (b) for any reason based on discrimination of any kind; – but does not include any act or omission arising only from, or inherent in, or incidental to, any lawful sanctions that are not inconsistent with the Articles of the International Covenant on Civil and Political Rights.”
- **Section 3** makes it a criminal offence for “any person who is a public official or who is acting in an official capacity” to commit, abet or incite an act of torture, or to incite, counsel, or procure any person to commit any act of torture. The Act also applies to attempt, conspiracy or accessory to 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 Act.

Crimes Act 1961

- **Section 151:** “Every one who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessities is under a legal duty – (a) to provide that person with necessities; and (b) to take reasonable steps to protect that person from injury.”
- **Section 2** defines a “vulnerable person” “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.”

Laws for specific type of detention

Prisons

Corrections Act 2004

Segregation

- **Section 57:** Segregation is defined 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.”
- The Corrections Act provides for the segregation of prisoners for the purpose of security, good order or safety (s 58), protective custody (s 59) or medical oversight (s 60).

Security, good order, or safety

- **Section 58(1):** A prisoner may be placed in segregation if the prison manager is of the opinion that “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.”
- **Section 58(2):** 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 of the direction and the reasons for it.
- **Section 58(3):** The decision to segregate someone may be revoked at any time by the chief executive or a Visiting Justice (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,
- **Sections 58(3)(c), 58(3)(d)(i):** 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.

- **Sections 58(3)(d)(ii), 58(3)(e):** 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.

Protective custody

- **Section 59(1):** 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 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
- **Section 59(2)(a):** A prisoner asking to be segregated must give consent in writing and can withdraw consent at any time.
- **Section 59(3):** 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.
- **Section 59(4)(a):** 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.
- **Section 59(4)(b)-(d):** 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.

Medical oversight

- **Section 60(1):** 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).
- **Section 60(2):** This decision must be given promptly in writing and the chief executive must be informed
- **Section 60(3):** This segregation continues until revoked by the prison manager or chief executive
- **Section 60(4):** The prison manager may not revoke the segregation unless advised to do so by the health centre manager
- **Section 60(5):** 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

Use of Force/Restraint

Subpart 4, sections 83 – 88 of the Corrections Act 2004

- **Section 83(1):** “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.”
- **Section 83(2):** If physical force is used in the circumstances referred to in s 83(1) it may not be more than is “reasonably necessary in the circumstances”.
- **Section 87(4):** “A mechanical restraint – (a) must not be used for any disciplinary purpose” and “must be used in a manner that minimises harm and discomfort to the prisoner.”
- **Section 87(5):** “A mechanical restraint must not be used on a prisoner for more than 24 hours at a time unless the use of the restraint for more than 24 hours – (a) is authorised by the prison manager and is, in the opinion of a medical officer, necessary to protect the prisoner from self-harm; or (b) is, in the case of a prisoner who has been temporarily removed to a hospital outside the prison for treatment, necessary to prevent the escape of the prisoner or to maintain public safety.”
- **Section 87(5A):** “An authorisation must be in writing, specify the type of restraint to be used, specify the time which the prisoner is to be kept under restraint; and include a record of the medical officer’s opinion that the restraint is necessary to protect the prisoner from self-harm.”
- **Section 87(6):** “Chains or irons must not be fitted or attached to a prisoner in any circumstances.”
 - But does not include handcuffs (s 87(7)).

Corrections Regulations 2005

Segregation

- **Part 6, Regulations 53-64** sets out the regulations on the segregation of prisoners including prescribed segregation and at-risk facilities and additional segregation and at-risk facilities

Use of Force/Restraint

- **Part 9** *Use of force, non-lethal weapons, and mechanical restraints*, regulations 118 – 129 sets out when force can be used, the use of non-lethal weapons, mechanical restraints and reporting on their use.
- **Schedule 5 Mechanical restraints**: section 3 sets out the types of restraints that can be used by a staff member and include hand-cuffs, waist restraints used in conjunction with handcuffs, torso restraints, head protectors, and spit hoods.
- As of December 2019, tie-down beds and wrist bed restraints can no longer be used.

