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# SOLITARY CONFINEMENT IN NEW ZEALAND PRISONS

Solitary confinement is the practice of socially and physically isolating a person in conditions of confinement for 22-24 hours per day. Although there is no official punishment or unit called ‘solitary confinement’ in New Zealand prisons, its use is widespread in the practices of isolation, segregation and separation.

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This report interrogates what is a commonplace practice in the prison system. It examines the conditions of solitary confinement in New Zealand prisons, as well as the number of people exposed to it. It then outlines the numerous and severe harms caused by solitary confinement, as well as the failure of the use of such practices to achieve the intended purposes of prison order, prisoner safety and suicide prevention. Recognising the effects of solitary on those who most experience it, it is argued that, according to international human rights standards, solitary confinement is inherently dehumanising and sometimes amounts to cruel, inhuman and degrading treatment, as well as torture. From these findings, the report recommends the abolition of solitary confinement in New Zealand prisons.

## INTRODUCTION

Solitary confinement is the harshest form of punishment available in the New Zealand prison system. It can cause severe physiological and psychological pain, exacerbating the risk of

self-harm and suicide of those exposed to it.<sup>1</sup> Its use in New Zealand prisons has come under increased scrutiny by United Nations,<sup>2</sup> the Office of the Ombudsman,<sup>3</sup> international human rights observers<sup>4</sup> and prison abolitionists.<sup>5</sup>

This report outlines why the use of solitary confinement in New Zealand prisons needs to end. First, it outlines the practice of solitary confinement and its distinct types. Second, it details the physiological, social and psychological effects of solitary on the people exposed to it. Third, it demonstrates that solitary confinement fails to achieve its purported goals and fourth, can amount to inhumane or degrading treatment and sometimes torture. Finally, it makes four policy recommendations stemming from the analysis.

If the Department of Corrections is to be believed, ‘Solitary confinement is not used in New Zealand prisons’.<sup>6</sup> While it is illegal to sentence a person to solitary confinement under the Crimes Act 1961,<sup>7</sup> Corrections’ assertion

is demonstrably false. The denial of the use of solitary confinement in prisons is not unique to the New Zealand Department of Corrections, with international counterparts making the same argument.<sup>8</sup> Indeed, the term ‘solitary confinement’ is associated with degrading and torturous treatment, something Departments of Corrections would prefer not to be associated with.<sup>9</sup>

In recent years, a consensus has emerged as to the meaning of solitary confinement within academic literature and human rights standards. Solitary confinement is the social and physical isolation of people in places of confinement for 22 to 24 hours per day.<sup>10</sup> This definition includes situations where a person is not necessarily held in a single cell for 22-24 hours per day but is still physically isolated from others.<sup>11</sup> ‘Prolonged’ solitary confinement, according to the 2015 United Nation’s Standard Minimum Rules for the Treatment of Prisoners (‘Mandela Rules’), is any period of solitary lasting longer than 15 days.<sup>12</sup> Prolonged solitary confinement is prohibited under the Mandela Rules.<sup>13</sup>

According to Sharon Shalev, who recently produced a comprehensive study of solitary confinement in New Zealand for the NZ Human Rights Commission,<sup>14</sup> solitary confinement has three main components: social isolation, reduced stimulation and lack of control over one’s environment.<sup>15</sup> First, ‘Solitary confinement removes the individual from the company of others and deprives him or her of most forms of meaningful and sympathetic social interaction, as well as any physical contact’.<sup>16</sup> Of course, it is impossible to isolate a person from all other humans completely. They still need to be fed, use the bathroom, and be let out of their cell from time-to-time. However, in solitary conditions, ‘only rarely will this contact be

socially and psychologically meaningful’.<sup>17</sup> To have meaningful contact, people need the ability to socialise with peers or receive therapeutic intervention.

Second, solitary confinement involves ‘reduced activity and stimulation’.<sup>18</sup> This entails having little to no way to pass one’s time while isolated, creating a sometimes-unbearable, monotonous environment.<sup>19</sup> Some solitary confinement cells give the person nothing at all to do to pass the time. Other cells allow them books, writing material and televisions. Finally, solitary confinement often removes prisoners’ ability to control almost all aspects of their lives.<sup>20</sup> They become completely dependent on the prison for managing environmental conditions, such as light and heating, as well as deciding when they will eat, who they will see and when they will leave their cell.

The conditions described above are widespread in New Zealand prisons. Indeed, there are multiple names that are used to describe what is effectively solitary confinement. As the Chief Ombudsman states,

Isolation, segregation, separation and cellular or solitary confinement are some of the terms used to describe a form of confinement whereby prisoners are held alone in their cell for up to 24 hours a day, and are only allowed to leave it, if at all, for an hour or so of outdoor exercise. Based on this definition, prisoners assessed as at risk and managed in safe cells are essentially in solitary confinement.<sup>22</sup>

In their separate examinations of solitary confinement in New Zealand prisons, Shalev and the UN Subcommittee for the Prevention of Torture agree with the finding that there

is widespread and concerning use of solitary confinement.<sup>23</sup> Similarly, the Office of the Ombudsman has regularly referred to ‘solitary confinement’ units in its reports into New Zealand prisons.<sup>24</sup>

Shalev states that, in solitary units in New Zealand generally, a ‘typical daily “regime” included only access to a shower, telephone call and solitary exercise in a small, barren yard or cage’.<sup>25</sup> New Zealand uses solitary confinement largely for the same purposes as prison systems abroad. These purposes include discipline, prison administration and cell management, to protect a person from other prisoners and to prevent self-harm.<sup>26</sup> Prisoners in solitary confinement are usually placed in a ‘management’ unit, a ‘separates’ area or unit, or in the At-Risk Unit (ARU). There is, however, a lack of consistency across the prison estate in the names used for solitary confinement units. The previously mentioned names are used here for the sake of consistency, as they are used by the Office of the Ombudsman and Shalev.

There are five main ways through which a person can be placed in solitary confinement in New Zealand prisons. These are directed segregation, directed protective segregation, cell confinement, at-risk status and de facto solitary confinement. Each of these types of solitary confinement is examined below.

#### **DIRECTED SEGREGATION**

First, prisoners can be segregated for the ‘purpose of security, good order, or safety’.<sup>27</sup> This is generally referred to as ‘directed segregation’. If a prison manager deems that a prisoner poses a risk to the ‘security or good order of the prison’ or ‘the safety of another person or prisoner, the manager is empowered to restrict or entirely deny their association with other prisoners’.<sup>28</sup>

This segregation directive automatically expires after 14 days but can be extended indefinitely.<sup>29</sup> Prisoners on directed segregation are held in management units.<sup>30</sup>

As the then National Commissioner Jeremy Lightfoot states in response to an Official Information Act request, ‘Directed segregation is not a means of discipline’.<sup>31</sup> In this way, it is comparable to what is called ‘administrative segregation’ in the United States and Canada, where a prisoner is isolated from other prisoners without having necessarily gone through a disciplinary process or having been sentenced to solitary confinement.

That being said, the conditions in the management units are punitive and directed segregation is used for disciplinary purposes.<sup>32</sup> Directed segregation can be used to house disruptive prisoners as a de facto punishment, especially when officers deem their behaviour to be threatening.<sup>33</sup> Further, as Shalev finds, ‘Although Management units were not meant to be punitive, the problems of bleak environment and impoverished regimes identified above were very much evident in them too’.<sup>34</sup> These ‘impoverished regimes’ refer to being confined in cells for 22-24 hours per day with little to no meaningful activities. In its 2013 review of New Zealand prisons, the Office of the Ombudsman states that ‘Most prisoners placed on directed segregation were not receiving their daily minimum entitlement of one hour in the open air at Rimutaka, Mt Eden and Auckland’ prisons.<sup>35</sup> At Spring Hill prison, the Chief Ombudsman observed that prisoners in the management unit were ‘not allowed to mix, save in exceptional circumstances’,<sup>36</sup> while prisoners at Waikeria prison were only allowed ‘one hour’s exercise and in that time they were required to have a shower, use the telephone and clean their

cell'.<sup>37</sup>

Even when prisoners are allowed out of their cells to exercise, their ability to do so is limited to 'yards'. In 'most of the prisons visited, the outside yards had roofs, which prevented exposure to sunlight. In numerous instances, the so-called "outdoor exercise" yards were not really "outdoor" at all. At Mount Eden prison, the SPT [UN Subcommittee for the Prevention of Torture] observed that prisoners were very pale and were reportedly given vitamin D pills due to the lack of exposure to daylight'.<sup>38</sup> In other words, even where prisoners on directed segregation are granted the ability to leave their cells and 'exercise', this is still in a caged and degrading environment.

The second form of solitary confinement is a subcategory of directed segregation called directed protective segregation. However, before examining directed protective segregation, it is important to distinguish it from voluntary protective segregation. If a prisoner's safety is at risk from another prisoner or prisoners, they can request to be placed in voluntary segregation. Approximately 25% of prisoners are in voluntary segregation.<sup>39</sup> In theory, prisoners on voluntary segregation can freely associate with other prisoners in their unit and engage in purposeful activities.<sup>40</sup> For that reason, voluntary segregation usually does not amount to solitary confinement.

If voluntary segregation is too dangerous for a prisoner, they can be placed in directed protective segregation. Directed protective segregation can occur where 'there is no reasonable way to ensure the safety of the prisoner otherwise'.<sup>41</sup> A protective segregation directive can last indefinitely, needing only

to be reviewed on a three-monthly basis after the initial 14 days.<sup>42</sup> Prisoners on protective segregation are usually held in management units, alongside prisoners on punitive directed segregation.<sup>43</sup> This means that, like regimes of protective custody abroad,<sup>44</sup> prisoners under protective segregation effectively experience the same conditions as prisoners segregated for disciplinary reasons.<sup>45</sup> In its 2014 report, the UN Subcommittee for the Prevention of Torture (SPT), describes the situation where New Zealand prisoners on protective segregation are held in management units as 'de facto, being held in semi-permanent solitary confinement'.<sup>46</sup>

Management units are also used to house prisoners who are not in either form of directed segregation. At Spring Hill, 'Management cells were regularly used for non-segregated prisoners, including youth, when the muster [prison population] was high'.<sup>47</sup> Similarly, at Otago Corrections Facility, 'Voluntary segregated prisoners (in the management unit) are being managed on a directed segregation regime with prisoners only receiving minimum entitlements'.<sup>48</sup> In other words, prisoners who do not otherwise qualify for placement in solitary confinement are being placed in management units because of prison overcrowding.<sup>49</sup>

Data released under the Official Information Act show a rapid increase in the use of directed segregation over the past nine years.<sup>50</sup> Between December 2009 and March 2017, the snapshot number of people held in directed segregation at any given time has increased by 151.79%, from 56 to 141 people. The total number of people placed in directed segregation has increased from 676 in 2010 to 1,718 in 2016, an increase of 154.14%. The number of people in directed

segregation has nearly trebled since 2010.

