USES AND ABUSES OF SOLITARY CONFINEMENT OF CHILDREN IN STATE-RUN INSTITUTIONS IN AOTEAROA NEW ZEALAND

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Uses and abuses of solitary confinement of children in state-run institutions in Aotearoa New Zealand

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July 2022

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Table of contents

Uses and abuses of solitary-confinement of children in state-run institutions in Aotearoa New Zealand

1. Introduction

1.1. I am an international expert on the use and consequences of solitary confinement and other restrictive practices in institutional settings. I have conducted research in countries including England and Wales, Canada, the United States and New Zealand, and have published widely on the subject.

1.2. I have been asked by the Royal Commission of Inquiry on Abuse in Care to provide an expert report on:

"Solitary confinement (also referred to as seclusion or secure care in some settings) including commenting on:

> (i) The use of solitary confinement a) as a "behavioural management tool" including for children and young persons (CYP) and vulnerable adults with highly challenging behaviours; b) for CYP with mental health conditions who require monitoring; and c) for CYP who are at risk of self-harm.
>
> (ii) The risks and impacts of solitary confinement in State youth justice and youth psychiatric care
>
> (iii) whether solitary confinement facilitates abuse, whether solitary confinement is a form of abuse; whether the risks and impacts of solitary confinement differ for different groups including children, young people and vulnerable adults, those from different ethic or cultural groups, and neurodiverse or disabled people.
>
> (iv) Risk mitigation and elimination of solitary confinement including whether solitary confinement can be made safe and/or whether it should be abolished in all or some circumstances and/or for all or some groups; and
>
> (v) The alternatives to solitary confinement including any barriers to implementation and how these barriers might be addressed."

1.3. To facilitate the writing of this report, I was provided with:

-Witness testimonies and written survivor accounts submitted to the Royal Commission of Inquiry into Abuse in Care.

-Copies of publicly available historical inquiry reports[1] on practices in residences for children during the 1960s to 1980s, including survivor accounts, accounts by staff, parents and others, as reported in the above and in Elizabeth Stanley's excellent 2016 monograph[2] 'The Road to Hell: State Violence against Children in Post-war New Zealand.'

-Copies of Rules and Regulations governing the operation of residences for children during the 1970s to 1980s.

This report is based on my professional experience and expertise on solitary confinement practices around the world; on the materials listed above; and, where relevant, on my own observations from two visits in Epuni Care and Protection Residence, in 2016 and in 2020, and two reports I wrote for the New Zealand Human Rights Commission on these visits.[3]

1.4 I am grateful to the Royal Commission of Inquiry into Abuse in Care for inviting me to contribute to its important work. I should also like to express heartfelt thanks and appreciation to the survivors whose deeply troubling but powerful testimony forms the cornerstone of this report.

[1] And in particular, 1) A 1978 report based on transcripts of Inquiry into Social Welfare Homes organised by Auckland Committee on Racism and Discrimination following public allegations of cruel and inhuman treatment towards children entrusted to the Social Welfare Department's care (including submissions by men and women who spent time in a home between the 1960s and 1970s; six former staff members from different residences, a counsellor, educator, psychologist; parents, grandparents, people living next to one residence), and 2) A 1982 report by the Human Rights Commission in response to complaints raised in the 1978 report, including testimonies from children, staff, parents and officials.

[2] Elizabeth Stanley (2016) The Road to Hell: State Violence against Children in Postwar New Zealand. Auckland, NZ: Auckland University Press

[3] Shalev, S. (2020) 'Time for a paradigm shift: a follow up review of seclusion and restraint practices in New Zealand'. Auckland: New Zealand Human Rights Commission (10 December 2020). See also: Shalev, S. (2017). *Thinking outside the box? Seclusion and restraint practices in New Zealand.* Auckland: New Zealand Human Rights Commission (April 2017).

REPORT

2. Solitary confinement: definition, health effects, international standards

2.1 What is solitary confinement?

The practice of solitary confinement - isolating a person from their peers, typically in a small barren space where they will spend the majority of the day alone with limited, if any, access to programmes and activities- is known by many names. Isolation, seclusion, separation, closed confinement, the 'box', 'pound', 'block', are some of the commonly used terms to describe what is essentially the same practice. In children's residences, the focus of this report, the practice is called 'secure'.

This report adopts the internationally agreed definition of solitary confinement as articulated in the United Nations revised Standard Minimum Rules for the Treatment of Prisoners (the 'Nelson Mandela Rules') which define solitary confinement as:

"The confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days." (Mandela Rule 44)

In line with the UN Convention on the Rights of the Child (CRC), this report takes 'child' to mean any person under the age of 18.

2.2 The health effects of solitary confinement on children and young people

Human beings are social creatures. Being isolated from human company and human touch is painful and profoundly damaging to the health and wellbeing of individuals with normal resilience and no prior health issues. For those with pre-existing health conditions and for people who are vulnerable because of their age, gender, disability or personal history, solitary confinement can be particularly damaging.

Solitary confinement 'attacks' the isolated individual in two ways: it places them in highly stressful conditions, and it takes away the usual coping mechanisms- access to human company, nature, and things to do. Perhaps unsurprisingly, the documented adverse health effects of solitary confinement, both psychological and physiological, are wide ranging and long lasting. Commonly reported problems include anxiety, panic attacks, depression, hopelessness, anger, poor impulse control, cognitive disturbances, perceptual distortions, paranoia, psychosis, and a significantly increased risk of self-harm and suicide. Physiological problems include gastro-intestinal and genito-urinary problems, insomnia, deterioration of eyesight, weakness, profound fatigue, migraine headaches, joint pains, and an aggravation

of pre-existing medical issues. (Grassian, 2006; Shalev, 2008; World Health Organisation, 2015; Haney, 2018).[4] A growing body of neuroscientific research highlights the damaging effects that social and environmental deprivation can have on brain functioning as well as brain architecture, meaning that some of the consequences of solitary confinement may be irreversible (Akil, 2019; See also Coppola, 2019).[5]

As noted above, children and young adults, who are still in the process of maturing physically, psychologically, relationally, and socially, are particularly vulnerable to the ill effects of solitary confinement. Children's brains are also still maturing. Researchers using imaging techniques found "Striking growth spurts can be seen from ages 6 to 13 in areas connecting brain regions specialized for language and understanding spatial relations, the temporal and parietal lobes. This growth drops off sharply after age 12.[6]" The brain continues to grow until our mid-20s, with one of the last brain regions to mature being the frontal lobe, which is in charge of executive functioning – planning, reasoning, and impulse control. Placement in the 'deep freeze' of solitary confinement, then, can hinder brain development, and is unlikely to contribute to any 'lesson learning' processes.

The vulnerability of children is further compounded by disabilities and/or by histories of trauma and abuse. For those who have suffered traumatic life events, abuse, or neglect previously, the experience of solitary confinement can re-trigger trauma and exacerbate symptoms.

Learning difficulties and attention-deficit/hyperactivity disorder (ADHD), common in children in closed environments, are also risk factors for exacerbation of mental and behavioural issues in children who are held in solitary confinement.

> "[Separation] may trigger more impulsive risk behaviour that warrants further consequences and therefore trigger a downward spiral of behaviour that the young person cannot get themselves out of without support." (Royal College of Psychiatrists (2019 at 1.10)

[4] For fuller referencing and a review of the health effects of solitary confinement see: World Health Organisation (WHO) Prisons and Health (2015) chapter 5: 'Solitary confinement as a prison health issues', pp 27-35. WHO: Copenhagen. Online at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf; Shalev, S. Sourcebook on Solitary Confinement (2008) LSE: London. ; Haney, C. (2018). The psychological effects of solitary confinement: A systematic critique. Crime and Justice, 47(1), 365-416. https://doi.org/10.1086/696041. See also: Human Rights Watch (HRW) & American Civil Liberties Union (ACLU). (2012). Growing Up Locked Down: Youth in Solitary Confinement in Jails and Prisons across the United States.; Birckhead, T. R. (2015). Children in isolation: The solitary confinement of youth. *Wake Forest L. Rev.*, *50*, 1.