Health and Disability facilities

Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act)

- Provides health care providers with the power to compulsorily detain and treat any individual who is determined to be “mentally disordered” which is defined in the Act as any person who “(a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself.”
- **Section 71(2)**: “A patient may be placed in seclusion in accordance with the following provisions:
 - (a) 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:
 - (b) 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:
 - (c) except as provided in paragraph (d), seclusion shall be used only with the authority of the responsible clinician:
 - (d) 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:
 - (e) the duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129(1)(b).”
- **Section 122B(1)**: “A person exercising a power specified in subsection (2) may, if he or she is exercising the power in an emergency, use such force as is reasonably necessary in the circumstances.

- **Section 122B(4):** “If force has been used under this section, – (a) the circumstances in which the force was used must be recorded as soon as practicable; and (b) a copy of the record must be given to the Director of Area Mental Health Services as soon as practicable.”
- In November 2018, the Government Inquiry into mental health and addiction, published the He Ara Oranga Report which recommended that the Mental Health Act be repealed and replaced to “reflect a human rights based approach, align with modern models for mental health care and minimise the use of compulsion, seclusion and restraint.”

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act)

- **The IDCCR 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(1)** defines seclusion as: “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.”
- **Section 60(2):** “A care recipient may be placed in seclusion to prevent them from “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(3)(a):** “A person who places a care recipient in seclusion – must ensure that the care recipient is not placed in seclusion for longer than is necessary to achieve the purpose of placing the care recipient in seclusion.”
- **Section 61(1):** Care recipients may be restrained to prevent them from “endangering the health or safety of the care recipient or of others” and/or “seriously damaging property” and/or “seriously compromising the care and well-being of the care recipient or of other care recipients.”
- **Section 61(2):** “A care recipient may not be restrained under subsection (1) by the application of a mechanical restraint if – (a) 1 or more authorised individuals can personally restrain the care recipient to achieve the purpose for which the care recipient is to be restrained; and (b) it is reasonably practicable for those individuals to do so.”
- **Section 61(3):** When a care recipient is restrained the following conditions apply:
 - “(a) 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.

- (b) 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.
- (c) 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.
- (d) the duration and circumstances of each episode of restraint must be recorded in a register kept in accordance with guidelines issued under section 148."

Standards and Guidelines

Health and Disability Services (General) Standard

- Seclusion is defined as where "a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit."

Health and disability Services (Restraint Minimisation and Safe Practice) Standards

- "Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions in the care setting, and always in the context of the requirements of this Standard, and current accepted good practice. Restraint should be applied only to enhance or maintain the safety of consumers, service providers, or others. Service provider training and competency is critical, both to the appropriate and safe use of restraint, and to minimising the use of restraint." [p. 6]

Oranga Tamariki Residences

Oranga Tamariki Act 1989

In 2017, the Oranga Tamariki Act replaced the Children, Young Persons and Their Families Act 1989

Secure Care

- **Section 368(1):** "A child or young person may be placed in secure care in a residence ... (a) to prevent the child or young person absconding from the residence where any 2 of the conditions specified in subsection (2) apply; 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."

- **Section 370(1):** "Subject to subsection (2), no child or young person shall be kept in secure care for a continuous period of more than 72 hours, or on more than 3 consecutive days (whether continuously or not), unless an approval has been granted under section 376."
- **Section 370(2):** "No child or young person ... shall be kept in secure care for a continuous period of more than 24 hours unless an approval has been granted under section 376."
- **Section 371(1):** "Where a child or young person is placed in secure care pursuant to section 367, the chief executive may apply to the Family Court or the Youth Court or, where it is not practicable to apply to the Family Court or the Youth Court, to the District Court for approval for the continued detention of that child or young person in secure care."
- 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.