### CELL CONFINEMENT

Although it is not officially used for prison discipline, directed segregation is unofficially used for disciplinary purposes. Prisoners in solitary confinement who have been formally punished are placed in ‘cell confinement’. This is the third avenue for solitary confinement. Prisoners can be placed in cell confinement following a disciplinary process, when they have been charged with an offence against discipline and that offence has been proven. When the charge has been proven before a hearing adjudicator, usually a prison officer, the prisoner can be sentenced to cell confinement for up to seven days.<sup>52</sup> When the charges are heard by a Visiting Justice, the penalty is up to 15 days of cell confinement.<sup>53</sup> Prisoners in cell confinement are usually housed in a ‘separates’ unit.<sup>54</sup>

In general, prisoners in separates spend up to 24 hours per day in their cells, with only about one hour outside, if at all.<sup>55</sup> Prisoners in separates units have no meaningful interactions with other people. At Hawke’s Bay Regional Prison, it ‘was apparent that the prisoners were locked up and largely left to their own devices as there was no routine staff presence other than to issue meals, accompany the nurse during medication rounds and conduct hourly checks’.<sup>56</sup>

The conditions in the separates units have been widely criticised by observers.<sup>57</sup> At Arohata Women’s prison, the Chief Ombudsman found

The cells used for cell confinement (following a misconduct hearing) have no power outlet. All cells have been designed to increase surveillance to enable prolonged solitary confinement and to minimise contact between prisoners and staff. Cells are self-

contained with a toilet and shower. Other measures, such as a barren exercise yard and feeding-slots built into cell-doors serve to reduce prisoner movement in and out of the unit. All cells are monitored on camera, including the unscreened toilet area.<sup>58</sup>

The same conditions have been found in other prisons. In particular, separates cells do not usually contain power outlets, meaning that prisoners in those cells cannot use electricity for things such as watching television to pass the time.<sup>59</sup> The Office of the Ombudsman reported, ‘Waikeria Separates Cells, which can only be described as deplorable, have no windows and therefore prisoners have no access to natural light or fresh air for 23 hours a day’.<sup>60</sup> Other cells do not have running water, meaning prisoners have to request water from guards.

Prisoners’ complete lack of control over their environment, alongside a lack of ventilation, means they are often housed in uncomfortable temperatures. In 2017 at Spring Hill, inspectors found cell temperature averaged at 28°C, as vents had not been working for several months. Inspectors stated that ‘This, combined with lengthy periods of lockup, (up to 22 hours a day) has the potential to increase prisoner unrest’.<sup>61</sup> Further, prisoners in separates cells at Christchurch Women’s Prison were only allowed three showers per week,<sup>62</sup> while the shower facilities for people at Arohata Women’s Prison were in the open air and possibly observable by CCTV.<sup>63</sup>

The use of cell confinement, the condition for being placed in a separates unit, has also increased rapidly in the last nine years.<sup>64</sup> The number of people on cell confinement at any given time has increased by 210% between December 2009 and March 2017, from 30 to



93. The total number of times a sentence of cell confinement was implemented rose from 4,879 in fiscal year 2009/2010 to 6,609 in 2015/2016.<sup>65</sup> This is an increase of 35.46%, while the average prison population rose by 9.25% in the same period.<sup>66</sup> The annual use of solitary in separates cell-solitary confinement is growing at a rate 3.83 times greater than the overall prison population.

#### AT-RISK UNITS

The fourth reason for solitary confinement occurs when a prisoner is deemed ‘at-risk’ and is placed in an At-Risk Unit (ARU); ‘The stated purpose of an ARU is to enable the observation and safe management of prisoners at risk of harming themselves’.<sup>67</sup> Under section 60 of the Corrections Act 2004, prisoners may be segregated for the purposes of ‘medical oversight’.<sup>68</sup> The scope of ‘medical oversight’ extends to prisoners who are at risk of self-harm, allowing them to be segregated in ARUs.<sup>69</sup> Stays in ARUs are of an indefinite length and can last as long as is deemed necessary by Corrections officials.<sup>70</sup> This form of solitary confinement requires complicity from medical professionals, as confinement for reasons of ‘medical oversight’ can only occur if the prison health centre manager recommends it.<sup>71</sup>

There are 14 ARUs across New Zealand’s 18 prisons.<sup>72</sup> The conditions in these units are bleak.<sup>73</sup> According to the Chief Ombudsman, ‘Routines within ARUs are similar to the regimes within management/separates units. At-Risk prisoners are placed in isolation with limited interaction and therapeutic activities’.<sup>74</sup> This finding is reiterated by Shalev who found that “‘At Risk units”, where vulnerable prisoners were housed, were mostly identical to those in other solitary confinement units’.<sup>75</sup>

ARU cells are typically bare, with few of the limited amenities provided to non-segregated prisoners. An investigation of the Department of Corrections reported, ‘Each cell in an At Risk Unit typically has a smooth concrete ledge used for a bed, with a plastic-covered mattress on it. There is a stainless steel toilet, and an in-built light and security camera. A solid, barrel-shaped stool is bolted to the floor’.<sup>76</sup> Most ARUs contain ‘round rooms’, ‘round cells’ or ‘dry cells’.<sup>77</sup> These are the most spartan cells in the New Zealand prison system and are used ‘for the management of violent or very disorientated prisoners’.<sup>78</sup> They contain ‘nothing at all other than a concrete slab with a thin mattress covered by tear-proof plastic, and a cardboard bedpan’.<sup>79</sup> These cells are extremely dehumanising.<sup>80</sup>

The National Health Committee noted that ‘Prisoners in at-risk units have no access to the outside world, no fresh air, and almost no human contact’.<sup>81</sup> The Chief Ombudsman similarly found that at-risk units have ‘minimal natural light and fresh air’.<sup>82</sup> When prisoners are allowed out of their cells, they experience ‘yards’ similar to those in directed segregation units. Shalev describes the ‘yard’ in the Christchurch Men’s Prison ARU as an ‘internal room with no equipment’, while in the Invercargill Prison ARU, the Chief Ombudsman states the ‘small exercise yard is run-down and bleak with no direct sunlight’.<sup>83</sup>

The Office of the Ombudsman’s inspectors have found that access to even this small yard is extremely limited. Prisoners in ARUs are ‘generally only allowed to leave their sparsely furnished cell for one hour to exercise, alone, in a barren yard’.<sup>84</sup> In other words, prisoners in ARUs usually spent up to 23 hours per day in their cells and, when they are permitted to

‘exercise’, they must do so alone.<sup>85</sup> Even when they are out of their cells, these prisoners are denied meaningful social interaction. Some prisoners do not receive their one hour of ‘fresh air’ daily. At Hawke’s Bay Regional Prison, inspectors found that prisoners in the ARUs did not get to exercise some days because efforts to keep prisoners isolated made it challenging to ensure that all prisoners had time in fresh air.<sup>86</sup>

Prisoners in ARUs, like those in other forms of solitary, are served their food through a hatch or flap in their cell door.<sup>87</sup> Their meals are ‘usually finger food as cutlery is not permitted’.<sup>88</sup> They are required to eat it close-by to a cover-less toilet, if their cell has a toilet.<sup>89</sup> One prisoner told an inspector, ‘I had no contact with the staff other than at meal times when they gave me sandwiches’.<sup>90</sup> There are CCTV cameras in almost all ARU cells, which fully capture the cell. The Office of the Ombudsman has been highly critical of this, especially the ability of any person in proximity of the CCTV monitors to observe prisoners who are naked or who are using toilet or shower facilities, which are usually unscreened.<sup>91</sup>

ARUs invite extreme boredom and limited stimulation. Prisoners in ARUs have told investigators of having basically nothing to do to pass the time. For example, ‘They stated that they do not have access to a TV in their cell or reading and writing material, as this is deemed a safety risk (some sites exercise discretion and provide reading and writing material in their cell). On occasions, false teeth and prescription glasses are also removed’.<sup>92</sup> Each ARU has ‘activities’ rooms but, over the course of the Office of the Ombudsman’s recent inspections, inspectors have not observed these rooms ever being used. Prisoners recently told the inspectors, ‘All I could do was stare at the

walls’<sup>93</sup> and ‘I was alone with my thoughts – they weren’t good’.<sup>94</sup> Indeed, the ‘lack of any positive stimulus for prisoners considered to be at risk is a significant concern’.<sup>95</sup>

There is near consensus among observers that the conditions in the At-Risk Units are poor for prisoners’ mental health.<sup>96</sup> For people with pre-existing conditions, isolation and minimal stimulus are ‘likely to exacerbate their poor state of mental health’.<sup>97</sup> This unit, which is supposedly designed to manage people who are at risk of self-harm, offers prisoners limited, if any therapeutic intervention.<sup>98</sup> When prisoners are visited by a member of the ‘mental health team’, the Chief Ombudsman has described the care they provide as ‘perfunctory due to time constraints and a lack of privacy (health staff are escorted by discipline staff)’.<sup>99</sup>

ARUs are entirely inappropriate for the treatment of people with mental illnesses and can be actively damaging to their well-being. Prisoners also view ARUs as a form of punishment. As one former prisoner told the National Health Committee,

I needed time out. Somewhere quiet, peaceful and safe. But there’s only [the at-risk unit] ... an empty room with no stimulus. It makes you go crazy. It’s a punishment. You lose all privileges. After your first time you do everything you can to avoid it in the future.<sup>100</sup>

Prisoners have reported learning to avoid showing any emotions because if they did, they might end up in the ARU.<sup>101</sup> At Hawke’s Bay Regional Prison, inspectors found that when new prisoners arrived at the ARU, prison officers placed them in round rooms. The aim ‘was to not make the prisoner’s experience in the

ARU too comfortable, so they would return to mainstream units earlier'.<sup>102</sup>

The number of people subjected to this treatment has not increased at the same rate as cell confinement and directed segregation.<sup>103</sup> Between December 2009 and March 2017, the number of people in ARUs at any given time has increased from 88 to 105, but has generally fluctuated between 80 and 120 people. The total number of people placed in an ARU cell per year fell between 2010 and 2014 from 3,276 people to 2,509 people, a 23.4% decrease. The number of people placed in an ARU cell in 2016 was 3,217, 59 fewer than in 2010 or a decrease of 1.8%.

A considerable number of people in ARUs experience prolonged solitary confinement (exceeding 15 days). Between June 2013 and June 2017, 'of all prisoner stays in at-risk units, 13924 (75%) were for 7 days or less, 2964 (16%) were for 8-20 days, and 1650 (9%) were longer than 20 days'.<sup>104</sup> Unfortunately, these data are not broken down to show the number of people

in ARUs for more than 15 days. Nonetheless, this shows there are on average at least 330 people per year who experience prolonged solitary confinement in ARUs. As I outline later, prolonged solitary confinement may amount to cruel, inhumane and degrading treatment, or torture.

#### DE FACTO SOLITARY CONFINEMENT

The final way in which a person can be placed in solitary confinement occurs because of their 'regime'. Although the prisoner may never have been segregated explicitly under the Corrections Act, their regular imprisonment may amount to de facto solitary confinement, where they are confined to their cells for more than 22 hours per day. Numerous reports by the Office of the Ombudsman into New Zealand prisons have found that a substantial number of prisoners are regularly denied access to fresh air and are confined for more than 20 hours per day.<sup>105</sup>

Table 1 outlines the results of questionnaires provided to prisoners by inspectors from the

**TABLE 1: PRISONER RESPONSES TO OFFICE OF THE OMBUDSMAN'S SURVEYS ABOUT CONDITIONS OF CONFINEMENT**

Prison (year visited)	Percentage without fresh air daily	Percentage in cell for 20+ hours per day	Percentage in cell for 22+ hours per day
Arohata (2015)	N/A <sup>109</sup>	17%	4%
Invercargill (2016)	7%	38%	6%
Manawatu (2016)	N/A	38%	6%
Otago (2016)	13%	45%	10%
Rolleston (2016)	13%	9%	4%
Hawke's Bay (2017)	12%	25%	16%
Spring Hill (2017)	4%	39%	8%



Office of the Ombudsman. The questionnaires were carried out with the Ombudsman's authority to inspect prisons under the Crimes of Torture Act (COTA) 1989. They are a section of what are referred to as the COTA reports. These reports were not publicly available until they were requested under the Official Information Act in 2016. All COTA reports have now been requested under the Official Information Act.<sup>106</sup> On August 28 2017, the Department of Corrections said it would release all the COTA reports 'soon'.<sup>107</sup> As of the date of publication, only 15 out of more than 50 reports have been released. Table 1 shows the outcomes of surveys for all COTA reports publicly available since November 2017.<sup>108</sup>

Table 1 contains some startling results. 4-13% of prisoners, according to the surveys, did not receive their basic minimum entitlement to one hour of fresh air daily.<sup>110</sup> Similarly, 4-16% of prisoners surveyed were spending 22-24 hours per day in their cell. Noting the aforementioned definition of solitary confinement, where a person is isolated in place of confinement for 22-24 hours per day, it is striking that up to 16% of prisoners in some prisons may be in solitary confinement. Some people experiencing these hours of unlock will be in officially sanctioned segregation cells in the ARUs, separates units or in management units (subsequently referred to as 'sanctioned solitary confinement'). However, from my analysis of data received from Corrections, people in those units make up only around 3% of the total prison population.<sup>111</sup> In other words, in some prisons, there may be more people in solitary confinement conditions in a regular unit than in all three sanctioned solitary confinement units combined.