[5] Akil, H. (2019). The Brain in Isolation. In: Lobel, J., & Smith, P. S. (Eds.). (2019). Solitary confinement: Effects, practices, and pathways toward reform. Oxford University Press. pp 199-2019. DOI:10.1093/oso/9780190947927.001.0001; Coppola, F., The Brain in Solitude: An(other) Eighth Amendment Challenge to Solitary Confinement, *Journal of Law and the Biosciences*, 1–42 (2019) DOI:10.1093/jlb/lsz014

[6] US Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health, "Teenage Brain: A Work in Progress," 2001. Online: https://www.psychceu.com/Brain_Basics/teenbrain.pdf (accessed 30/5/22)

Considering that many children in care are likely to have experienced trauma prior to being placed in care, and further trauma due to the placement itself, adding solitary confinement to the mix makes it a particularly toxic one with potential life-long repercussions for the individual concerned, as noted by Ford and colleagues (2016):

> "Such polyvictimization places youth at significant risk for ongoing emotional, developmental, academic, and behavioral problems. Persistent post-traumatic stress can lead to serious long-term mental health problems for youth, including post-traumatic stress disorder (PTSD), substance abuse, anxiety, disordered eating, depression, self-injury, conduct problems, and revictimization, all of which further increase the likelihood of involvement in delinquency, crime, and the justice system".[7]

Some cannot endure the pain and take their own life. One study found that half of suicides committed by young people in Federal prisons in the United States were committed whilst they were in solitary confinement, and 62% of those who committed suicide had previously been in solitary confinement.[8] Others carry the harms of their experience and its psychological scars for the rest of the lives. A study of post-release experiences of youth who had been subjected to abuse during their incarceration (including solitary confinement) found that the more frequently a youth was exposed to abuse during incarceration, the more likely they were to report post-traumatic stress reactions, depressive symptoms, and continued criminal involvement post-release.[9]

Protective factors, such as family contact and education,[10] are often not available for children who are in solitary confinement. Instead, as will be discussed below, solitary confinement or 'Secure' units are barren and unstimulating environments where children have little or no access to education, and where family contact is not encouraged.

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[7] Ford, J. D., Kerig, P. K., Desai, N., Feierman, J. (2016). 'Psychosocial interventions for traumatized youth in the juvenile justice system: Research, evidence base, and clinical/legal challenges'. *Journal of Juvenile Justice*, 5(1), 31–49. https://www.ncjrs.gov/pdffiles/249840.pdf. The term 'polyvictimisation' refers to "the experience of multiple types of victimization such as sexual abuse, physical abuse, neglect, bullying, and exposure to family violence versus multiple episodes of the same kind of victimization." (See: http://polyvictimization.org/. Accessed 5/7/22)

[8] Cited in: Simkins, S., Beyer, M., & Geis, L. M. (2012). The harmful use of isolation in juvenile facilities: The need for post-disposition representation. *Wash. UJL & Pol'y*, *38*, 241. At 249. https://openscholarship.wustl.edu/law_journal_law_policy/vol38/iss1/8 (accessed 30/5/22)

[9] *Dierkhising, C.B., Lane, A., & Natsuaki, M.N. (2014). Victims behind bars: A preliminary study of abuse during juvenile incarceration and post-release social and emotional functioning. Psychology, Public Policy and Law, 20, 181-190.* This chimes with recent (August 2022) findings of the 'Care to Incarceration' research report, published by the Royal Commission of Inquiry on Abuse in Care, which found that, in New Zealand, "One in five and, sometimes, as many as one in three of those children and young people who had been in State residential care, went on to serve a criminal custodial sentence later in life". (p 4). The report is available online on the Commission's website at: https://www.abuseincare.org.nz/our-progress/library/v/500/care-to-custody-incarceration-rates-research-report.

[10] Ruch, D.A., & Yoder, J. (2018). The Effects of Family Contact on Community Reentry Plans Among Incarcerated Youths. *Victims & Offenders, 13*, 609 - 627.

The implications of the increased psychological stress caused by solitary confinement, the interruption of the child's psychological, physiological, social, and neurological development, and the lack of protective factors are grave and can last long into adulthood.

2.3 International human rights law and professional standards regarding the solitary confinement of children

International human rights law recognises solitary confinement as an extreme practice which may constitute cruel, inhuman, or degrading treatment, and even torture, in violation of international law. The damaging effects of solitary confinement, particularly on vulnerable people, including children and people with disabilities, are also recognised by professional bodies, and addressed by them publicly.[11] The international consensus on solitary confinement is articulated in the UN Nelson Mandela Rules[12] as follows.

Rule 43

> (1) In no circumstances may restrictions or disciplinary sanctions amount to torture or other cruel, inhuman or degrading treatment or punishment. The following practices, in particular, shall be prohibited: (a) Indefinite solitary confinement; (b) Prolonged solitary confinement; (c) Placement of a prisoner in a dark or constantly lit cell; (d) Corporal punishment or the reduction of a prisoner's diet or drinking water; (e) Collective punishment.

Rule 45

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

[11] For statements by professional bodies see, for example: British Medical Association, Royal College of Psychiatrists (RCPsych) and Royal College of Paediatrics and Child Health (RCPCH) Joint position statement on the medical role in solitary confinement (2018); American Academy of Child & Adolescent Psychiatry Policy Statement on the Solitary Confinement of Juvenile Offenders (2012).
[12] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) A/RES/70/175 17/33 2.

The 'UN standards and norms' referred to in Mandela Rule 45(2) include Rule 67 of the 1990 United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules) which prohibits the use of solitary confinement as a disciplinary measure for children:

> All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, **placement in a dark cell, closed[13] 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 (emphasis added).

The United Nations Committee on the Rights of the Child, the body that monitors the implementation of the UN Convention on the Rights of the Child (CRC), has similarly stated that any disciplinary measure must be consistent with the inherent dignity of the juvenile and with Article 37 of the CRC,[14] which prohibits torture or other cruel, inhuman, or degrading treatment or punishment on children. Detention of a child must conform with the law and be used only as a measure of last resort and for the shortest appropriate period of time. The detained child "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."

The Committee on the Rights of the Child also addressed solitary confinement directly in its General Comment on Children's Rights in Juvenile Justice, where it reiterated that,

> 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.[15]

The UN Special Rapporteur on Torture similarly stated that the imposition of solitary confinement on children "constitutes cruel, inhuman or degrading treatment or punishment or even torture"[16] and called on states "to prohibit solitary confinement of any duration and for any purpose [for juveniles.]" (ibid. at 86(d)).

Whilst children and young people are nonetheless still housed in solitary confinement in many countries, the growing body of neuroscientific research demonstrating its devastating

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[13] 'Closed confinement' refers to being locked in a room in conditions akin to solitary confinement.

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

[15] General Comment No 10 (2007) CRC/C/GC/10, 25 April 2007 (section 89). Available online at: http://www.refworld.org/docid/4670fca12.html

[16] *Report of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment*, par. 44, Human Rights Council, U.N. Doc. A/HRC/28/68, (Mar. 5, 2015, citations omitted).

effects on developing minds (as discussed above) and the clear position set out in human rights instruments have led to an increased focus on efforts to eliminate, or at least reduce, the practice of holding them locked up in isolation cells. In the United States, where children can spend very long periods in extreme solitary confinement,[17] this imperative has been gaining momentum. In 2015 the then US President, Barack Obama, announced a complete ban on the solitary confinement of juveniles in Federal prisons. Writing for the Washington Post, he explained, "How can we subject prisoners to unnecessary solitary confinement, knowing its effects, and then expect them to return to our communities as whole people? It doesn't make us safer. It's an affront to our common humanity.[18]" Several states have followed this lead and introduced various restrictions on the use of solitary confinement for children and young people. Similar calls have been made in Australia. The Royal Commission and Board of Inquiry into the protection and detention of children in the Northern Territory (2017) found that the isolation of children was contrary to international human rights law, and that children were,

> "Confined in a wholly inappropriate, oppressive, prison-like environment that is detrimental to their health, wellbeing, and prospects of rehabilitation, and subject to a behaviour management regime that involves being locked down in confined spaces with minimal out of cell time and little to do for long periods of time."[19]

The Commission recommended that solitary confinement ('isolation') for the purposes of behaviour management or punishment, and extendable periods in isolation beyond 24 hours be prohibited. Though these recommendations are yet to be fully implemented, they demonstrate the direction of travel with regard to locking up vulnerable children in conditions of solitary confinement.

The UN Convention on the Rights of Persons with Disabilities (CRPD) guarantees equal rights to all persons with disabilities, including children, and reinforces the prohibition on torture and cruel, inhuman, or degrading treatment or punishment. Article 15 requires States to "take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment."