Oranga Tamariki (Residential Care) Regulations 1996

Part 2 Limitations on powers of punishment and discipline

- **Section 21** Torture, cruelty, and inhuman, humiliating, or degrading discipline and treatment prohibited:
- "No member of staff of a residence shall discipline or treat or speak to any child or young person in the residence in a manner which –
 - inflicts on the child or young person any torture or cruelty, or is inhuman; or
 - degrades or humiliates that child or young person; or
 - is likely to induce an unreasonable amount of fear or anxiety in that child or young person."
- **Section 22(1):** "No member of staff of a residence shall use physical force in dealing with a child or young person in the residence unless that member of staff has reasonable grounds for believing that the use of physical force is reasonably necessary –
 - (a) in self defence, or in the defence of another person, or to protect that child or young person from injury; or
 - (b) to prevent that child or young person from damaging any property; or
 - (c) to prevent that child or young person from leaving the residence if not authorised to do so; or

- (d) to secure the containment of that child or young person in secure care; or
- (e) subject to section 384H of the Act, for the purpose of carrying out any search authorised by section 384C or section 384E of the Act.”
- Section 22(2): “Any person who uses physical force for any of the purposes referred to in subclause (1) shall –
 - (a) use no more than the minimum amount of force that is reasonably necessary in the circumstances; and
 - (b) record in the daily log the details of the use of such force, and of the circumstances giving rise to its use.”
- **Section 22(3):** “No member of staff of a residence shall in any circumstances threaten to use physical force against any child or young person in the residence unless the actual use of physical force by that member of staff against that child or young person in those circumstances would be permissible pursuant to subclauses (1) and (2).”

Part 5 Secure Care

- Section 47 Review of placement in secure care
 - “(1) Subject to subclause (4), the member of staff of a residence who is for the time being in charge of the secure care unit in that residence shall review daily the case of every child or young person who is being kept in secure care in that residence in order to determine whether or not the child or young person should continue to be kept in secure care.”
- **Section 48(1):** “No child or young person placed in secure care shall be confined in his or her own room between the hours of 8 am and 8 pm on any day unless such confinement is necessary –
 - (a) on account of any illness, injury, or extreme emotional disturbance suffered by that child or young person; or
 - (b) in any case of emergency, or in order to maintain and restore order in the residence; or
 - (c) in the case of a confinement between 5 pm and 8 pm on any day to enforce a sanction under a specific behaviour management programme being applied to the child or young person.
- **Section 48(2):** “Any confinement under subclause (1) shall be for no longer than is reasonably necessary for the purpose.”
- **Section 48(3):** “The manager shall ensure that the details of the confinement of any child or young person in any room pursuant to subclause (1), and the reasons for it, are recorded in the daily log.”

- **Section 49:** Contact with other children and young persons
 - “Subject to regulation 48, every child or young person placed in secure care shall be permitted to communicate freely at all reasonable times between the hours of 8 am and 8 pm each day with any other child or young person placed in secure care.”
- **Section 50:** Meals of children and young persons in secure care
 - “(1) No child or young person placed in secure care shall be required to eat meals in his or her room unless the child or young person is confined to that room pursuant to regulation 48.(2) No child or young person shall be required to eat meals in any room in which there is any toilet facility.”
- **Section 51** Range of planned, purposeful, and varied activities to be provided
 - (1) Subject to the need to maintain the security of the children and young persons in a residence placed in secure care, every child or young person placed in secure care, including a child or young person who is confined to any room pursuant to regulation 48, shall have access to a range of planned, purposeful, and varied activities which are designed to enhance the life skills, social skills, and competency skills of the child or young person.
 - (2) The activities specified in subclause (1) – (a) shall include (where practicable) cultural, recreational, social, sporting, and educational activities; and (b) shall be made available at all reasonable times during a child’s or young person’s placement in secure care.

Part 6 Records

- **Section 56:** “Every residence established for the purpose of section 364(2)(d) of the Act shall maintain a secure care register.”
- **Section 56(2):** lists the particulars to be entered in the secure care register.