This high rate of extended lockdown can occur for multiple reasons. First, the Chief

Ombudsman's inspectors found 'creeping regimes' at multiple prisons.<sup>112</sup> This is where the hours of unlock reduce over time in response to under-staffing and prisoner management. Second, whole units are sometimes locked down for punishment and security reasons. The UN Subcommittee for the Prevention of Torture, was 'particularly concerned that extended lock-downs are often used as a form of collective punishment for all those in a block or unit where there has been an incident, regardless of their involvement in an alleged offence'.<sup>113</sup>

In March 2017, it was alleged by prisoners' families that 'an entire unit at Spring Hill Corrections Facility [was] on 22-hour lockdown for months'.<sup>114</sup> At the time, Corrections emphatically denied the accusation, claiming 'The prison has been running a regime similar to other prisons across the country where prisoners are generally unlocked between 8am and 5pm each day'.<sup>115</sup> The Office of the Ombudsman's investigation into Spring Hill at that time, however, found that was demonstrably false, with 39% of prisoners surveyed at the prison spending fewer than four hours per day out of their cells.<sup>116</sup>

The above fits with a pattern of denial from Corrections relating to hours of unlock.<sup>117</sup> Indeed the SPT 'saw for itself that the periods of "out of cell time" were, in practice, significantly shorter than was claimed'.<sup>118</sup> They reported,

The SPT is concerned that the information provided by the prison management on the daily regime of detainees differed markedly from what most detainees described and what the SPT saw for itself. For example, many detainees are said to be "out of cell" from 8.00 to 17.00, sometimes with an hour lockdown at midday. This, however,

describes the working day of custodial staff and detainees usually still [sic] in their cells until 8.30 and locked up well before 4.30, meaning that, in reality, many detainees are in their cells for 18-19 hours per day, and even longer at weekends. The SPT is concerned at the possible harmful effects of being held in so strict a regime for many years, especially those held at the Maximum Security facilities in Auckland.<sup>119</sup>

In addition, Ombudsman investigations have found that people on voluntary segregation in Spring Hill and Arohata Prisons, as well as those in High Medium units at Hawke's Bay, were locked up for 20-24 hours per day, with few purposeful activities.<sup>120</sup>

However, some of the prisoners on extended lockdown will not technically be experiencing solitary confinement. Although many of these prisoners will be alone in their cells for this time, others will be celled with another person (double-bunked). It is not possible to tell from these data how many of those confined for 22-24 hours per day are double-bunked. While double-bunked prisoners are not in solitary confinement per se, as they are not socially isolated, they may nonetheless experience some of the pains of it. As Grassian observes, 'Confined groups comprising just two individuals may be the most pathogenic of all, associated with especially high rates of mutual paranoia and violent hostility'.<sup>121</sup> A former prisoner told the National Health Committee that

Double-bunking basically means you don't get any privacy at all. To me that's a real issue. A real health issue. A mental health issue as well. No moment's peace. Gets you irritated ... As soon as they shut the door [the cellmates] start beating up on each

other... I've known those situations where they fought for an hour and a half before the guards finally went down and dealt with it. High stress – all of the effects of high stress. Over-production of adrenaline.<sup>122</sup>

Similarly, the Chief Ombudsman has found a link between double-bunking and prison violence at Spring Hill, stating that the 'increase of double-bunking at the Prison has led to an increase in assaults and incidents'.<sup>123</sup> For inmates double-bunked for 22-24 hours a day, the 'pressurized contact can become the occasion for explosive violence'.<sup>124</sup> In other words, while some of the 4-16% of prisoners in Table 1 who spend 22-24 hours per in their cell are double-bunked, those conditions are still potentially damaging.

#### WHO GOES TO SOLITARY?

Corrections will not provide reliable data based on the hours of unlock of prisoners, therefore, it is not possible to determine the exact number of people in solitary confinement in New Zealand prisons. From data provided under the Official Information Act, in March 2017 there were 339 people in sanctioned solitary confinement, meaning they are in either directed segregation, a separates unit or an ARU. That is 3.38% of the total prison population at the time. This is a conservative estimate of the number of people in solitary confinement. Of the prisons surveyed, at least 4% of prisoners and up to 16% of Hawke's Bay prisoners could be in de facto solitary confinement. Therefore, it is likely an underestimate to state that 3.38% of prisoners in New Zealand are in solitary confinement.

From the Official Information data, between December 2009 and March 2017, the number of people in sanctioned solitary confinement at any given time has increased from 2.11% of the total prison population to 3.38%. In her

investigation into solitary confinement in New Zealand prison, Shalev examined the number of instances of segregation in the year to November 30, 2016.<sup>125</sup> She found 16,370 recorded instances where a person was placed in sanctioned solitary confinement and ‘Of the 16,370 stays in segregation, 1,314, or 8 per cent lasted for 15 days or longer’.<sup>126</sup> This is a rate of segregation of 167.1 per 100 prisoners, which is four times greater than the rate in England and Wales.

Shalev’s analysis also shows that the use of sanctioned solitary confinement disproportionately affects Māori and Pacific peoples. According to Shalev, Māori and Pacific peoples make up 62% of all those placed in sanctioned solitary confinement and 80% of people on directed segregation.<sup>127</sup> Māori and Pacific peoples make up just 23% of the general population of New Zealand. The use of solitary confinement is thus at a disproportionate rate against Māori and Pacific peoples, demonstrating that it is an institutionally racist form of punishment.

Other groups are also disproportionately likely to be placed in solitary confinement. Once imprisoned, women are 69% more likely than men to be placed in solitary confinement and for longer.<sup>128</sup> International studies show that LGBT people, particularly transgender women,<sup>129</sup> people with disabilities, and young people are also more likely to be placed in solitary confinement.<sup>130</sup>

Notably, there is a pattern emerging of imprisoned young people being placed in de facto solitary confinement, or conditions approaching it. In March 2017, the Ombudsman’s inspections of Spring Hill found ‘Youth were usually located on Unit 16A [the

voluntary segregation unit] where they spent the majority of their time locked in their cells (approximately 20 hours a day)’.<sup>131</sup> As noted earlier, young people in the same prison were also found to be placed in the solitary confinement-management unit ‘when the muster was high’.<sup>132</sup> In 2014, the UN Subcommittee for the Prevention of Torture found that youth prisoners on remand at Mt Eden Prison were being held in 19-hour lockdowns,<sup>133</sup> while the Office of the Ombudsman reported that youth prisoners at Mt Eden had ‘limited access to fresh air’.<sup>134</sup> In a follow-up visit in 2015, the Office found ‘the time spent out of cells for youth had reduced considerably to between one and two hours a day, with minimal access to programmes and facilities’.<sup>135</sup>

Although there are currently no studies on the prevalence of mental illness in the sanctioned solitary confinement units in New Zealand, studies from the US, UK, Canada and Denmark have found that people with serious mental illnesses are significantly more likely to be placed in solitary confinement for both punitive and protective purposes.<sup>136</sup> People in New Zealand prisons are, however, much more likely than the general population to have experienced mental illness in their lifetime or to be experiencing it currently. A 2016 study by the Department of Corrections found that 91% of prisoners had a lifetime diagnosis of a mental health or substance use disorder and 62% had a diagnosis in the past 12 months. This is compared to 62% and 21% respectively in the general population.<sup>137</sup> Therefore, people with mental illnesses are substantially more likely to end up in prison and, once there, more likely to end up in solitary confinement. As I detail below, there are extremely concerning consequences to “disappearing” psychiatrically disabled

individuals into correctional settings'.<sup>138</sup>

### EFFECTS OF SOLITARY CONFINEMENT

Thus far I have outlined the regimes of sanctioned and de facto solitary confinement in New Zealand prisons and the conditions in which people in them are exposed. There is unanimity within the literature on solitary confinement that its impact on those who endure it depends on several factors.<sup>139</sup> These factors include: personal capacity to withstand isolation and limited stimulus, the physical conditions of confinement, the levels of restriction, the hours of unlock, the extent and quality of social interaction, the reason for the confinement (whether it was voluntary, involuntary, for protected, or punitive purposes), the duration of the confinement and whether the confinement is for indefinite period.<sup>140</sup>

Solitary confinement can have negative physiological impacts. These include back, knee and joint pain, stomach, intestinal, heart, and genitourinary problems, diaphoresis, insomnia, deterioration of eyesight, weight loss, shaking, migraine headaches, profound fatigue and the aggravation of existing medical conditions.<sup>141</sup>

The most marked impact on people in solitary confinement is, however, the psychological pain it can inflict. There is an emerging consensus among reputable studies that solitary confinement is psychologically damaging.<sup>142</sup> There are, however, a small number of studies that have found no psychological harm arising from solitary confinement. Where studies have failed to find negative effects of solitary, they have tended to use volunteers,<sup>143</sup> were conducted as experiments,<sup>144</sup> were outside of prisons,<sup>145</sup> had methodological flaws,<sup>146</sup> and were for short periods of time.<sup>147</sup> Some studies using volunteers had significant participant drop-out rates, which

could indicate that those who were least able to endure the conditions of confinement were not represented in the findings.<sup>148</sup> Others<sup>149</sup> concluded that solitary had no harmful effect despite finding negative symptoms in their participants.<sup>150</sup> While multiple studies have found harm from even short periods of solitary confinement, as Haney and Lynch note, there 'is not a single study of solitary confinement wherein non-voluntary confinement that lasted for longer than 10 days failed to result in negative psychological effects'.<sup>151</sup>

Overall, the literature 'suggests that between one-third and more than 90 percent experience adverse symptoms in solitary confinement, and a significant amount of this suffering is caused or worsened by solitary confinement'.<sup>152</sup> Specifically, solitary confinement can dramatically increase the risk of hospitalisation of prisoners for psychiatric reasons. A Danish study of prisoners in solitary confinement found that the probability of being admitted to hospital for psychiatric reasons increased as time went on for prisoners in solitary confinement.<sup>153</sup> They concluded, 'If a person remained in SC [solitary confinement] for 4 weeks the probability of being admitted to the prison hospital for a psychiatric reason was about 20 times as high as for a person remanded in nSC [non-solitary confinement] for the same period of time'.<sup>154</sup>

Solitary confinement can be damaging to anyone, especially for prolonged periods of time.<sup>155</sup> Even people whom researchers deemed to have 'a history of relatively strong psychological functioning prior to their confinement' experienced 'significant psychopathological reactions to their prolonged confinement in a setting of severe environmental and social isolation. These included perceptual disturbances, free-floating anxiety, and panic

attacks'.<sup>156</sup>

However, solitary confinement can have more severe psychological impacts on people with serious mental illnesses.<sup>157</sup> As Haney describes,

prisoners who enter these places with pre-existing psychiatric disorders suffer more acutely. The psychic pain and vulnerability that they bring into the lockup unit may grow and fester if unattended to. In the absence of psychiatric help, there is nothing to keep many of these prisoners from entering the abyss of psychosis.<sup>158</sup>

Solitary confinement can cause severe pain and suffering to people with pre-existing mental illnesses.