The United Nations Sub-committee on the Prevention of Torture (SPT) has said that solitary confinement must never be used in health care settings as it segregates persons with serious or acute illness and leaves them without constant attention and access to medical services. The SPT regards restraints, both physical and pharmacological, as forms of

[17] On the use of solitary confinement in US prisons and jails, see Kysel, I. (2012), Growing Up Locked Down: Youth in solitary confinement in jails and prisons across the United States. Human Rights Watch & American Civil Liberties Union report. New York: Human Rights Watch.

[18] "Why we Must Rethink Solitary Confinement" Washington Post Opinion, by **Barack Obama** January 25, 2016 (https://www.washingtonpost.com/opinions/barack-obama-why-we-must-rethink-solitary-confinement/2016/01/25/29a361f2-c384-11e5-8965-0607e0e265ce_story.html)

[19] Report of the Royal Commission and Board of Inquiry into the protection and detention of children in the Northern Territory (2017). Commonwealth Of Australia, at p 8

deprivation of liberty that should be considered only as measures of last resort for safety reasons. Their use must be subject to a strict framework as there is a high potential for abuse. Restraints must never be used for convenience[20].

The UN Special Rapporteur on Torture further elaborates:[21]

> The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment (A/63/175, paras. 55-56). The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment (A/66/268, paras. 67-68, 78). Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electroshock procedures. Therefore, the Special Rapporteur calls on all State Parties to impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as narcoleptics, the use of restraint and solitary confinement, for both long- and short-term application.

Noting the particular vulnerability of children with disabilities to "violence, including corporal punishment, neglect and abuse, in all settings, such as the family home, mental health, educational, or childcare institutions," a recent joint statement by the Committee on the Rights of the Child and the Committee on the Rights of Persons with Disabilities[22] notes that

> State Parties have the obligation to adopt clear and targeted strategies for de-institutionalization, with specific timeframes and adequate budgets, in order to eliminate all forms of discrimination and segregation of children with disabilities. Specific attention should be paid to children with intellectual or psychosocial disabilities and children requiring high levels of support, who are usually at a higher risk of institutionalization.

[20] Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent, adopted at the 27th session of the SPT (16-20 November 2015), pars. 9- 10.
[21] www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf
[22] Joint statement on the Rights of Children with Disabilities, Committee on the Rights of the Child and the Committee on the Rights of Persons with Disabilities, 21 March, 2022

Many of the instruments discussed above are directed at the protection of children and young people involved with the criminal justice system. If solitary confinement is viewed as damaging and hence prohibited practice for justice involved youth, it must follow that where younger children in care of the state are concerned, there should be an even stronger presumption against its use.

In what follows, I examine solitary confinement practices in state-run residences and disability facilities in New Zealand between the 1960s and 1990s and to date.

3. Practices in solitary confinement rooms for children in state-run residences and health and disability institutions

3.1 The use of solitary confinement for children in residences: introduction

I was informed, by way of background, that:

The use of solitary confinement (called 'secure') was widespread in state residences. Most residences had a secure unit which was comprised of individual secure cells. According to the Human Rights Commission's 1982 report, at the time there were Secure facilities in 14 of the 22 institutions which operated at the time. Of sample of 85 witness statements received by the Royal Commission of Inquiry into Abuse in Care from survivors of State residences, 62 reported having spent time in a 'secure room'- the term used in Care & Protection residences for rooms used for solitary confinement.

From 1974, New Zealand law allowed for a judge or magistrate to order a child or young person (CYP) before disposal of complaint (of being out of 'proper control') or following arrest, to be held in custody if in the court's opinion the child was likely to abscond, in need of care, or if it was in the interests of the CYP. (Children and Young Persons Act 1974, s 43.)

The Director of Social Welfare was by the same legislation empowered to create and maintain institutions for CYP in the care or guardianship of the State, which included secure care facilities. (s 67.)

Until 1989 there was no distinction between children who were placed in state residential care for care and protection reasons, and children who were in state care because they had trouble with the law, albeit often in a very minor way. It is important to note that a proportion of children in the residences were placed in care because of adverse life events including death in the family, neglect, and abuse.

The key operational regulations for care residences, including the use of 'secure rooms', from the mid-1970s to mid-1980s were stipulated in the ***Residential Social Workers Manual, 1975*** (drafted 1971 and amended 1986), hereafter 'Regulations' and 'Manual' respectively. The Regulations have since been amended again, but the 1975 Manual and 1986 amendments were in force during the key relevant periods.

In what follows, I first examine what the Manual said about a) Reasons for placement in solitary confinement, and b) The daily regime and practices in solitary confinement. This is followed by a selection of survivor and witness testimonies on why they were placed in solitary confinement in the different residences, the duration of their stay (where available), and what daily life was like. I also examine what survivors said about the physical design and appearance of solitary confinement rooms and units.[23]

3.2 Reasons for and purpose of placing a child in solitary confinement.

What the regulations[24] said about reasons for placement in solitary confinement

The Residential Social Workers Manual 1975 stipulates that placement in Secure should be seen as a temporary, emergency measure:

> *Confinement of any child or young person in close custody is to be generally regarded as an* ***emergency procedure*** *to be terminated as soon as behaviour warrants release.* (Section F7.02)
>
> *In certain cases of absconding or serious and persistent misbehaviour it may be necessary to use secure facilities* ***as punishment****.* (Section F6.09)
>
> *It is sometimes necessary in a young person's or* ***child's own interests****, or as a measure designed to* ***protect the interests of the community, the institution and/or the individual****, or because a young person remanded in our custody is considered* ***likely to abscond****, that he be detained under secure conditions.* (Section F7)

The Manual also allows for children to be housed in Secure facilities **directly on admission** where:

[23] The examples in the following sections focus on children's care and protection residences, as the majority of survivor testimonies are from people who have spent time in residences. Where relevant and possible, we refer to health and disability facilities too.
[24] See Appendix 1 for key historical regulations as stipulated in the 1975 Manual and 1986 amendments.

> *[it is] likely to involve elements of an emergency or disturbance or difficult behaviour … Under no circumstances is it an acceptable procedure for all new admissions to be admitted direct to secure facilities* (Section F1.06).

The 1986 amendments formalise placement procedures and requirements, and list permissible grounds for placement in Secure as below; notably, punishment is no longer listed as a permissible ground for placement.

> *28. Placement of children and young persons in secure care-(I) No child or young person in an institution shall be placed in secure care unless- (a) It is necessary to place the child or young person in secure care*
> *(i.) To prevent that child or young person absconding from the institution; or*
> *(ii) To prevent that child or young person behaving in a manner likely to cause physical harm to that child or young person or to any other person, or to damage any property; or*
> *(b) The behaviour of the child or young person is so disruptive or disturbed that that child or young person cannot be permitted to remain in the institution except in secure care; or*
> *(c) The principal of the institution considers that secure care is the most suitable environment in which to provide appropriate treatment for that child or young person; or*
> *(d) Placement of the child or young person in secure care is the only practicable means by which that child or young person may be protected from harmful behaviour directed at that child or young person by other children or young persons in that institution; or*
> *(e) The child or young person requests in writing to be placed in secure care.*

Despite the introduction of an assumption against Secure placement, the seemingly detailed list of grounds for placement in Secure in the 1986 Amendments is non exhaustive and, notably, it leaves staff with very wide discretion as to when and why to place a child in Secure. Furthermore, though reporting requirements and justifications required for placements beyond 14 days increase with time, the regulations contain no upper limit for Secure stays. I now turn to examine why children were placed in Secure in practice.

What survivors, witnesses and officials said about reasons for housing children in solitary confinement

According to the Department for Social Welfare, Secure rooms were necessary for a variety of reasons. Using distinctly punitive language more attuned to a prison than to a place of care and protection, the department asserted that,

"Secure accommodation is necessary to cover a wide range of needs. Some youngsters on admission are highly disturbed, acting out and aggressive, others openly threaten violence

and to abscond. A number of sophisticated serious offenders needs to be segregated pending an appearance in courts. Often very little is known about the personalities and problems of many young persons who are being admitted by the police, and how they will react, and a short period in the Secure units may be necessary bearing in mind the Department's responsibility to the young person, to the others already in residence, the courts, the police, and the community."[25]

Practices appeared correspondingly geared towards disruptive troublemakers who require punitive supervision rather than vulnerable children who require care and protection. Recalling her time in Allendale Girls' Home, one woman said: "We had to be very good, or we'd get put in solitary. We were threatened with Arohata [a women's prison]". In a number of residences, all newly admitted children were placed in Secure for several days, regardless of the reason for their admission to the residence or their behaviour.

