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

Dr Sharon Shalev

Executive Summary

Background:

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

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

Key findings:

- Overall, the data revealed a high use of seclusion and restraint in New Zealand, and an overrepresentation of ethnic minority groups, in particular Māori, in seclusion and in prison segregation units, which is a matter of concern. In prisons, women were also much more likely than men to be segregated, and for longer periods.
- Some of the forms of mechanical restraint used were inherently degrading to the individual. Of particular concern was the use of restraint or tie-down beds in prisons and the use of restraint chairs in police custody.
- Stark physical environments and impoverished regimes in seclusion, secure care and segregation units, and in a number of cases no access to basic fixtures such as a call-bell to alert staff, a toilet or fresh running drinking water.
- Access to basic entitlements including daily access to a shower and an hour long exercise in the fresh air were not always guaranteed.
- The physical design and material conditions in the so-called 'At Risk Units' in prisons, where vulnerable prisoners were housed, were mostly identical to those in other solitary confinement units. These units may be contrary to international standards which prohibit the placement of prisoners with physical or mental disabilities in solitary confinement.
- Children and young people in Care and Protection residences could be held in separation from their peers in 'Secure Care' units which were identical to prison segregation units. These were inappropriate.
- The deprivation of social interaction which is inherent in all solitary confinement practices was often made worse by the deprivation of other provisions which could have helped to mitigate the harmful effects of seclusion. These included restrictions on family visits and in-room provisions such as books, hobby and craft materials or a TV set.
- A small but persistent number of people in health and disability facilities were subjected to very long-term restrictive measures, and discussion of future plans for these individuals appeared to be focused on variants of seclusion and restraint. For the individuals concerned, prolonged seclusion and /or restraint (and often both) had thus become a chronic state rather than an emergency short term response to an acute situation.
- Review processes were not always robust, and some stays in restrictive conditions were far too long.

Other concerns identified in the report included:

- Seclusion and segregation cells were not always used for their intended purpose.
- Lack of individual autonomy and over-reliance on the goodwill and availability of staff.
- Seclusion and restraints were not always used as emergency last resort tools for the shortest time possible.

- Risk aversion and staff safety taking precedence over the detained individual's rights and needs.
- Blanket restrictive policies being applied to detained individuals, rather than ones tailored to their individual risk and needs.

Good practice observed:

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

Key recommendations:

- The use of seclusion, segregation and all forms of restraints should be significantly reduced, and reserved for the most extreme of cases, and then used only for a very short time.
- Decisions to use seclusion or restraint should be based on an individualised and proportionate risk-needs based approach, and be regularly and substantively reviewed.
- Inherently degrading forms of restraint, in particular restraint beds and restraint chairs, should be abolished altogether.
- Minimum standards for the provision of decent living conditions and essential provisions as set out in human rights instruments must always be met. Specifically, cells and rooms must be of a reasonable size, clean, safe, well ventilated, well lit and temperature controlled. Basic requirements regarding access to fresh air and exercise, food and drinking water must always be adhered to across all detention contexts.
- All cells/rooms must be equipped with a means of attracting the attention of staff, and these must be regularly checked to ensure that they are in good working order.
- Facilities which were found not to be fit for purpose, including the so-called 'pound' punishment blocks in prisons and Wellington police custody suite should be decommissioned as soon as practicable.
- Data on the use of seclusion/segregation/secure care units and the application of restraints should be recorded more fully and analysed for trends and protected characteristics such as age, gender and ethnic origin. The apparent overrepresentation of ethnic minorities, in particular Māori, in seclusion and segregation units in prisons, in health and disability units, and in the application of restraints should be investigated further as a matter of urgency. The higher use of segregation with women in prisons should also be investigated.
- Confidential and accessible complaint mechanisms must be closely safeguarded in all places of detention, and even more so in units where people are separated from others and thus potentially more vulnerable to mistreatment. People with disabilities and anyone who may have difficulties in accessing the complaints system should be provided with assistance to enable them to do so.
- Oversight mechanisms need to be strengthened, in particular with regard to placement in, and ways out of, seclusion and segregation units. These should be made proportionally more exacting as time in seclusion/segregation progresses. In the case of the 'chronic' stays in solitary confinement (in prisons, and in health and disability settings), the setting up of a national multi-disciplinary oversight body which includes expertise from outside the detaining agencies, should be considered.