In what follows, some of the effects found from dozens of studies on the impacts of solitary confinement are outlined. This list is not exhaustive but details many of the recurring symptoms. First, prisoners in solitary confinement commonly experience severe anxiety.<sup>159</sup> Haney's study of prisoners in solitary confinement in Pelican Bay Prison in California found that 91% of prisoners experienced anxiety.<sup>160</sup> This can range from 'feelings of tension to full blown panic attacks'.<sup>161</sup> People in solitary confinement are also more likely to experience depression.<sup>162</sup> As one New Zealand prisoner said about their time in an ARU, 'If I wasn't depressed going in, I would be coming out – no distractions – zero stimulation'.<sup>163</sup> Symptoms can include low mood, feelings of hopelessness, social withdrawal, apathy, lethargy and severe depression.<sup>164</sup>

Prisoners in solitary confinement often report experiencing hallucinations.<sup>165</sup> Studies have found the onset of hallucinations after two<sup>166</sup>

or three weeks.<sup>167</sup> Hallucinations can affect all five senses. For some prisoners in solitary, 'the environment around them is so painful and so painfully impossible to make sense of, that they create their own reality' where the 'line between their own thought processes and the bizarre reality around them becomes increasingly tenuous'.<sup>168</sup>

Others respond to their conditions of confinement with anger and rage.<sup>169</sup> The 'deprivations, the restrictions, and the totality of control fills them with intolerable levels of frustration. Combined with the complete absence of activity or meaningful outlets through which they can vent this frustration, it can lead to outright anger and then to rage'.<sup>170</sup> This, alongside a deterioration in impulse control,<sup>171</sup> can lead prisoners to lash out against their environment and their captors.<sup>172</sup>

Prisoners experiencing reduced levels of stimulation can become hypersensitive to external stimuli.<sup>173</sup> As a prisoner told Grassian, 'You get sensitive to noise – the plumbing system. Someone in the tier above me pushes the button on the faucet, the water rushes through the pipes – it's too loud, gets on your nerves. I can't stand it – I start to holler. Are they doing it on purpose?'<sup>174</sup> Another prisoner found it 'Difficult to breathe, stale, awful smell from the toilets—the stench starts to feel unbearable'.<sup>175</sup>

Studies have also found prisoners experience cognitive dysfunction and lose their ability to concentrate.<sup>176</sup> Scharff Smith writes, 'As a result, isolated prisoners are sometimes apparently unable to read and cannot even watch television, although that may be one of the very few ways to pass the time'.<sup>177</sup> On the other hand, prisoners in solitary sometimes struggle to shift their attention, experiencing tunnel vision. Grassian



observed, ‘Individuals in solitary confinement easily become preoccupied with some thought, some perceived slight or irritation, some sound or smell coming from a neighboring cell, or, perhaps most commonly, by some bodily sensation. Tortured by it, such individuals are unable to stop dwelling on it’.<sup>178</sup>

Being confined in a small space for 22-24 hours per day can also exacerbate claustrophobia,<sup>179</sup> with one study finding prisoners experiencing ‘feelings of spatial compression akin to claustrophobic panic’.<sup>180</sup> Finally, solitary confinement can also induce paranoia and psychosis.<sup>181</sup> This can range from ideas of persecution, ‘Recurrent and persistent thoughts (ruminations) often of a violent and vengeful character (e.g. directed against prison staff)’, to ‘Psychotic episodes or states: psychotic depression, schizophrenia’.<sup>182</sup> Therefore, solitary confinement can cause severe psychological pain and harm.

Social confinement can also cause serious social maladaptation. Even prisoners who do not experience substantial psychological harm from solitary confinement may nonetheless experience social harms.<sup>183</sup> First, ‘The experience of total social isolation can lead, paradoxically, to social withdrawal’.<sup>184</sup> As prisoners become more isolated from others over time, what little social contact they have becomes increasingly difficult and uncomfortable, ‘They move from being starved for social contact to being frightened by it’.<sup>185</sup>

Because of the totality of control over their lives, ‘prisoners become entirely dependent upon the structure and routines of the institution for the control of their behavior’.<sup>186</sup> This process of institutionalisation within the prison, or prisonisation, occurs throughout the prison

system. However, it is intensified within solitary confinement.<sup>187</sup> On release from solitary, prisoners sometimes struggle with the increased independence, not knowing ‘how to behave without the constantly enforced restrictions, tight external structure, and totality of behavioral restraints’.<sup>188</sup> Others lose the ability to initiate any behaviour ‘because they have been stripped of any opportunity to do so for such prolonged periods of time. Chronic apathy, lethargy, depression, and despair often result’.<sup>189</sup>

Although prisoners overall take their own lives at a rate greater than the general population, the literature also consistently finds that exposure to solitary confinement can substantially increase prisoners’ risk of suicide.<sup>190</sup> Even relatively short exposure to solitary confinement can exacerbate feelings of self-harm and suicidality. A study of suicides in solitary confinement in New York State Prison found that for the ‘majority of inmates who completed suicide in a disciplinary cell [punishment-solitary confinement cell], the length of stay was fairly short’.<sup>191</sup> Another study of prisoners on remand in the New York City jail system found that, in the three-year period assessed, only 7.3% of people admitted to the prison were placed in solitary confinement. However, people who had experienced solitary accounted for 53.3% of acts of self-harm generally and 45.0% of acts of potentially fatal self-harm.<sup>192</sup> The study concludes that solitary confinement has a ‘strong effect’ on rates of self-harm, regardless of pre-existing serious mental illness.<sup>193</sup>

Therefore, solitary confinement can induce or exacerbate depression, ‘sometimes culminating in suicidal attempts’.<sup>194</sup> The literature suggests there may be additional reasons for high rates of suicide and self-harm in solitary confinement. G. D. Scott and Paul Gendreau find that self-harm

in isolation is ‘a result of sudden frustration from situational stress with no permissible physical outlet. Self-addressed aggression forms the only activity outlet’.<sup>195</sup> Shalev details that ‘Former prisoners have testified that self harm played another role for them when they were held in segregation – it asserted that they were still alive’.<sup>196</sup> Whatever the factors influencing self-harm while in solitary, the heightened risk of self-harm can continue following release from solitary confinement. A study of former prisoners in Arizona who had been held in long-term solitary confinement found that at least 50% of the male participants had considered suicide between their release and their first interview (sometimes less than a week following release).<sup>197</sup>

My research into deaths in custody in New Zealand prisons concurs with findings from abroad.<sup>198</sup> The research involved analysing every coroner’s finding into a death in New Zealand prisons that had been published between July 2007 and February 22, 2017. Of the 108 findings analysed, 37 included a self-inflicted death. Of those 37, five (13.51%) were in a sanctioned solitary confinement unit, nine (24.32%) were in a non-solitary unit, and the type of unit was unclear or unknown in 23 (62.16%) findings. In that period, people in sanctioned solitary made up only 2-3% of the total prison population, while people in solitary made up at least 13.51% of people who took their own lives. Therefore, people in solitary confinement in New Zealand prisons are disproportionately likely to take their own lives compared to mainstream prisoners. It is important to note that this likely underestimates the proportion of self-inflicted deaths in solitary confinement. This is due to a lack of detail from coroners and the possibility of some of the self-inflicted deaths occurring in de

facto solitary confinement.

Further, the Department of Corrections’ primary method of addressing suicide in prisons is to place people in At-Risk Units, a form of solitary confinement. Boshier stated, ‘Prisoners placed in ARUs are fundamentally isolated or secluded – they do not meaningfully interact with other prisoners and staff interaction is limited, yet a great deal of research states that isolation increases suicidal ideation’.<sup>199</sup> Although the Department of Corrections has referred to ARU cells as ‘suicide proof’,<sup>200</sup> people have in fact taken their own lives in ARUs.<sup>201</sup> Further, of the 37 self-inflicted deaths, the coroner mentions the deceased having spent time in an ARU in 16 instances (43.24%). Four people (10.81%) took their lives within one day of being released from an ARU and eight people (21.62%) within the first week. There is not enough data here to suggest that a stay in an ARU caused self-inflicted death. However, international literature suggests that, shortly following release from solitary confinement conditions that make suicide difficult, prisons often act on unaddressed or exacerbated thoughts of self-harm.

Craig Haney finds that, ‘while locked in a room and while being closely observed, they do not try to harm themselves, but they think about it. Then, when they are released to the open ward or to their homes, they carry out the plans they had been quietly hatching while they were restrained from actually harming themselves’.<sup>202</sup> In other words, where a suicidal person is isolated but has no means to take their own lives, the isolation can nonetheless exacerbate their suicidality. However, the resulting self-harm may only occur following release from extreme isolation. This may be the case with

self-harm and suicide following periods of isolation in an ARU, as illustrated above.

As previously discussed, there is a consensus in the literature that any stay in solitary confinement longer than 10 days is harmful. There is more uncertainty about the effects of solitary for shorter periods of time, with some studies concluding there are limited negative consequences of short-term solitary.<sup>203</sup> There are, however, a significantly larger number of studies that have found negative effects after very short periods in solitary.<sup>204</sup> According to Stuart Grassian and Nancy Friedman, some ‘prisoners only became symptomatic after many days in solitary confinement, yet other (and in the literature many others) became grossly symptomatic in only a few hours’.<sup>205</sup>

Scott and Gendreau found that just seven days of solitary confinement can cause a decline in brain activity, correlated with a lack of stimulation and ‘apathetic, lethargic behaviour’.<sup>206</sup> Up to seven days, they found this decline in brain activity was ‘reversible, but if deprived over a long period this may not be the case’.<sup>207</sup> Within four days, participants in Peter Suedfield and Chunilal Roy’s study of prisoners in disciplinary solitary confinement were symptomatic, becoming agitated and beginning to ‘show inappropriate behaviour such as giggling and staring into space for long periods’.<sup>208</sup> They also found participants experiencing hallucinations and becoming incoherent after two weeks.<sup>209</sup>

While the negative impacts of solitary confinement can occur within hours or days, the risk of further harm increases with the length of time in solitary.<sup>210</sup> As Haney notes, solitary ‘is capable of creating clinical syndromes in even healthy personalities, and can be psychologically destructive for anyone who enters and endures it

for significant periods of time’.<sup>211</sup>

Prisoners in New Zealand can spend substantial periods of time in solitary confinement. As noted above, Shalev found that in the year to November 30, 2016, 1,314 stays (8%) in sanctioned solitary confinement were prolonged, lasting more than 15 days. Similarly, between June 2013 and June 2017, 1,650 stays (9%) in the ARUs lasted longer than 20 days, meaning on average at least 330 people per annum experienced prolonged solitary confinement in ARUs.