"I was put into the secure unit as soon as I arrived at Kohitere. My records say that I was in there for 3-4 days, but to me it felt like I had been in there for at least a week. I was left alone in there. I am still unsure as to why I was immediately put in the secure unit, I think it could be because I used to run away from my family home." (Boy, 14, state ward)

"I was surprised to see, in my records, that Secure was not supposed to be used as a punishment but that it was a place of therapeutic or rehabilitative value for the boys. That was not my experience at all. In my experience, the Secure Unit was definitely used as a punishment for other boys and me" (Boy, 13-14, Kohitere, mid 1980s).

"They took me straight to secure when I first got there. It was a jail. You can't get out, there are locked steel doors. …. I think I was in secure for a few days when I first got there." (Boy, 13, state ward, Owairaka)

Sent to Secure on arrival at the home for "a few weeks" (Boy, state ward, 13, Hamilton Boys' Home).

A common use of Secure, in line with the Residential Social Workers Manual 1975 Manual (see Appendix 1), was for children who had absconded upon their return, or to prevent them from absconding, as residences did not have gates, and could not be secured. Girls who absconded from Bollard Girls' Home were placed in Secure, as were boys in different residences.

"I kept running away [from Owairaka.] I would get caught, get locked up, the same shit. It was easy enough to get out."

[25] Department for Social Welfare written response to the Human Rights Commission's 1982 report, cited in the Commission's report at p 67.

"The routine was: run away; get caught; back to Kohitere; get a beating; return to the pound and be made to do PT." (mid-late 1980s)

Rather than encouraging children not to run away from residences, placing them in solitary confinement appeared to have the opposite result with children even more determined to run away as soon as they got the chance. A number of survivors testified that there were running away from abuse, either at the hands of staff or from other residences. Yet, as one man commented, no one has ever asked him why he kept running away.

Secure was also used to achieve compliance. One particularly disturbing example of this was the practice, in several homes, to place newly admitted girls in Secure until they could be internally examined by a doctor for sexually transmitted disease (regardless of their age or sexual experience).
Girls who refused to be examined would remain in Secure. (Staff member, Bollard Girls' Home, in HRC, 1982). One 13-year-old girl, a state ward who was sent to Bollard in the late 1970's described how "I wouldn't take the VD test. I was put in Secure, but I still wouldn't agree. In the end, 3 or 4 staff came in and I was taken and strapped down for it… you were in pyjamas all the time in Secure" (HRC 1982:18). Another woman, who was at Bollard when she was 15, described how, on arrival, "you were stripped of your clothes and stripped of your privacy … I had to strip in front of all these ladies; then put in a cell... We wore pyjamas all day… they often didn't fit well which was very demoralising. The VD check was very demoralising too. I had it twice". (HRC, 1982)

Finally, Secure was used as a response to nuisance behaviours, according to a former staff member:
"[Secure was for] people who were incessant talkers. Or loud talkers. Or misbehaving or bad attitudes." (HRC 1982). None of these reasons, of course, was part of the official narrative around the use of Secure.

In health and disability facilities, solitary confinement ('Seclusion' or 'time out box') was used to manage 'difficult behaviours'. The idea, according to a former staff member, was to "use an unpleasant stimulus as a consequence, to discourage that behaviour". In one psychiatric hospital for children, solitary confinement was used in this way alongside other practices including "electric shocks, medication …. and cold showers/ being hosed down with a fire hose". (Former staff). Survivors testified that they were placed in seclusion as punishment for minor incidents. One survivor said she sometimes spent as long as 4-5 weeks in a barren, toilet-less seclusion room as punishment. Another survivor spent several periods of 10-15 days each in seclusion.

Reasons for use of solitary confinement & its duration: summary

To sum up this section, survivor and witness statements spanning 30 years confirm that children were held in conditions of solitary confinement in so-called 'Secure' rooms in the majority of residences examined. Duration of stays lasted from a few days to several weeks.

In at least one case, a 13-year-old boy had been recorded as spending 320 days in Kohitere Secure unit.

Rather than being a response to 'serious or persistent misbehaviour' as mandated in the Residential Social Workers Manual 1975 Manual, in some cases, placement in Secure was routine practice for all new arrivals at the residence, in others it was routine practice for certain transgressions – from absconding to refusing to undergo an internal medical examination to 'having an attitude'. Survivor and witness statements indicate that in health and disability facilities children could similarly be isolated for minor incidents classified as 'bad behaviours' rather than a manifestation of the child's disability or distress.

None of the reasons constituted an emergency, nor was solitary confinement used as last resort. With regards to children who absconded, I would note that a more reasonable solution might have been to ensure that the perimeter of the residence could be secured and allow children to join activities and socialise within the residence, rather than keep residences open, and lock up children in prison like secure cells. As to the enforced internal examinations of girls, as well as being inappropriate, the manner in which these were carried seems to me akin to an assault, and an experience which is likely to have left long lasting psychological scars on those who had to endure it.

3.3 Design and physical provisions in Secure and Seclusion rooms

What the regulations said about the design of solitary confinement rooms

Secure room conditions must provide "adequate light, ventilation, and warmth. Safety must be assured. (1975 Manual, Section 7.09)

What survivors and witnesses said about the physical design and provisions in solitary confinement

The solitary confinement units in each facility differed slightly, but common to them all was a prison-like design and appearance. Some examples, as described by survivors, include:

Owairaka Boys' Home:

"It was a jail. You can't get out, there are locked steel doors. The walls were concrete, and you had a toilet and sink in your cell. There was a steel bed and a little window. That was it."

"That unit was built with a flat roof and heating in the floor and the sun used to belt down on the roof in the summertime, and they were like ovens inside" (former staff)

“Cell 7 ‘the digger’ was a punishment cell. No privileges, no light. One window but it was covered. No reading materials.”

“The coldest place I have ever been to… no smiles at all” (Mother of a 14 year old who was in Secure for 8 weeks, HRC 1982).

Kohitere:

“The Secure Unit was a punishment unit. It was pretty much a thick, concrete block. There were no external windows and heavy gauged mesh on the roof. There was an open courtyard and about twelve cells with big wooden doors. In my room at the Secure Unit, there was a wooden bed which was attached to a wooden table. There was also a small sink and toilet.”

“The secure unit was sort of square shaped, it had cells down the two sides and across one end and more of an admin area on the other end, in the middle was 2 layers of wire over the top of the courtyard. At the front was grills and a door that you entered the unit through. The bed was fixed to the floor of your cell, and you had a steel basin and toilet and a bench. The cells were not all exactly the same, some had a bit of daylight and others had none.”

“I was taken to the pound at Kohitere, which was the name for the secure block. I was in secure
the whole time I was at Kohitere. The pound was all single cells.”

Hamilton Boy’s Home (Melville):

Time out room:
“The Time Out room was narrow and looked like a storage cupboard. The room felt a bit like a padded cell. It was as wide as the door itself and between 2.5 — 3 metres long. There was nothing in there except a built-in seat. There was carpet on the walls and ceiling. It had a thick door. Mr x locked the door and I had to stay in the room overnight. There was barely enough room for me. There were no toileting facilities in the room. I banged on the door for ages, but nobody came to take me to the toilet. I had to urinate and defecate in the corner and sleep in my own waste. There was barely any room to stretch out.” (Boy, 12, state ward)

‘Secure’ cells
“The cell was concrete, about six paces by four paces in size. There was fixed bed bolted to the floor, a stainless-steel toilet and basin. There was no natural light, the door had a flap on it so they could look in on you.”

Epuni Care and Protection Residence:

“Solitary was a concrete cell the same size as a normal prison cell. It had a basin, a toilet and concrete slab with a mattress for a bed.”

"The secure cell was grey concrete, it was about 4 metres by about 2 or 3 metres. there as a drawing of a Kenworth truck on the wall. There was a slab with a foam mattress, a sheet, grey blanket and pillow. There was a basin and a toilet too. There was a window high up that I had to jump up to see out of it but it was covered with iron bars." (10 year old; state ward)

Hokio:
"Hokio secure had 2 cells side by side. The toilet was separate to the cell. There was no bed, just a mattress on the floor. There was some natural light but because the window was so high up you couldn't see out. There was nothing to do or read in there."

Bollard Girls' home:
"[Secure cell] was very small, with a bed, rubber mattress and a toilet. You were given four squares of toilet paper for all day."

Allendale Girls' Home
"I spent most of my time in Secure, in solitary confinement. There was a bed and a pan and a non-opening window. You got out for a bath or a shower. Meals were brought, and that was the only times you saw anybody." (HRC 1982)

Health and disability residential ward 'time out boxes':
"There was no lid on the time out boxes, but the boxes were so small that the kids could barely move while in time out. No one ever went into time out willingly. As there were many kids for the staff to look after, I imagine that some kids would have been left in there for longer than intended at times" (Former staff witness).