As noted, ‘Prisoners with pre-existing mental illness are at particular risk for developing psychiatric symptoms in solitary confinement’.<sup>212</sup> As people in ARUs are deemed to be at risk of self-harm, it is particularly concerning that so many people experience prolonged solitary confinement in ARUs. This is concerning given that ‘Cells in general, and most particularly solitary confinement cells, are grossly inappropriate for the mentally ill’.<sup>213</sup> Numerous reports into ARUs have found people experiencing extended stays,<sup>214</sup> with the National Health Committee discovering that a woman had been held in an ARU almost continuously for 18 months.<sup>215</sup>

People with the most serious mental illnesses and who are recognised as needing forensic care are usually placed in ARUs awaiting transfer to a forensic mental health facility.<sup>216</sup> A 2012 report into healthcare in prisons found that, because inpatient forensic facilities tend to operate at 100% occupancy, prisoners are often waitlisted to receive an assessment or treatment.<sup>217</sup> The Office of the Ombudsman’s inspectors ‘have spoken with a number of acutely unwell prisoners in ARUs waiting for a forensic bed. Some prisoners had been waiting several months

with little to no therapeutic interaction'.<sup>218</sup> Inspectors at Hawke's Bay Regional Prison similarly found that a man with an intellectual disability was held in the ARU awaiting transfer to a forensic facility.<sup>219</sup> Further, 'Staff advised that this was not the first time a prisoner with intellectual disabilities had been placed in the ARU'<sup>220</sup> and there were 'limited therapeutic interventions' for these people.<sup>221</sup>

Returning to the effects of solitary confinement, some of these effects will subside upon release, while others may continue.<sup>222</sup> These lasting effects can include 'sleep disturbances, nightmares, depression, anxiety, phobias, emotional dependence, confusion, [and] impaired memory and concentration'.<sup>223</sup> Kupers claimed that 'for just about all prisoners, being held in isolated confinement for longer than 3 months causes lasting emotional damage if not full-blown psychosis and functional disability'.<sup>224</sup> Studies of the effects of solitary confinement on former prisoners of war in the Korean War found lasting psychological effects more than 40 years after their release.<sup>225</sup>

Social adaptations that occur while in solitary can make life outside of solitary unbearable. For some people coming out of solitary, their 'extreme adaptation' to the environment is 'too ingrained to relinquish'.<sup>226</sup> Some prisoners emerge from isolation, experiencing 'a continued intolerance of social interaction, a handicap which often prevents the inmate from successfully readjusting to the broader social environment of general population in prison and, perhaps more significantly, often severely impairs the inmate's capacity to reintegrate into the broader community upon release from imprisonment'.<sup>227</sup>

Therefore, solitary confinement can cause

severe pain and suffering. This pain can be physiological, social and psychological. Although almost anyone can experience the pain of solitary confinement, its psychological effects are especially detrimental to people with pre-existing mental illness. The harm and maladaptation caused by solitary confinement does not always subside with release, and can cause life-long disability.

#### **DOES SOLITARY CONFINEMENT WORK?**

Despite the harmful effects of solitary confinement, the Department of Corrections continues to use it. The reasons Corrections offer to justify their use of solitary include the need to protect vulnerable prisoners from others, to prevent self-harm and suicide and to ensure prison discipline and order. However, the effects of solitary confinement undermine the reasons for its use. Four of these effects are outlined in this section of the report.

First, New Zealand prisoners are sometimes placed in solitary confinement for their protection. However, regardless of the reason for solitary confinement, it can have negative consequences.<sup>228</sup> Even those who request to be placed in solitary, as in some cases of protective segregation, can also experience the negative effects. Stanley Brodsky and Forrest Scogin's study of prisoners in protective segregation found that, where prisoners in protective segregation experience conditions of solitary confinement, 84% experienced anxiety and nervousness, 77% depression, 71% irrational anger, 65% had confused thought processes and 42% experienced hallucinations.<sup>229</sup> Although solitary confinement as protective segregation is allegedly not for punishment reasons, it can nonetheless cause severe pain. In effect, prisoners who are most vulnerable in prison, and who are most likely to be placed in protective

solitary confinement, are punished because of their vulnerabilities.

It is important to note that protective segregation per se does not necessarily cause greater harm than imprisonment generally. Brodsky and Scogin did not find any of the negative effects of solitary confinement in prisoners in protective segregation who had regimes of long unlock, the ability to associate with other segregated prisoners freely, and who had purposeful activities to engage in.<sup>230</sup> Indeed, while some prisoners may request to be segregated even further than voluntary protective segregation, there is no reason why they should be in solitary confinement conditions. As Gordon argues ‘these prisoners should be placed in housing at “safe distances” from specific prisoners or groups of prisoners’.<sup>231</sup>

Second, placing people at risk of suicide in solitary confinement is a poor policy decision. Ensuring meaningful social interaction is a crucial element of suicide prevention, while social and physical isolation can seriously exacerbate the risk.<sup>232</sup> Kaufman describes isolation cells to house suicidal prisoners as ‘inhumanities in the name of psychiatry’.<sup>233</sup> In recognition of its harmful effects to suicidal people, within the mental health system in New Zealand ‘seclusion is not used for managing depression or self-harm and is only used in the context of aggression or violence’.<sup>234</sup> There is evidence of a ‘revolving-dooring’ between ARU and mainstream units where prisoners are placed in isolation in an ARU, do not receive therapeutic intervention, and then, once they have returned to the mainstream units, express or act on thoughts of self-harm.<sup>235</sup> For people in prison who are at risk of self-harm and suicide, placement in solitary confinement in an ARU is

dangerous and cruel.

Third, there is unanimity in the literature that solitary confinement is not an effective method for controlling prison violence. At best, solitary confinement fails to act as a deterrent to those who would commit violence in prison and has no effect on the overall rate of violence in the prison system.<sup>236</sup> There is, however, considerable evidence to suggest that solitary confinement can be counter-productive for controlling prison violence.<sup>237</sup> The effects of solitary confinement can include rage and reduced impulse control, as well as persecutory delusions. These combined symptoms can lead prisoners to irrationally act out both during their time in solitary and once released. International studies have found that, despite having much more restrictive regimes, violence is disproportionately likely in solitary confinement units.<sup>238</sup> Once released, people ‘tend to emerge from lock-up acting with pent-up rage and cumulated resentments, and it is therefore not surprising that they may engage in further violence’.<sup>239</sup>

Shalev notes that the rates of prisoner violence in the Californian prison system increased substantially following the introduction of solitary confinement-only prisons.<sup>240</sup> A similar trend was found in Arizona, where the opening of a solitary-only prison ‘was associated with a significant, temporary increase in staff injuries’.<sup>241</sup> On the other hand, reducing the number of people in solitary confinement has been found to reduce levels of overall violence in the prison system. A study of the effects of reducing the number of people in solitary confinement in a Mississippi prison from 900 to around 100 people found ‘an almost 70% drop in serious incidents, both prisoner-on-staff and prisoner-on-prisoner’.<sup>242</sup>



Further, the production of higher rates of violence by solitary confinement is even more apparent when ‘violence against the self’<sup>243</sup> and ‘prisoners assaulted or killed by guards’<sup>244</sup> are factored in. Therefore, the use of solitary confinement for prisoner discipline is ineffective at best and counterproductive at worst.

Fourth and finally, solitary confinement can also exacerbate the rate of recidivism, particularly violent recidivism.<sup>245</sup> Daniel Mears and William Bales found that any period in solitary confinement may increase the rate of violent recidivism.<sup>246</sup> In their study, prisoners who had been isolated had a rate of violent recidivism 18% higher than prisoners who had not been. Similarly, a Canadian study found segregated prisoners were 55.87% more likely than non-segregated to be reimprisoned within three years.<sup>247</sup> Therefore, solitary confinement can make people more likely to engage in criminalised activities, particularly violent crimes.

Not only can solitary confinement severely harm the people exposed to it, it also fails to achieve its stated purposes. Protective segregation unnecessarily punishes the most vulnerable prisoners, and ARUs are an extremely damaging response to suicidal behaviour. Solitary also fails as a mechanism for controlling prison violence, potentially increasing incidents of violence by people in prison and once they are released.

#### **DEGRADATION, TORTURE**

Even if solitary confinement achieved each of its intended purposes, its use in New Zealand prisons would remain unacceptable. Solitary confinement can cause severe psychological harm, as well as social pains from isolation. Additionally, the isolation component of solitary confinement is inherently dehumanising and

degrading, regardless of its length.<sup>248</sup>

Human beings are social animals.<sup>249</sup> We can only understand ourselves and the world around us through our interaction with others. One can only begin to grasp at the sense of oneself in relation to and with others.<sup>250</sup> Solitary confinement denies people satisfaction of this basic need for social interaction.<sup>251</sup> It not only denies access to other people but also to one’s ability to make sense of oneself and one’s surroundings. Solitary confinement deprives people of their fundamental human need for meaningful social interaction and is thus inherently dehumanising.<sup>252</sup>

In recognition of the effects of solitary as outlined in this report, there is increasing acceptance that solitary confinement often amounts to cruel, inhuman and degrading treatment, which is prohibited under the UN Convention Against Torture and incorporated into New Zealand law.<sup>253</sup> The UN Special Rapporteur on Torture found that the solitary confinement of juveniles and people with disabilities<sup>254</sup> ‘of any duration’ is cruel, inhuman or degrading treatment.<sup>255</sup> Because of the ‘adverse acute and latent psychological and physiological effects of prolonged solitary confinement’ that ‘constitute severe mental pain or suffering’, ‘solitary confinement beyond 15 days constitutes torture or cruel, inhuman or degrading treatment or punishment, depending on the circumstances’.<sup>256</sup> As noted earlier, there is widespread solitary confinement of people with mental illnesses in New Zealand prisons, particularly in ARUs. Shalev’s study also found in a single year that 1,314 instances of solitary confinement were prolonged.<sup>257</sup> Therefore, according to the standards outlined by the Special Rapporteur, there is extensive use of cruel, inhuman or degrading treatment in New

Zealand prisons.

In some cases, solitary confinement may amount to torture. The Special Rapporteur has found even short periods of solitary can amount to torture.<sup>258</sup> They stated, ‘Where the physical conditions of solitary confinement are so poor and the regime so strict that they lead to severe mental and physical pain or suffering of individuals who are subjected to the confinement, the conditions of solitary confinement amount to torture’.<sup>259</sup> Solitary confinement can cause pain as ‘clinically distressing as physical torture’.<sup>260</sup>

While solitary confinement in some instances has been found to be torture,<sup>261</sup> within New Zealand law, the definition of torture is limited. In the Crimes of Torture Act 1989, the definition of torture has three elements. First, it is an ‘act or omission by which severe pain or suffering, whether physical or mental’ is caused.<sup>262</sup> Second, it is ‘intentionally inflicted on a person’,<sup>263</sup> and third it is for a purpose or due to discrimination.<sup>264</sup> The argument here is complex but nonetheless important. The question of severity is answered easily. International studies have demonstrated solitary confinement, particularly for people with pre-existing mental illnesses and where it is prolonged, can cause severe psychological pain and suffering. As a prisoner told Ombudsman’s inspectors, ‘Feeling so isolated was terrifying’.<sup>265</sup> Not all instances of solitary confinement in New Zealand prisons cause severe pain and suffering, but some certainly do.

The more difficult question, then, is whether this pain and suffering was inflicted on a person intentionally. Department of Corrections could perhaps argue that a Corrections Officer, Prison Manager, or Chief Executive only places a person

in solitary confinement for the purposes of protective segregation, prison order, discipline or because they are at risk of self-harm. In theory, they do not place people in solitary to cause them severe pain and suffering. However, the officials’ actions can be considered intentional for the purposes of the definition. Tracey Hresko argues that prison officials must have knowledge of the severe psychological effects of solitary confinement given its clear effects on some prisoners.<sup>266</sup> This knowledge of the pain solitary can cause, can fulfil the intent element of the definition.<sup>267</sup> Where one knows that the likely outcome of one’s action or omission will cause another person severe pain and suffering, the decision to act, or omit from action, is made with consent to its outcomes. Therefore, a decision made to place or continue to house a person in solitary confinement, with knowledge of its likely effects, is a decision that intentionally puts that person at risk of severe pain and suffering.