Design and physical provisions in Secure: summary

To sum up, survivors' descriptions of secure rooms in different residences and seclusion rooms in health and disability facilities alike paint a consistent picture of barren, austere, prison-like rooms, containing minimal furniture (a bed), and no personal belongings. Having visited solitary confinement rooms and units in prisons, psychiatric hospitals, and children's care homes, I can personally attest that secure and seclusion cells were no different to prison segregation (solitary confinement) cells, and in some cases, in my opinion, they were worse.

3.4 Daily routines and procedures in Secure

What the regulations said about daily routines

The procedures and 'entitlements' for children in Secure, set out in the regulations (see below and Appendix 1) are extremely similar to those in prison segregation (solitary confinement) units in that they essentially guarantee only one hour outside the cell/room

and a shower, with any other provisions discretionary and capable of being easily withdrawn.

Children and young people "must have a daily shower or bath, not less than one hour of physical activity outside secure room per 24 hours"; and "No special restriction on quantity of food is permissible, the child or young person in close custody being provided with the same general diet, at all times, as provided for others in the institution. Where practicable it is expected that meals will be taken together in the common room and that staff will eat with their charges. Suitable conditions for eating are to be arranged e.g. special table etc. The conclusion of a meal, especially the evening meal, gives a valuable opportunity for round table discussion and for becoming better acquainted. Young persons should not be locked up immediately after meals without good reason." (F7.09).

Section F7 ('Close custody') of the Manual (1975) stipulates procedures on admission to Secure, and provides that children and young people should:

-Be kept constructively occupied "as far as practicable" while in close custody including a "programme of activity for at least part of the day, e.g. in outside work teams, use of gym, handcraft in workroom or hobby in secure room";

-Have access to suitable reading material, and a "programme of activities before bedtime. Games, comics, radio, opportunities for letter writing to be provided within reason for leisure time.";

-Those in secure for more than three days must be "visited by [a] teacher and encouraged to continue formal education" (F7.08).

The 1978 Regulations also allow for corporal punishment. This was revoked in the 1986. Amendments which specifically prohibited the use of corporal punishment (See Appendix 1). The 1986 Amendments also set out a more structured routine and time out of room for children in Secure as follows:

> *SS.* ***Confinement to rooms of children and young persons in secure care****-*
> *(1) No child or young person placed in secure care shall be confined on that child's or young person's own in any room between 9 a.m. and 5 p.m. 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 or restore order*
> *(2) The principal of the institution shall ensure that the details of the confinement of any child or young person in any room pursuant to subclause (1) of this regulation, and the reasons for it, are recorded in the daily log.*
> *84.* ***Contact with other children and young persons****-*
> *Subject to regulation 33 of these regulations, and to any plan of treatment, every child or young person placed in secure care shall be permitted to communicate freely at all*

reasonable times between the hours of 9 a.m. and 5 p.m. each day with any other child or young person placed in secure care.

S5. 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 that child's or young person's room unless the child or young person is confined to that room pursuant to regulation 33 of these regulations.

(2) No child or young person shall be required to eat meals in any room in which there is any toilet facility that is not completely covered.

S6. Educational and recreational activities to be provided-

Subject to the need to maintain the security of the children and young persons in an institution 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 33 of these regulations,-

(a) Shall have access to an appropriate form of educational or vocational activity for not less than 4 hours on each day except Saturday, Sunday, and any day on which State schools in the district are normally closed; and (b) Shall be entitled to participate in an appropriate form of sporting or recreational activity for not less than 2 hours on each day.

Whilst undoubtedly an improvement over their predecessors, the language of the 1986 Amendments remained sufficiently loose as to allow for a considerable degree of staff discretion. Moreover, as illustrated below, survivors' accounts give reason to believe that practices on the ground remained largely unchanged even after their introduction.

What survivors and witnesses said about daily routines and procedures in Secure[26]

The daily routine described by survivors was very much like the daily routine in prison segregation (solitary confinement) units – being locked up in a cell for most of the day, with an hour or so for fresh air and exercise and a shower. Where there was a 'regime' of sorts, it was an abusive one, reminiscent of army drills, as described below.

Kohitere:

"The routine in Secure began with getting up at around six in the morning and going outside for physical training ("PT"). We would wear a yellow t-shirt and grey shorts. We would go out to run around in circles, counting back from 100. Every 24 laps or so, the staff in charge would make us do sit-ups and press-ups. They would be shouting at us the whole time." (Boy, 13, mid 1980s)

"PT was part of the routine in the security block. I was made to run carrying a heavy medicine ball. I was also made to do star-jumps, sit-ups, press -ups and six-inch raises. while

[26] This section only covers the use of secure rooms in care and protection residences. We do not have sufficient information on daily routines in health and disability wards to ascertain what these were, but it would appear to be the case that routines were similarly minimal and involved the child spending all or most of the day in a barren room.

I was doing PT they would tell me that my parents were dead or did not want me. I think that they were trying to break me. They made me [do] PT until they pushed me past the point of break down. I think this was a big-part of what has made me 'anti-social' today."

“There was nothing to do in Secure all day, just stay in my cell until I got bedding in the evening (my bedding was taken away every day). There was no systemic education and there were no activities. I was taken out of the Secure Unit for school a couple of times. However, as I have stated, schooling was not encouraged and most of us boys were out in the workforce.”

“We had to run for food, do PT, we got the smack around the head.”

“They took your mattress and blankets away from you during the day, so you were just in a cell by yourself. You could get books, but I wasn't a reader. If you were lucky, you had somebody else in one that was close, and you could talk to each other through the doors.

“… A gruelling and unstimulating environment. The staff in charge of the Secure Unit were harsh and punitive, and the system was not geared to teenagers. It felt like a prison.” (mid-late 1980s)

Owairaka Boys' Home

“They would put you in a cell and tell you the rules — you were not allowed near the windows, there was no yelling and no talking. Once a day you were allowed out of the cell to do physical training (PT). You were never allowed out of the cell otherwise and could only run out to get dinner and breakfast. You might not have a shower for two or three days.

At PT you would have two or three housemasters standing there and laughing. We had to run around the asphalt for an hour. They used to run us ragged.

There was no education in secure. We had no books. We weren't allowed anything. We were not told what was going on. The staff would just make sure you were sitting there. There was nothing to do and all you had was yourself. And your brain in your head. Sometimes I used to think I was going crazy. It wasn't just that though, they would drag you out sometimes and give you a hiding.”

Boys in Secure were not provided with underwear. The reason for this, according to an employee, was that the Secure block,

"was built with a flat roof and heating in the floor and the sun used to belt down on the roof in the summer time, and they were like ovens inside”

Another staff member told the Human Rights Commission (HRC) that "on occasions it has not been issued. This was not seen as a punishment, but rather as a move to increase the

comfort of youngsters in a secure unit which was quite hot in summer. This unit has not been fitted with extensive ventilation." (HRC 1982)

Epuni Care and Protection residence

“You got taken out for half an hour or an hour by yourself to the gym while the other boys were not in that area, and you were allowed to exercise.” (Ward of state, aged 11 or 12)

“They put me in a cell and I remained there all the time. I had to eat my meals in there and I was not allowed out. I was not allowed anything, not books, pens or paper. Most of the time I spent curled up in foetal position crying for my Mum and Dad." (10 year old; badly abused at home)

“The Secure Unit was like a pig cell. I sat in the cell all day and talked to myself. There was nothing in the cell except a toilet and a mattress. I had no time outside, no physical training, and no communication with anyone. I remember that there was a camera in the corner of the cell”.

Hamilton Boys’ Home

“I had nothing just the uniform I was given. I had nothing to read and there was no education provided.

The only time out of cell was for a shower, PT or a meal. Meals were given to you in a small dining room that was part of secure, but when you finished it was back to your cell. “

Weymouth

“Each time I was put in the Secure Unit, staff members strip-searched me. Sometimes, I would
be taken to the Secure Unit for a strip search, before being taken back to my unit. Other times, I
was strip-searched in the Care and Protection Unit. This usually happened each time I was readmitted to the unit, and each time I left and returned to Weymouth. Sometimes, I was strip-searched in the Time Out room. I had to take all my clothes off at once, and I had to squat. I didn't know at that time that there were really limited legal grounds for things like strip searches at Weymouth."

Education

Solitary confinement typically involves being deprived not only of human company, but also of participation in educational, vocational, and recreational activities and access to therapeutic and rehabilitative treatment. This would appear to have been the case also in Secure and Seclusion units for children, including after the introduction of the 1986 amendments to the Manual and an increased emphasis on access to school. Access to education is, of course, also guaranteed in a wide range of international laws and conventions, and schooling is compulsory for children aged 6 to 16 in New Zealand.

The lack of access to education for children in Secure was commented on by staff who worked in residences and by parents whose children were housed in Secure. In its response to the HRC's 1982 report, the Department of Welfare asserted that ..."[for] the brief period young persons are in the secure unit, the emotional state often accompanying them, and the circumstances of admission, militate against an effective educational experience" (HRC 1982:70)). The Department of Social Welfare therefore considered that it complied with its treaty obligations (Article 13 of International Covenant on Economic, Social and Cultural Rights- the right to education) to the "fullest extent possible in the various circumstances presented in its function as the caretaker of *children and young people who are frequently mentally disturbed, socially disruptive or so unused to any form of mental discipline that formal education is impractica*l" (HRC 1982:118, my emphasis)

Once again, the condescending language and the (negative) assumptions about the educational and social needs and abilities of children in care were very evident. The irony of the fact that some of the children were first taken into care because they skipped school did not escape HRC or parents of children who spent time in Secure. One mother whose son was in Secure in Owairaka for 8 weeks for absconding told HRC that her son "Never saw a teacher. Yet, if a child misses school for 13 days, the parents can be taken to court and fined" (HRC, 1982:7).

Finally, as noted earlier, education is a protective factor which can help stay some of the harms of solitary confinement. As the mother cited above put it:

"My son is made a State Ward because they accuse me that I can't take care of him. But he's not being taken proper care of".

Family visits

Family visits to children in Secure were allowed, but not encouraged. A former staff member at Owairaka said: "I always used to make it difficult to start with...it was only to make them make an effort themselves and to see whether they really could come in the visiting hours" (In HRC, 1982).

The judgemental language regarding children's families was evident also the Department of Welfare's response to HRC's 1982 report, stating that "the department goes to great lengths in encouraging family relationships, and significant adults in a child or young person's life are often quite remiss in honouring promises to visit.... quite often the members of the family can upset a child or young person and staff are left to 'clean up'.".

Physical and sexual abuse

As noted earlier, the 1978 Regulations allowed for corporal punishment, which survivors and witnesses told us happened regularly including what one staff witness described to the Human Rights Commission in 1982 as 'very violent beatings with a strap, including incidents of extreme violence'.

As well as the degrading practices described above- the strip searches, the wearing of pyjamas, the disciplinarian practices and so on, the separate location of Secure rooms made them ideal sites for abuse, including physical ill treatment (beatings, excessive PT) and sexual abuse, which was reported by several of the children. One man described how, when he was 12 or 13 years old and a state ward at Owairaka Boys' Home,

“For me and so many others I know of it was the sexual abuse that was the worst. A lot of things happened down in the secure unit. I can still hear the screams and cries from other boys when they'd get taken into the shower block. That's where the abuse happened — in the secure shower unit.”

Ethnicity and cultural respect

There is no indication in survivor testimonies that any cultural sensitivities were exercised in the way in which children were treated in Secure. As one survivor put it,
“They never acknowledged our culture or ethnicity in a positive sense”.

Where ethnicity was referred to, it was in the form of racial slur. Survivors described racial abuse from staff and from other children. This was reported by Pakeha, Māori, and Pacific People children alike. One man said,

“The racism was another thing. You had the white boys who were treated not too bad. Then you had the Māori who were treated like shit. But then if you were an Islander you were dog shit. They would step all over you. Staff used to tell me nobody wanted me and other things like 'you're useless, you should go and kill yourself'. Don't get me wrong, the Māori were treated like shit. But if you were underneath that, you were absolutely nothing. All we were in their eyes was Pacific Islanders. There were a few of us Islanders there and lots of Māori.”

3.5 Solitary confinement in secure and seclusion rooms: summary

My analysis of regulations (see Appendix 1) and practices in Secure rooms and units in different residences from (at least) the 1960s suggests that: a) Practices in Secure units constituted solitary confinement, and was sometimes prolonged, as defined in international law. b) Solitary confinement was widely and routinely used, and c) Its use adhered to neither national regulations nor international law.

Survivor and witness testimonies spanning over three decades paint a consistent picture of children being placed in solitary confinement in rooms reminiscent of prison cells and

subjected to a prison-like regime of solitary confinement, spending most of the day locked up in a small room for periods ranging from a few days to weeks and months, sometimes as routine practice and sometimes as a response to distressed behaviours.

Survivor testimonies suggest that not only was solitary confinement used inappropriately and for too long, thus constituting a form of ill treatment in itself, potentially triggering and retraumatising already vulnerable children, but the fact that solitary confinement rooms and units are out of sight meant that it was also facilitated abuse. Several survivors described being abused whilst in Secure, and others described hearing others being abused. It should be noted that witnessing others being abused / suffering also has adverse effects on individuals.

People who spent time in Secure as children reported:

-Solitary confinement: being locked up in their room for upwards of 22 hours a day, without meaningful human contact.

-Prolonged solitary confinement: some stays in solitary confinement lasted for many weeks and even months, constituting prolonged, and hence prohibited for all (not just children) treatment.

-Abuse: both physical (from slapping and caning to excessive exercise with inappropriate footwear) and sexual (from straightforward sexual abuse including rape to dubious practices with sexual undertones such as internal examinations of girls and not providing boys with underwear).

-No access to education or other activities

-Limited access to family (and degradation of families when they visited)

-Lack of respect to cultural heritage and practices (and degrading attitudes when culture is noted)

Contemporaneous national rules and regulations appear to be taken directly from the prison world, guaranteeing only the very bare minimum to children in solitary confinement: an hour outside their room, a shower, and limited time in the fresh air. Even that was often not provided.

Clear alternatives were available, for example ensuring that facilities had a perimeter which could be secured – with a gate, or a door, or similar, rather than using Secure for children seen to be at risk of absconding. For children who were mentally unwell, the obvious alternative would have been mental health support / treatment in the community; for children with behavioural problems- more intensive support. Solitary confinement, as an Evidence Report on Therapeutic Residential Care prepared by Oranga Tamariki concluded, was ineffective and causes further damage.

> "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.[27]"

Where a short 'cooling down' period may be useful, it should not last longer than a few hours, as noted by the UK's joint Committee on Human Rights:

"We acknowledge that short-term separation has a role to play in allowing 'cooling off' after difficult incidents, and longer-term separation is sometimes necessary for medical observations and treatment, although it poses risks. Separation is not appropriate for other purposes. We conclude that the use of separation from human contact is harmful to children if used for more than a few hours at a time and, beyond that, it can amount to inhuman or degrading treatment that is a breach of children's rights". (UK Parliament's Joint Committee on Human Rights in concluding its examination of the use of solitary confinement in the youth estate, at para. 45)

In conclusion, the very use of solitary confinement for children contravenes international law and good practice. The reasons or justifications for the placement of children in Secure rooms did not always align with official guidance and regulations, and they in turn did not align with international law and with a requirement for such placements to be a tool of last resort, and to be used for as short a time as possible. Furthermore, once in Secure everyone was treated in the same way, regardless of the reasons for their placement, rendering meaningless any assertions about the purported utility of solitary confinement as a behaviour management tool.

[27] Therapeutic Residential Care: Evidence Brief, Wellington, New Zealand: Oranga Tamariki—Ministry for Children. February 2020, at page 37).

4. Concluding remarks: Looking Back, Looking Forward

Practices in secure and seclusion rooms, as set out in historic regulations and as recounted by survivor and witness testimonies, constituted solitary confinement as internationally defined and prohibited for use with children and people with disabilities. The picture of the punitive ethos and some of the abusive practices in secure rooms in the different residences – as painted by survivors and supported by witness evidence from parents, whānau, former residence staff and by inquiry and inspection reports- was broadly consistent. The use of solitary confinement was out of line with the requirement for it to only be used as last resort in cases of emergency, even for adults, and appeared to take little account of the fact that this was afflicted on young, vulnerable, and often traumatised children. Survivors recounted feeling terrified and alone when locked up. They told the Commission of long-term difficulties- including with sleep, concentration, mood control, maintaining intimate relationships – which align to what we know of the health effects of solitary confinement. The known health effects of their solitary confinement coupled with the vulnerability of children, in particular neurodiverse children and those who had endured previous abuse, neglect and trauma, resulted in a toxic and life changing mix. For these children, solitary confinement was a form of abuse.