Finally, for an act to be defined as torture must occur for a specific purpose or due to discrimination. With cases of non-protective directed segregation and cell confinement, this report has shown a punitive element to that decision.<sup>268</sup> Prisoners are segregated under those conditions as punishment for their alleged actions. For prisoners in ARUs, solitary confinement is also, arguably, a form of punishment for expressing or acting on thoughts of self-harm. As noted above, former prisoners who spoke to the National Health Committee viewed the ARU as a form of punishment, effectively disciplining them whenever they showed emotion. Further, solitary is used disproportionately against some social groups.<sup>269</sup> It can thus amount to the discriminatory treatment of: mentally unwell prisoners, who are more likely to be placed in solitary confinement for both self-protective and punishment

purposes;<sup>270</sup> people who are most vulnerable in prisons,<sup>271</sup> including transgender women;<sup>272</sup> and Māori and Pacific peoples.<sup>273</sup> Although there are likely instances of interpersonal discrimination leading to solitary confinement, the disproportionate confinement of these groups suggests an institutional discrimination that exceeds the prison system.

Although Corrections may claim that there is no alternative to solitary confinement and, therefore, it must be used regardless of the pain it can induce, the counter-productive effects of solitary confinement outlined above demonstrate that there is no legitimate use for it. Because solitary confinement does not keep people safe from others or themselves, can exacerbate suicidality, and undermine prison discipline, it fails to achieve the stated purposes of its use. The extreme pain and suffering that people in solitary confinement can experience is unjustifiable even according to its own standards.

However, even if solitary did achieve its purposes, because the use of solitary confinement in New Zealand is an intentional act that can cause severe pain and suffering for the purposes of punishment or as a result of discrimination, it can still amount to torture regardless of the reason for its use. Further, 'the use of solitary confinement increases the risk that acts of torture and other cruel, inhuman or degrading treatment or punishment will go undetected and unchallenged'.<sup>274</sup> By hiding people away in conditions that can amount to torture, it becomes easier for even more degrading and dehumanising practices to occur. Thus, in some cases, solitary confinement in New Zealand prisons can be torture and cannot be excused.

## RECOMMENDATIONS

Recognising the severe harm that can be caused from even short stays in solitary confinement, as well as its negative effects on prison suicide, violence and recidivism, the use of solitary confinement in New Zealand prisons must be ended. Numerous researchers and human rights observers have called for the abolition of solitary confinement for young people and people with mental disabilities,<sup>275</sup> as well as its use for indefinite lengths of time,<sup>276</sup> and where it is prolonged.<sup>277</sup> In New Zealand, the Mental Health Commission in 2004 called for the 'eventual eradication' of solitary confinement ('seclusion') in mental health facilities, recognising that it 'poses significant risks to service users, including death, re-traumatisation, loss of dignity and other psychological harm'.<sup>278</sup>

Given that solitary confinement is potentially damaging to everyone who is exposed to it, solitary confinement must be abolished in all instances. There is a somewhat unintentional consensus in the literature on this recommendation. While many scholars and human rights observers do not explicitly call for the abolition of solitary confinement, their recommendations as to the treatment of people in segregation call for abolition in all but name. For example, those that recommend that all prisoners in segregation be granted the ability to have meaningful social interaction with others, more time out of their cells, and more purposeful activity,<sup>279</sup> are calling for the end to conditions of solitary confinement. Therefore, there is a substantial body of literature that not only calls for the abolition of solitary confinement for certain groups or in certain conditions but also, indirectly, for the abolition of solitary confinement entirely. This report joins a large body of research that calls for the end of

solitary confinement.

The following recommendations are made about the use of solitary confinement in New Zealand prisons, based on the findings of this report:

**1. REPEAL THE LEGISLATIVE FRAMEWORK FOR THE IMPOSITION OF SOLITARY CONFINEMENT**

Sections 57-61 of the Corrections Act 2004 allow for the denial of prisoners' ability to associate with others. Sections 133(3)(c) and 137(3)(c) allow for a sentence of cell confinement to be imposed on prisoners. These sections of the Corrections Act form sanctioned solitary confinement. Sections 57-61, 133(3)(c), and 137(3)(c) of the Corrections Act must be repealed.

**2. PROHIBIT THE USE OF SOLITARY CONFINEMENT IN ANY NEW ZEALAND PRISON**

In order to remove any uncertainty as to the effects of the first recommendation, the use of solitary confinement in New Zealand prison must be explicitly prohibited. The Corrections Act must be amended to include a prohibition of solitary confinement, defining solitary confinement to mean the social and physical isolation of a person for 22-24 hours per day.

**3. ENSHRINE THE RIGHT TO TIME OUT OF CELLS**

Due to the high rates of de facto solitary confinement in New Zealand prisons (up to 16% in Hawke's Bay), incarcerated people must also be provided with the positive rights to prevent de facto solitary confinement. While recognising that one to two hours per day is an insufficient amount of social contact, it is difficult to establish an exact minimum number of hours out of cells required for healthier conditions.<sup>280</sup> With that in mind, I propose a minimum of four hours

out of cell per be granted to prisoners as a right. The Corrections Act must be amended to enshrine the rights of all prisoners to a minimum of four hours out of cell per day.

**4. ESTABLISH ALTERNATIVES TO SOLITARY CONFINEMENT**

Research within the mental health setting in New Zealand suggests there are already-existing alternatives to solitary confinement. Te Pou, a mental health, addiction and disability research and training organisation, has done substantial work to reduce the use of seclusion in mental health facilities. In its 'Best Practice' guide to reducing the use of seclusion, as preventative measures it recommends improving the physical environment by ensuring 'there is no overcrowding and there are quiet spaces for people to go to',<sup>281</sup> providing people with meaningful activities, creating an 'Atmosphere of listening and respect',<sup>282</sup> 'Behavioural coaching and therapy',<sup>283</sup> de-escalation, sensory modulation and dispute resolution.<sup>284</sup>

A recent study which used alternatives to solitary confinement to address violent behaviour of prisoners in the New York City jail system led to a substantial decrease in the rate of self-harm. The Clinical Alternative to Punitive Segregation (CAPS) programme provided prisoners with serious mental illnesses who had broken jail rules with various therapeutic activities, normal hours of unlock and substantial opportunity for social interaction. The study found that prisoners who were undergoing treatment in the CAPS programmes had significantly lower rates of self-harm than those who had not, meaning 'clinical improvements among incarcerated patients with mental illness are linked to less restrictive and more therapeutic approaches'.<sup>285</sup>

While Te Pou's recommendations and a CAPS-like programme could help to reduce the number of people in solitary confinement in New Zealand prisons and lead to better mental health outcomes, prisons are 'are inherently stressful and non-therapeutic environments'.<sup>286</sup> Treatment of mental illness and problematic behaviour also tends to be much more successful in a non-carceral setting.<sup>287</sup> In this way, the authors of the CAPS study suggested that rather than establish CAPS programmes elsewhere, 'it may be preferable to reduce the rates of incarceration for mentally ill persons altogether'.<sup>288</sup> If, as the Office of the Ombudsman suggests, the 'prison environment itself poses a threat to mental wellbeing',<sup>289</sup> then the best alternative to solitary confinement and its ill-effects is not to imprison people in the first place. Therefore, therapeutic alternatives to solitary confinement must be established, including alternatives to imprisonment.

## CONCLUSION

This report has demonstrated the undeniable

necessity of the abolition of solitary confinement. Solitary confinement can cause severe pain and suffering. This pain can be physiological, social and psychological and can continue well after release. Solitary is inherently inhumane, depriving people of their basic need for social interaction. It can also, in certain circumstances, amount to torture. The conditions in the management, separates and At-Risk Units, which make up sanctioned solitary confinement, are often bleak and degrading. People in these units, as well as the countless others in de facto solitary confinement, are locked in their cells for 22-24 hours per day with minimal human contact. Being denied this basic human dignity, people coming out of solitary are more damaged and more likely to hurt others. Given the effects of solitary, as well as the fact that it can worsen prison discipline and exacerbates recidivism and suicidality, there is absolutely no justification for its use. As such, all forms of solitary confinement in New Zealand prisons must be abolished and alternatives established.



# NOTES

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1. Henrik Steen Andersen et al. 'A Longitudinal Study of Prisoners on Remand: Psychiatric Prevalence, Incidence and Psychopathology in Solitary vs. Non-Solitary Confinement', *Acta Psychiatrica Scandinavica* vol. 102, no. 1 (2000): 19–25; Bruce A. Arrigo and Jennifer Leslie Bullock. 'The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change', *International Journal of Offender Therapy and Comparative Criminology* vol. 52, no. 6 (2008): 622–640; Thomas B. Benjamin and Kenneth Lux. 'Solitary Confinement as Psychological Punishment', *Cal. WL Rev.* vol. 13 (1977): 265; Stanley Brodsky and Forrest Scogin. 'Inmates in Protective Custody: First Data on Emotional Effects', *Forensic Reports* 1 (1988): 267–280; Stuart Grassian. 'Psychopathological Effects of Solitary Confinement', *American Journal of Psychiatry* vol. 140 (1983): 1450–1454; Stuart Grassian and Nancy Friedman. 'Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement', *International Journal of Law and Psychiatry* vol. 8, no. 1 (1986): 49–65; Craig Haney. "'Infamous Punishment": The Psychological Consequences of Isolation', *The National Prison Project Journal* vol. 8, no. 2 (1993): 3–7; Craig Haney and Mona Lynch. 'Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement', *NYU Rev. L. & Soc. Change* 23 (1997): 477; Richard Korn. 'The Effects of Confinement in the High Security Unit at Lexington', *Social Justice* vol. 15, no. 1 (1988): 8–19; Terry A. Kupers. 'What To Do With the Survivors? Coping With the Long-Term Effects of Isolated Confinement', *Criminal Justice and Behavior* vol. 35, no. 8 (2008): 1005–1016; Holly A. Miller and Glenn R. Young. 'Prison Segregation: Administrative Detention Remedy or Mental Health Problem?', *Criminal Behaviour and Mental Health* vol. 7, no. 1 (1997): 85–94; Peter Scharff Smith. 'The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature', *Crime and Justice* vol. 34, no. 1 (2006): 441–528; G. D. Scott and Paul Gendreau. 'Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison', *Canadian Psychiatric Association Journal* vol. 14, no. 1 (1969): 337–341; Dorte Sestoft et al. 'Impact of Solitary Confinement on Hospitalization Among Danish Prisoners in Custody', *International Journal of Law and Psychiatry* vol. 21, no. 1 (1998): 99–108; Peter Suedfield and Chunilal Roy. 'Using Social Isolation to Change the Behaviour of Disruptive Inmates', *International Journal of Offender Therapy and Comparative Criminology* vol. 19, no. 1 (1975): 90–99.
2. Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT). 'Report on the Visit of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment to New Zealand' New York: United Nations, 28 July 2014. Last accessed 18 January 2018. [http://tbinternet.ohchr.org/Treaties/CAT-OP/Shared%20Documents/NZL/CAT\\_OP\\_NZL\\_1\\_7242\\_E.pdf](http://tbinternet.ohchr.org/Treaties/CAT-OP/Shared%20Documents/NZL/CAT_OP_NZL_1_7242_E.pdf)
3. Peter Boshier, 'OPCAT Findings Report: A Question of Restraint', Wellington: Office of the Ombudsman, 1 March 2017.
4. Sharon Shalev, 'Thinking Outside the Box? A Review of Seclusion and Restraint Practices in New Zealand' Auckland: Human Rights Commission, April 2017.
5. Ti Lamusse, Sophie Morgan, and Emilie Rākete, eds., *Abolitionist Demands: Toward the End of Prisons in Aotearoa* Auckland: No Pride in Prisons Press, 2016; Ti Lamusse, ed., *Torture in New Zealand Prisons: A Briefing* Auckland: No Pride in Prisons Press, 2017.
6. Rachel Leota quoted in Māori Television, 'Campaign Launched against Solitary Confinement', *Māori Television*, 16 October 2017. Last accessed 18 January 2018. <https://www.maoritelevision.com/news/national/campaign-launched-against-solitary-confinement>; Cleo Fraser, 'Solitary Confinement Slammed as "Completely Unethical"', *Newshub*, 15 October 2017. Last accessed 18 January 2018. <http://www.newshub.co.nz/home/new-zealand/2017/10/solitary-confinement-slammed-as-completely-unethical.html> The Department of Corrections also recently released a video on Twitter with Chief Custodial Officer Neil Beales claiming that there is no solitary confinement in New Zealand prisons. See here: <https://twitter.com/CorrectionsNZ/status/92557992167737984>.
7. Crimes Act 1961, § 17.
8. Craig Haney et al. 'Examining Jail Isolation: What We Don't Know Can Be Profoundly Harmful', *The Prison Journal* vol. 96, no. 1 (2016), p. 130.
9. Shalev, 'Thinking Outside the Box?', p. 16.

10. International Psychological Trauma Symposium, Istanbul. 'The Istanbul Statement on the Use and Effects of Solitary Confinement', 9 December 2007; Juan Méndez, 'Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', New York: United Nations General Assembly, 5 August 2011. Last accessed 18 January 2018. <http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf>; Scharff Smith. 'The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature'; Sharon Shalev. 'A Sourcebook on Solitary Confinement'. London: Mannheim Centre for Criminology, 2008; Shalev, 'Thinking Outside the Box?'; United Nations General Assembly. 'Resolution 70/175: The United Nations Standard Minimum Rules for the Treatment of Prisoners', 17 December 2015, rule 44.
11. Shalev. 'Thinking Outside the Box?', p. 16.
12. United Nations General Assembly. 'Mandela Rules', rule 44.
13. Ibid., rule 43.
14. Shalev. 'Thinking Outside the Box?'
15. Shalev. 'A Sourcebook on Solitary Confinement', p. 17; Shalev, 'Thinking Outside the Box?', p. 17.
16. Shalev. 'A Sourcebook on Solitary Confinement', p. 18.
17. Scharff Smith. 'The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature', p. 448.
18. Shalev. 'A Sourcebook on Solitary Confinement', p. 19.
19. Ibid.
20. Ibid., p. 20.
21. This dependence on the institution for decision-making occurs throughout the prison system but is intensified in solitary confinement.
22. Boshier. 'A Question of Restraint', p. 12.
23. Shalev. 'Thinking Outside the Box?'; SPT. 'SPT Report on New Zealand'.
24. Office of the Ombudsman. 'Monitoring Places of Detention: Annual Report of Activities under the Optional Protocol to the Convention against Torture (OPCAT) 1 July 2014 to 30 June 2015' Auckland: Human Rights Commission, 2015, p. 28. Last accessed 18 January 2018. [http://www.ombudsman.parliament.nz/system/paperclip/document\\_files/document\\_files/1580/original/monitoring\\_places\\_of\\_detention\\_2015.pdf?1466558391](http://www.ombudsman.parliament.nz/system/paperclip/document_files/document_files/1580/original/monitoring_places_of_detention_2015.pdf?1466558391); Peter Boshier. 'COTA Report: Report on an Unannounced Inspection of Corrections Service Arohata Prison Under the Crimes of Torture Act 1989' Wellington: Office of the Ombudsman, 19 November 2015, p. 13. Last accessed 18 January 2018. [http://www.corrections.govt.nz/\\_data/assets/pdf\\_file/0008/874682/Arohata\\_Prison\\_COTA\\_Report\\_2016\\_MARKED\\_FINAL\\_Redacted.pdf](http://www.corrections.govt.nz/_data/assets/pdf_file/0008/874682/Arohata_Prison_COTA_Report_2016_MARKED_FINAL_Redacted.pdf)
25. Shalev. 'Thinking Outside the Box?', p. 32.
26. Juan Méndez et al. 'Seeing into Solitary: A Review of the Laws and Policies of Certain Nations Regarding Solitary Confinement of Detainees' Washington, DC: United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2016; Shalev, 'A Sourcebook on Solitary Confinement'.
27. Corrections Act 2004, § 58.
28. Corrections Act 2004, § 58(1).
29. Corrections Act 2004, § 58(3).
30. Boshier. 'A Question of Restraint'.

31. Jeremy Lightfoot. 'Paremoremo (Official Information Act Response to Emmy Rākete)', *Fyi.org.nz*, 24 November 2016, p. 3. Last accessed 18 January 2018. <https://fyi.org.nz/request/4753/response/15966/attach/3/C80902%20Response.pdf>.
32. Boshier. 'A Question of Restraint'.
33. For example, Tipene Pomare was placed in directed segregation as 'punishment'. He took his own life after 13 days in solitary confinement. See: Coroner Garry Evans, 'Findings in the Matter of Tipene Dawson Pomare (Aka Dawson Te Huna)' Wellington: Coroner's Court, 11 December 2015.
34. Shalev. 'Thinking Outside the Box?', p. 33.
35. Office of the Ombudsman. 'Monitoring Places of Detention: Annual Report of Activities under the Optional Protocol to the Convention Against Torture (OPCAT) 1 July 2012 to 30 June 2013' Auckland: Human Rights Commission, 2013, p.14.
36. Peter Boshier. 'OPCAT Report: Report on an Unannounced Inspection of Spring Hill Corrections Facility Under the Crimes of Torture Act 1989' Wellington: Office of the Ombudsman, 2017, p. 12.
37. David McGee. 'Report on an Unannounced Follow-up Inspection of Department of Corrections' Waikeria Prison's West North & West South Units Under the Crimes of Torture Act 1989 22 September 2011' Wellington: Office of the Ombudsman, 2011, p. 8.
38. SPT. 'SPT Report on New Zealand', p. 16.
39. Based on my analysis of: Jeremy Lightfoot, 'Conditions of Segregation in Prisons (Official Information Act Response to Sophie Buchanan)', *Fyi.org.nz*, 15 August 2015. Last accessed 18 January 2018. <https://fyi.org.nz/request/2864/response/9175/attach/3/Department%20of%20Corrections%20C72257.pdf>.
40. As I demonstrate later in this section, this is not always the case.
41. Corrections Act 2004, § 59(1)(b)(ii)
42. Corrections Act 2004, §§ 59(4)(c)-(d)
43. SPT. 'SPT Report on New Zealand'. I acknowledge that this report, however, confuses voluntary and directed protective segregation.
44. Méndez et al. 'Seeing into Solitary: A Review of the Laws and Policies of Certain Nations Regarding Solitary Confinement of Detainees'.
45. SPT. 'SPT Report on New Zealand'.
46. *Ibid.*, p. 9.
47. Boshier. 'Spring Hill COTA Report 2017', p. 12.
48. Peter Boshier. 'COTA Report: Report on an Unannounced Inspection of Corrections Service Otago Corrections Facility Under the Crimes of Torture Act 1989' Wellington: Office of the Ombudsman, 2016, p. 8.
49. For an excellent explanation of the causes of the rapid increase in the prison population, see: Roger Brooking. 'How to Cut the Prison Population by 50% in Five Years – Quick Fix Solutions,' *Brookingblog*, December 16, 2017. Last accessed 18 January 2018. <https://brookingblog.com/2017/12/16/how-to-cut-the-prison-population-by-50-in-five-years-quick-fix-solutions/>.
50. Rachel Leota. 'Directed Segregation and ARU Numbers (Official Information Act Response to Ti Lamusse)', *Fyi.org.nz*, 15 September 2017. Last accessed 18 January 2018. <https://fyi.org.nz/request/6291/response/21676/attach/9/Correspondence%20from%20Corrections%20C87695.pdf>. The following is my analysis of this data.
51. Boshier. 'A Question of Restraint'.
52. Corrections Act 2004, § 133.

53. Corrections Act 2004, § 137.
54. Office of the Ombudsman. 'Monitoring Places of Detention: Annual Report of Activities under the Optional Protocol to the Convention against Torture (OPCAT) 1 July 2013 to 30 June 2014'. Auckland: Human Rights Commission, 2014, pp. 21–22.
55. Office of the Ombudsman. 'Monitoring Places of Detention 2015'.
56. Peter Boshier. 'OPCAT Report: Report on an Unannounced Inspection of Hawke's Bay Regional Prison Under the Crimes of Torture Act 1989'. Wellington: Office of the Ombudsman, 2017, p. 39.
57. Boshier. 'Arohata COTA Report 2015'; Peter Boshier. 'COTA Report: Report on an Unannounced Inspection of Corrections Service Manawatu Prison Under the Crimes of Torture Act 1989'. Wellington: Office of the Ombudsman, 2016; Boshier. 'Otago COTA Report 2016'; Boshier. 'A Question of Restraint'; Office of the Ombudsman. 'Monitoring Places of Detention 2014'; Shalev. 'Thinking Outside the Box?'; Beverley Wakem. 'Report on an Unannounced Inspection of Department of Corrections' Arohata Prison Under the Crimes of Torture Act 1989'. Wellington: Office of the Ombudsman, 2012.
58. Boshier. 'Arohata COTA Report 2015', p. 12.
59. Office of the Ombudsman. 'Monitoring Places of Detention 2014'; Beverley Wakem. 'Report on an Unannounced Inspection of Department of Corrections' Tongariro Prison (Cedar Units One and Two) Under the Crimes of Torture Act 1989'. Wellington: Office of the Ombudsman, 2012.
60. Office of the Ombudsman. 'Monitoring Places of Detention 2014', p. 22. This finding was also made by an earlier Office of the Ombudsman investigation: McGee. 'Waikeria COTA Report 2011'. These conditions vary from unit to unit and from prison to prison.
61. Boshier. 'Spring Hill COTA Report 2017', p. 21.
62. Shalev. 'Thinking Outside the Box?'
63. Wakem. 'Arohata COTA Report 2012'.
64. The following is my analysis of this Official Information Act request. Rachel Leota. 'Number of People in Separates Cells (Official Information Act Response to Ti Lamusse)', *Fyi.org.nz*, 14 July 2017. Last accessed 18 January 2018. <https://fyi.org.nz/request/5904/response/20574/attach/9/Correspondence%20from%20Corrections%20C85898.pdf>.
65. Unfortunately, the Department of Correction did not give me ARU, directed segregation and cell confinement data in a comparable format. While ARU and Direct segregation is measured in calendar year, cell confinement data is measured in fiscal year.
66. Average population increase is from my analysis of Corrections' Annual Reports: Department of Corrections, 'Annual Report: 1 July 2009 – 30 June 2010' (Wellington: Department of Corrections, 2010); Department of Corrections, 'Annual Report: 1 July 2015 – 30 June 2016'. Wellington: Department of Corrections, 2016.
67. Boshier. 'Hawke's Bay COTA Report 2017', p. 29.
68. Corrections Act 2004, § 60.
69. Corrections Regulations 2005, § 60–61, 63.
70. Corrections Act 2004, § 60.
71. For a discussion of medical ethics and solitary confinement see: Jeffrey Metzner and Jamie Fellner. 'Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics', *Journal of the American Academy of Psychiatry and the Law* vol. 38, no. 1 (2010): 104–108; Sharon Shalev. 'Solitary Confinement as a Prison Health Issue', in *Prisons and Health*, ed. Stefan Enggist et al. Copenhagen: World Health Organisation, 2014, pp. 27–35.
72. Boshier. 'A Question of Restraint'.
73. Peter Boshier. 'COTA Report: Report on an Unannounced Inspection of Corrections Service Invercargill Prison Under the Crimes