The use of seclusion rooms for children in health and disability institutions was similarly inappropriate and appears aimed at punishing vulnerable children for behaviours stemming from their disability. These children were essentially punished for being disabled.

Even allowing for differences in thinking and understanding of child development and child psychology at the time- solitary confinement practices were not only contrary to human rights law, but they were also contrary to basic principles of kind and compassionate treatment. The children subjected to solitary confinement were already vulnerable, and many carried trauma from a young age. Being subjected to solitary confinement and its associated restrictions is bound to have left a mark on the children who had to endure it. It can only be described as cruel, abusive, and profoundly damaging practice.

The remarkable similarities in survivors' testimonies from different institutions and across the decades rules out suggestions of individual or person-specific failings. The picture painted is one of systematic, institutional and institutionalised ill treatment.

Worse still, whilst some of the more extreme practices in the 1970s and 1980s appear to be mercifully absent in current day institutions, the use of 'secure' rooms and units for children persists and continues to be a source of grave concern.

In 2016, as part of a New Zealand nationwide review of solitary confinement and restraint practices, I visited a youth justice (jail) facility, and Epuni Care & Protection residence. My ensuing report noted the inappropriateness of keeping children and young people in conditions of solitary confinement, and the prison-like design, appearance and furnishings in

solitary confinement cells and yards in both places.[28] I noted the poor record keeping, lack of staff engagement with children in Secure and the lack of access to education and ways for children to occupy their time.

My key conclusions and recommendations were that:

- 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.

In 2020 I returned to Epuni for a short follow-up review and found that very little had changed.

> "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".[29]

I noted, again, 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 and that,

> "The design, appearance and very purpose of 'secure care' units in the Department's Care and Protection and Youth Justice residences 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: 'potentially mana-stripping practice.'" (ibid.)

[28] Shalev, S. (2017). *Thinking outside the box? Seclusion and restraint practices in New Zealand.* Auckland: New Zealand Human Rights Commission (April 2017).

[29] Shalev, S. (2020) 'Time for a paradigm shift: a follow up review of seclusion and restraint practices in New Zealand'. Auckland: New Zealand Human Rights Commission (10 December 2020).

It is sobering – and frustrating - to read that the similar observations had been made, and similar concerns had been expressed about the use of Secure and its likely detrimental effects on children, over 45 years ago. Reading some of the survivor testimonies about their lives prior to being put in care is heart wrenching. Many of them had to endure by the age of 10 or 11 what the majority of us will not have to face in a lifetime. And yet, when they were placed at the care of state institutions, some had to endure further abuse and the trauma of being placed alone in barren, barely furnished prison-cell like rooms, at times for weeks on end. When they escaped, rather than being asked what had happened to them and what they were running away from, they were further punished. Secure rooms were designed like prison cells, and the way children were treated in them was disciplinarian and at times abusive. Vulnerable children were subjected to worse treatment than that conferred on hardened adults in state prisons.

It is difficult to overstate the life-long harms of solitary confinement and similar practices, in particular for children and young people who are still developing, and more so for children and young people who have already endured adverse childhood experiences even before the placement in a residence- in itself a traumatic life event. **These children were let down by the state and its institutions at the very junction where trauma informed practice, compassion and kindness could have put their lives on an entirely different, positive, trajectory.**

They deserve acknowledgment of what was done to them, an apology, and the knowledge that other vulnerable children will not have to endure the same treatment that they were subjected to. This, in my view, is the very least that it owed to them by the state and its institutions.

Appendix 1: Regulations regarding the use of Secure rooms (historical)

1.The Residential Social Workers Manual 1975 (drafted 1971, amended 1986)

F7 CLOSE CUSTODY

01 Introduction

It is sometimes necessary in a young person's or child's own interests, or as a measure designed to protect the interests of the community, the institution and/or the individual, or because a young person remanded in our custody is considered likely to abscond, that he be detained under secure conditions.

Close custody is subject to the conditions set out below. These instructions apply to all Social Welfare institutions, both national and district.

02 Responsibility for use of secure

Directors or Principals of national institutions are responsible for the use made of secure facilities in any institutions under their control. This responsibility may be delegated to the Assistant Director (Social Work) or the Assistant Principal of a national institution. Directors and Assistant Directors Social Work may further delegate approval of admissions to the Principal of a district institution but they must personally satisfy themselves that the authority is being properly exercised. If a child or young person is admitted to close custody it will be assumed that this is done within the policy approved by one of the officers mentioned above.

Confinement of any child or young person in close custody is to be generally regarded as an emergency procedure to be terminated as soon as behaviour warrants release. While in some cases it might be appropriate to indicate a pre-determined 'sentence' it should be remembered that circumstances can alter a situation in a very short time and that the overriding factor controlling confinement in security should be the young persons response, emotional as well as social. Cases are to be reviewed regularly and opinions of the staff working with the child or young person considered when a change is likely or seems advisable. Staff are to act as they think best in emergencies.

03 On admission

When a child or young person is to be placed in secure custody whether from within the institution or on initial admission to the institution, he or she must have a complete change of clothing so that the possibility of taking contraband articles into security is minimised. This clothing change will normally coincide with the taking of a bath or shower on admission at which time a check should also be made for signs of bruising or hypodermic marks.

04 Restrictions on use of close custody

Close custody is only to be used where a child or young person's behaviour indicates a need for this, or where detention under secure conditions is implicit in a Court order or requested by the Court.
Any room or secure facility used to hold a child or young person must have been specially designed, adapted or built for this purpose with the approval of the Director General; no child or young person may be confined in any other room without the Director-General's prior approval. Not more than one child or young person is to be confined in any one secure room at one time unless in circumstances of real necessity. Where this is necessary Principals are to advise Head Office.
05 Accurate records to be kept
It is essential that a Secure Register be kept in each institution. This register must show the time at which the child or young person entered a secure room, the reason for detention, the name of the admitting officer and the time of release. This record must
be accurately completed as events occur and be available for perusal by Inspectors or other senior officers, officers responsible for approving admissions are to sign this register at least weekly. It is clearly in the interest of all institution officers that this instruction is meticulously observed,
06 Supervision of close custody
No child or young person is to be left unobserved during day-light hours for more than one half hour at a time. At night there must be checks at least at hourly intervals.
Reserved
F7.08 Constructive use of time
Controlling officers must take all reasonable steps to ensure that children or young persons restrained in close custody are constructively occupied as far as practicable.
Where possible a programme of activity should be available for at least part of the day, whether this involves membership of an outside work team for a few hours, use of a gymnasium or handcraft activity in the workroom of a secure unit or some hobby
pursued in the secure room itself.
F7.08 - F7.10
Children or young persons in close custody should also have access to suitable reading material. For the evening some programme should whenever possible be arranged before normal bedtime. Games, books, comics, radio and opportunities for letter writing etc., are to be provided within reason for leisure time.
Any child or young person of school age held in secure conditions for more than three days must be visited by a teacher, if a teacher is attached to the institution, and encouraged to continue his formal education. Efforts should be made to ensure that young persons beyond school leaving age have the opportunity to continue formal education if they wish and if a teacher is available at the institution.
F.09 Health and hygiene
Provision must be made for any child or young person in close custody to have a daily shower or bath, and not less than one hour of physical activity outside his secure room in any twenty-four hour period. If there are special reasons why the latter is impracticable this must be noted in the close custody record.

The controlling officer of the institution must satisfy himself that the child or young person is detained under conditions that provide adequate light, ventilation, and warmth and that safety is assured.
No special restriction on quantity of food is permissible, the child or young person in close custody being provided with the same general diet, at all times, as provided for others in the institution. Where practicable it is expected that meals will be taken together in the common room and that staff will eat with their charges. Suitable conditions for eating are to be arranged e.g. special table etc. The conclusion of a meal, especially the evening meal, gives a valuable opportunity for round table discussion and for becoming better acquainted. Young persons should not be locked up immediately after meals without good reason.
F.10 Written guide for staff
The Principal of any institution with secure facilities must prepare a written guide for staff based on this section. This should include instructions regarding normal precautions to be taken by staff:-
(a) to avoid contraband or self injury by residents, and
(b) for their own personal safety while on duty.
Instructions regarding action to be taken in fire or emergencies should also be included (Refer Part L) and all instructions should be reviewed frequently at training sessions of secure block staff.

2. The Children and Young Persons (Residential Care) Regulations 1986 (selection)

25. Silence not to be used as a punishment-No child or young person in an institution shall be required to remain silent for any period of time as a punishment.