- of Torture Act 1989'. Wellington: Office of the Ombudsman, 2016; Boshier. 'A Question of Restraint'; National Health Committee, 'Health in Justice: Kia Piki Te Ora, Kia Tika! – Improving the Health of Prisoners and Their Families and Whānau: He Whakapiki I Te Ora O Ngā Mauhere Me Ō Rātou Whānau'. Wellington: Ministry of Health, 2010; Shalev, 'Thinking Outside the Box?'; Beverley Wakem and David McGee. 'Investigation of the Department of Corrections in Relation to the Provision, Access and Availability of Prisoner Health Services'. Wellington: Office of the Ombudsman, 2012.
74. Boshier. 'A Question of Restraint', p. 5.
  75. Shalev. 'Thinking Outside the Box?', pp. 24–25.
  76. Wakem and McGee. 'Investigation of the Department of Corrections in Relation to the Provision, Access and Availability of Prisoner Health Services', p. 99.
  77. Shalev. 'Thinking Outside the Box?', p. 31; Wakem and McGee. 'Investigation of the Department of Corrections in Relation to the Provision, Access and Availability of Prisoner Health Services', p. 99.
  78. Wakem and McGee. 'Investigation of the Department of Corrections in Relation to the Provision, Access and Availability of Prisoner Health Services', p. 99.
  79. Shalev. 'Thinking Outside the Box?', p. 31.
  80. See my discussion of 'round rooms' in Ti Lamusse, *Grieving Prison Death*. Master's Thesis, University of Auckland, 2017.
  81. National Health Committee. 'Health in Justice', p. 35.
  82. Boshier. 'A Question of Restraint', p. 14.
  83. Boshier. 'Invercargill COTA Report 2016', p. 18.
  84. Boshier. 'A Question of Restraint', p. 13.
  85. The only exception I have been able to find to prisoners being held in their cells for 23 hours per day was at Otago Corrections Facility, where prisoners were locked up for 21–22 hours per day: Boshier. 'Otago COTA Report 2016', p. 17.
  86. Boshier. 'Hawke's Bay COTA Report 2017'.
  87. Shalev. 'Thinking Outside the Box?'
  88. Boshier. 'A Question of Restraint', 13. This varies from prison to prison.
  89. Boshier. 'A Question of Restraint'; Shalev. 'Thinking Outside the Box?'
  90. Boshier. 'A Question of Restraint', p. 44.
  91. Office of the Ombudsman. 'Monitoring Places of Detention 2014'; Boshier, 'Otago COTA Report 2016'; Boshier. 'A Question of Restraint'; Boshier, 'Hawke's Bay COTA Report 2017'.
  92. Boshier. 'A Question of Restraint', p. 13.
  93. *Ibid.*, p. 44.
  94. *Ibid.*, p. 45.
  95. Boshier. 'Invercargill COTA Report 2016', p. 19.
  96. Boshier. 'Invercargill COTA Report 2016'; Boshier. 'A Question of Restraint'; National Health Committee, 'Health in Justice'; SPT. 'SPT Report on New Zealand'; Wakem and McGee. 'Investigation of the Department of Corrections in Relation to the Provision, Access and Availability of Prisoner Health Services'.



97. Boshier. 'A Question of Restraint', p. 18.
98. Boshier. 'Manawatu COTA Report 2016'; Boshier, 'Otago COTA Report 2016'; Boshier. 'A Question of Restraint'; Boshier, 'Hawke's Bay COTA Report 2017'.
99. Exactly the same phrase is used in: Boshier. 'Manawatu COTA Report 2016', p. 17; Boshier. 'Otago COTA Report 2016', p. 18.
100. Quoting 'Siaki' in National Health Committee. 'Health in Justice', p. 35, ellipses original.
101. Boshier. 'A Question of Restraint'; National Health Committee. 'Health in Justice'.
102. Boshier. 'Hawke's Bay COTA Report 2017', p. 27. This comment contradicts the reality that many prisoners have limited to no say on whether they are transferred out of the ARU.
103. Based on my analysis of data provided to me under the Official Information Act: Leota, 'Directed Segregation and ARU Numbers'.
104. This data was given to me by Will Cosgriff, after I read it in his Bachelor of Law (Honours) thesis: Julie Miller, 'At-Risk Unit Stays (Official Information Act Request)', 14 September 2017, 2, Letter to Will Cosgriff; Will Cosgriff, *Thinking Outside the Box: The Treatment of Sentenced Offenders at-Risk of Self Harm*. Bachelor of Laws (Honours) Dissertation, University of Otago, 2017.
105. Boshier. 'Arohata COTA Report 2015'; Boshier, 'Invercargill COTA Report 2016'; Boshier. 'Manawatu COTA Report 2016'; Boshier. 'Otago COTA Report 2016'; Peter Boshier. 'COTA Report: Report on an Unannounced Inspection of Corrections Service Rolleston Prison Under the Crimes of Torture Act 1989'. Wellington: Office of the Ombudsman, 2016; Boshier. 'Hawke's Bay COTA Report 2017'; Boshier. 'Spring Hill COTA Report 2017'.
106. I initially requested all the reports in late 2016. See here: Ti Lamusse, 'COTA Reports (Official Information Act Request)', Fyi.org.nz, 10 December 2016. Last accessed 18 January 2018. <https://fyi.org.nz/request/5084-cota-reports#comment-1838>.
107. Richard Waggott. 'COTA Reports 2013 (Official Information Act Response to Justine Rose)', Fyi.org.nz, 28 August 2017. Last accessed 18 January 2018. <https://fyi.org.nz/request/6310/response/21368/attach/9/Response%20C87705.pdf>.
108. There are eight other reports that are now publicly available, but they do not contain questionnaire results for the questions in Table 1.
109. The way the questionnaire was phrased means there at Arohata and Manawatu means there is no comparable data.
110. This entitlement is enshrined in the Correction Act 2004, § 70.
111. Leota. 'Directed Segregation and ARU Numbers'; Leota, 'Number of People in Separates Cells (Official Information Act Response to Ti Lamusse)'. I provide further analysis of these data below.
112. Boshier. 'Invercargill COTA Report 2016', p. 7; Boshier. 'Otago COTA Report 2016', p. 8.
113. SPT. 'SPT Report on New Zealand', p. 9.
114. NZ Herald, 'Corrections Denies Group's Claim Spring Hill Prisoners Kept in 22-Hour Lockdown', NZ Herald, 14 March 2017. Last accessed 18 January 2018. [http://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=11818650](http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11818650).
115. Neil Beales quoted in *ibid*.
116. Boshier. 'Spring Hill COTA Report 2017'.
117. Boshier. 'Otago COTA Report 2016', p. 8.
118. SPT. 'SPT Report on New Zealand', p. 7.
119. *Ibid.*, p. 16.
120. Boshier. 'Arohata COTA Report 2015'; Boshier. 'Spring Hill COTA Report 2017'; Boshier. 'Hawke's Bay COTA Report 2017'.

121. Stuart Grassian. 'Psychiatric Effects of Solitary Confinement', *Washington University Journal of Law & Policy* 22 (2006), p. 357.
122. 'Scott' quoted in National Health Committee. 'Health in Justice', p. 29. Ellipses original.
123. Boshier. 'Spring Hill COTA Report 2017', p. 29.
124. Haney. "'Infamous Punishment": The Psychological Consequences of Isolation', p. 4.
125. Shalev. 'Thinking Outside the Box?'
126. *Ibid.*, p. 26.
127. *Ibid.*
128. *Ibid.*
129. See: Jason Lydon et al. 'Coming out of Concrete Closets: A Report on Black & Pink's National LGBTQ Prisoner Survey'. Black & Pink, 201).
130. Méndez. 'Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment', p. 13. Studies into the prevalence of solitary confinement for these groups have not been completed in the New Zealand context.
131. Boshier. 'Spring Hill COTA Report 2017', p. 21.
132. *Ibid.*, p. 12.
133. SPT. 'SPT Report on New Zealand'.
134. Office of the Ombudsman. 'Monitoring Places of Detention 2014', p. 23.
135. Office of the Ombudsman. 'Monitoring Places of Detention 2015', p. 29.
136. Andersen et al. 'A Longitudinal Study of Prisoners on Remand'; Jeremy Coid et al. 'Psychiatric Morbidity in Prisoners and Solitary Cellular Confinement, II: Special ('strip') Cells', *Journal of Forensic Psychiatry & Psychology* vol. 14, no. 2 (September 2003): 320–340; Allison Hastings et al. 'Keeping Vulnerable Populations Safe under PREA: Alternative Strategies to the Use of Segregation in Prisons and Jails'. Washington, DC: National PREA Resource Center, 2015; Sheilagh Hodgins and Gilles Côté. 'The Mental Health of Penitentiary Inmates in Isolation', *Canadian Journal of Criminology* vol. 33 (1991): 1751–82; Shira E. Gordon. 'Solitary Confinement, Public Safety, and Recidivism', *University of Michigan Journal of Law Reform* vol. 47, no. 2 (2014): 495–528; Terry A. Kupers et al. 'Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs', *Criminal Justice and Behavior* vol. 36, no. 10 (2009): 1037–1050.
137. Devon Indig, Craig Gear, and Kay Wilhelm. 'Comorbid Substance Use Disorders and Mental Health Disorders among New Zealand Prisoners'. Wellington: Department of Corrections, 2016.
138. Kupers. 'What to Do with the Survivors?', p. 1006.
139. Grassian. 'Psychopathological Effects of Solitary Confinement'; Grassian, 'Psychiatric Effects of Solitary Confinement'; Miller and Young. 'Prison Segregation'; Scharff Smith. 'The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature'; Shalev. 'A Sourcebook on Solitary Confinement'; Sharon Shalev. 'Solitary Confinement and Supermax Prisons: A Human Rights and Ethical Analysis', *Journal of Forensic Psychology Practice* vol. 11, no. 2 (2011): 151–183.
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194. Benjamin and Lux. 'Solitary Confinement as Psychological Punishment', p. 266.
195. Scott and Gendreau. 'Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison', p. 340.
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198. See: Lamusse, *Grieving Prison Death*.
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200. Unnamed Corrections officer quoted in Coroner Tim Scott. 'Findings in the Matter of [Name Redacted]' Palmerston North: Coroner's Court, 10 August 2012. For my analysis of 'suicide proof' cells, see: Lamusse, *Grieving Prison Death*.
201. See: Coroner Garry Evans. 'Findings in the Matter of Antoine Roni Dixon'. Wellington: Coroner's Court, 17 April 2013.
202. Kupers. 'What to Do with the Survivors?', p. 1011.
203. See: Ecclestone, Gendreau, and Knox. 'Solitary Confinement of Prisoners'; Scott and Gendreau, 'Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison'; Walters, Callagan, and Newman. 'Effect of Solitary Confinement on Prisoners'. Notable, however, each of these studies found negative effects of solitary on their research participants but those findings did



- not lead them to conclude solitary was harmful. For more discussion see: Haney and Lynch, 'Regulating Prisons of the Future'; Scharff Smith, 'The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature'.
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224. Kupers. 'What to Do with the Survivors?', pp. 1005–1006.
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227. Grassian. 'Psychiatric Effects of Solitary Confinement', pp. 332–33.

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254. From the context of Méndez's report, it is clear he means both people with intellectual disabilities and people experiencing mental illness.
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