26. Confinement to room restricted-(I) Subject to subclause (2) of this regulation, no child or young person in an institution shall be confined on that child's or young person's own in any room in that institution for any continuous period of more than 1 hour between the hours of 7 a.m. and 8 p.m. each day.

2. PART III SECURE CARE

27. Areas for provision of secure care to be designated-
The principal of every institution shall designate that part of the institution that is to be used for the provision of secure care, and every such part shall be readily identifiable at all times by all children and young persons in that institution.

28. Placement of children and young persons in secure care-(I) No child or young person in an institution shall be placed in secure care unless- (a) It is necessary to place the child or young person in secure care
(i.) To prevent that child or young person absconding from the
institution; or

(ill To prevent that child or young person behaving in a manner likely to cause physical harm to that child or young person or to any other person, or to damage any property; or
(b) The behaviour of the child or young person is so disruptive or disturbed that that child or young person cannot be permitted to remain in the institution except in secure care; or
(cl The principal of the institution considers that secure care is the most suitable environment in which to provide appropriate treatment for that child or young person; or
(d) Placement of the child or young person in secure care is the only practicable means by which that child or young person may be protected from harmful behaviour directed at that child or young
person by other children or young persons in that institution; or
(e) The child or young person requests in writing to be placed in secure care.
(2) Where any child or young person is placed in secure care pursuant to subclause (I) (e) of this regulation, that child or young person shall, on that child's or young person's request, be released from secure care forthwith.

29. Child or young person may be examined before placement in secure care-(l) Subject to subclauses (2) to (4) of this regulation, before any child or young person is placed in secure care, that child or young person may be required to undress and be examined for the purpose of ensuring that that child or young person does not have in that child's or young person's possession, or concealed on that child's or young person's body, any article, drug, or other substance which could, while that child or young person is in secure care, be harmful to that child or young person or
to any other person.
(2) Every examination of a child or young person pursuant to subclause (1) of this regulation shall be conducted with decency and sensitivity by an adult member of the staff of the institution who is of the same sex as the child or young person examined.
(3) Any child or young person who is required to undress for the purposes of any examination pursuant to subclause (1) of this regulation shall be required to remain undressed only for so long as is reasonably necessary for the purposes of that examination.
(4) Before any child or young person is examined pursuant to subclause (l) of this regulation, it shall be explained to the child or young person that the sole purpose of the examination is to ensure that child's or young person's own safety and the safety of others.
…
SI. Notice to be given where child or young person placed in secure care-(I) Subject to subclause (5) of this regulation, where any child or young person is placed in secure care and it is intended to require that child or young person to remain in secure care for any period exceeding 24 hours, the principal of the institution or any member of the staff of the institution designated for the purpose shall give notice that the child or young person has *been* placed in *secure* care to-
(a) The person named in the Admission Register as the parent of the child or young person; or
(h) Any person, other than the Director·General, who is named in the Admission Register as the guardian of the child or young person; or

(cl The person named in the Admission Register pursuant to regulation 37 (2) (f) of these regulations as the person nominated by the child or young person to receive such notice.
(2) Every notice under subclause (I) of this regulation shall-
(a) Specify the grounds for placing *the* child or young person in secure care; and
(b) Be given by letter sent not later than 24 hours after the child or young person is placed in secure care.
(3) Subject to subclause (5) of this regulation, where any child or young person is placed in secure care and it is intended to require that child or young person to remain in *secure* care for a period exceeding 7 days, the principal of the institution or any member of the staff of the institution
designated for the purpose shall. not later than 10 days after the placement of that child or young person in secure care, give notice of that placement to the Director-General_
(4) Every notice under subclause (3) of this regulation may be given by letter, and shall specify the grounds for placing the child or young person in secure care_
(5) Where any child or young person is placed in secure care and it is intended to require that child or young person to remain in secure care for a period exceeding 14 days, the principal of the institution or any member of the staff of the institution designated for the purpose shall give notice of that intention to-
(a) The Director-General; and
(b) The person named in the Admission Register as the parent of the child or young person; or
(c) Any person, other than the Director-General, who is named in the Admission Register as the guardian of the child or young person; or
(d) The person named in the Admission Register pursuant to regulation 37 (2) (f) of these regulations as the person nominated by the child or young person to receive such notice_
(6) Every notice under subclause (5) (a) of this regulation shall specify
a) The reasons why the child or young person is to be kept in secure care for a period exceeding 14 days:
(b) Details of the plan of treatment proposed for the child or young person while that child or young person is in secure care during that period:
(cl Details of any medical, psychiatric, psychological, or other opinions regarding the mental or physical health of the child or young person and any recommended treatment.
(7) Every notice under paragraph (b) or paragraph (cl or paragraph (d) of subclause (5) of this regulation shall specify in simple, non-technical language,-
(a) The reasons why the child or young person is to be kept in secure care for a period exceeding 14 days:
(b) Details of the plan of treatment proposed for the child or young person while that child or young person is in secure care during that period
(8) Every notice under subclause (5) of this regulation shall be given forthwith, and, in the case of a notice under paragraph (b) or paragraph (c) or paragraph (d) of subclause (5) of this regulation, shall be given by letter.

(9) Where any notice required by this regulation to be given to any person is given by letter, such notice shall be deemed to have been received by that person when the letter would have been delivered in the ordinary course of post, and in proving that the notice was given it shall be sufficient
to prove that the letter was properly addressed and posted
S2_ **Periodic review of placement in secure** care-
(l) Subject to subclauses (3) and (4) of this regulation, the member of the staff of an institution who is in charge of the secure care unit in that institution shall review daily the case of every child or young person who is being kept in secure care in that institution in order to determine whether that child or young person should continue to be kept in secure care.
(2) Subject to subclauses (3) and (4) of this regulation, where a child's or young person's continued placement in secure care has been reviewed pursuant to subclause (1) of this regulation, that child or young person shall he discharged from secure care unless the staff member who carried out
that review certifies that that staff member is satisfied-
(a) That-
(i) The ground on which that child or young person was placed in secure care continues to apply; or
(ij) The continued placement of that child or young person in secure care is justified on any other ground on which that child or young person might be placed in secure care; and
(b) That adequate management of that child or young person cannot reasonably be undertaken except in secure care.
(3) Subject to subclause (4) of this regulation, no child or young person shall be kept in secure care for a continuous period of more than 72 hours unless, before the expiry of that period, the principal of the institution, or some other senior member of the staff of the institution designated by the
principal for that purpose, carries out a review of that child's or young person's case pursuant to subclause (1) of this regulation, and certifies that he or she is satisfied as to the matters in respect of which a staff member is required to be satisfied under subclause (2) of this regulation.
(4) No child or young person shall be kept in secure care for a continuous period of more than 7 days unless, before the expiry of that period, and at intervals not exceeding 7 days thereafter, the principal of the institution or some other senior member of the staff of the institution designated by the principal for that purpose, carries out a review of that child's or young person's case pursuant to subclause (1) of this regulation, and certifies that he or she is satisfied as to the matters in respect of which a staff member is required to be satisfied under subclause (2) of this regulation.
(5) Every certificate given for the purposes of this regulation shall (a) Be given in writing; and (b) Be recorded in the Secure Care Register, which record shall be signed by the person giving the certificate.
SS. **Confinement to rooms of children and young persons in secure** care-

(1) No child or young person placed in secure care shall be confined on that child's or young person's own in any room between 9 a.m. and 5 p.m. 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 or restore order
(2) The principal of the institution shall ensure that the details of the confinement of any child or young person in any room pursuant to subclause (1) of this regulation, and the reasons for it, are recorded in the daily log.
84. **Contact with other children and young** persons-
Subject to regulation 33 of these regulations, and to any plan of treatment, every child or young person placed in secure care shall be permitted to communicate freely at all reasonable times between the hours of 9 a.m. and 5 p.m. each day with any other child or young person placed in secure care.
S5. 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 that child's or young person's room unless the child or young person is confined to that room pursuant to regulation 33 of these regulations.
(2) No child or young person shall be required to eat meals in any room in which there is any toilet facility that is not completely covered.
S6. Educational and recreational activities to be provided-
Subject to the need to maintain the security of the children and young persons in an institution 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 33 of these regulations,-
(a) Shall have access to an appropriate form of educational or vocational activity for not less than 4 hours on each day except Saturday, Sunday, and any day on which State schools in the district are
normally closed; and (b) Shall be entitled to participate in an appropriate form of sporting or recreational activity for not less than 2 hours on each day.