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The use of ‘tie down’ in New Zealand prisons—what is the role of the health sector?

Julia Carr, Paula King

ABSTRACT

We draw upon two recent reports from the Chief Ombudsman that describe the prison management of people assessed at risk of self-harm or suicide, as cruel, inhuman or degrading treatment or punishment. People were mechanically restrained on ‘tie-down’ beds by their legs, arms and chest or placed in waist restraints with their hands cuffed behind their backs over prolonged periods. These practices occurred at the direction of, or were approved by, health professionals. We highlight ethical issues for health professionals party to ‘tie down’ and examine the current guidance and regulatory framework for health professionals working in coercive environments. This article is timely in the context of current Government Inquiries into the criminal justice system and mental health and addictions, the review of the health and disability system, the Correction’s Amendment Bill before parliament, and Government plans to expand Waikeria prison to include a 100-bed mental health facility. We call for the use of ‘tie down’ to be abolished in New Zealand prisons, and for all health professionals to refuse to participate in this practice. Government must make provision for sufficient forensic mental health capacity and capability in the health sector, and ensure timely, equitable access to high-quality, trauma-informed and culturally safe services.

Two recent reports from the Chief Ombudsman describe the management of people in New Zealand prisons as cruel, inhuman or degrading treatment or punishment. People assessed at risk of self-harm or suicide were mechanically restrained on ‘tie-down’ beds or in waist restraints with their hands cuffed behind their backs over prolonged periods of time. In every reported case, this restraint occurred at the direction of, or with approval by, a health professional.^{1,2}

In March 2017, the Ombudsman published *A Question of Restraint, Care and management for prisoners considered to be at risk of suicide and self-harm: observations and findings from OPCAT Inspectors*.² The report documents people in prisons mechanically restrained on ‘tie-down’ beds by their legs, arms and chest or in waist restraints with their hands cuffed behind their backs over prolonged periods, ‘tie-down’ beds used for behaviour modification, and use of spit-hoods (restraint device

intended to stop someone from biting or spitting). Additionally, the Department of Corrections (Corrections) had not followed expected procedures with respect to application of mechanical restraints. The report also comments on the interface between Corrections and District Health Board (DHB) Regional Forensic Psychiatric Services, with considerable gaps in service provision evident.² The Ombudsman considered that “the use of the tie-down bed and/or waist restraints in the circumstances of [five prisoners] amounted to cruel, inhuman or degrading treatment or punishment for the purpose of Article 16 of the Convention against Torture”.^{2,3}

Conditions in New Zealand prisons, and their impact on the health, welfare and rights of people in prison have been the subject of many reports in the past 10 years.⁴⁻⁷ Coroners’ inquiries have exposed negligence and barriers to what would be regarded as a normal standard of healthcare.^{8,9} Recent reports examine the use

of solitary confinement^{10,11} and give voice to the everyday degradation and brutality of the prison environment.^{5,10-12} The State has a ‘duty of care’,¹³ and health professionals in particular are bound by codes of conduct and professional values intended to apply in all settings, including coercive settings such as prisons.¹⁴⁻¹⁶

This article raises questions about the responsibilities, scope of practice, standards and accountability of health professionals in prisons, and their role in upholding human rights and humane values. It is timely in the context of Government Inquiries underway into the criminal justice system and mental health and addictions, the review of the health and disability system, the Correction’s Amendment Bill before parliament, and the Government’s plans to expand Waikeria prison to include a “‘first of its kind’ 100-bed mental health facility”.¹⁷⁻²¹

We consider the changes needed to protect the health of people that are imprisoned in New Zealand. Not only does the prison population have a high prevalence of mental health and addiction disorders,²² approximately 50% are Māori.²³ Given inequitable incarceration rates resulting from colonisation and racism in addition to higher prevalence of mental health issues,²⁴ Māori are likely to be at increased risk of having such practices used on them.

Use of ‘tie down’ in New Zealand prisons

The Ombudsman describes ‘tie down’ as:

“...a form of mechanical restraint. It is a specialist bed comprised of attached ankle, torso and wrist restraints. An individual tied to such a bed is rendered incapable of free movement. The only movement they will have is the ability to move their head from side to side.”²

The minimum standard for the healthcare of people in New Zealand prisons is set out in section 75(1) of the Corrections Act 2004 (the Act). It states a person “is entitled to receive medical treatment that is reasonably necessary” and that the “standard of healthcare...must be reasonably equivalent to the standard of healthcare available to the public”.¹³ Additionally, a Memorandum of Understanding (MOU) between Corrections and the Ministry of Health (the Ministry) states that “health services...

provided to prison inmates will be the same standard as is provided to the general population”.²⁵ The Ombudsman notes:

“...tie-down beds are not permitted for use in [NZ] mental health settings, but only in [NZ] correctional facilities. Tie-down beds are not used in comparable jurisdictions that have ratified the [Optional Protocol to the Convention Against Torture] OPCAT, such as England and Wales, Scotland and Sweden.”²

Although mechanical restraints are not permitted in New Zealand healthcare services, the Act allows for the use of specified mechanical restraints, including ‘tie-down’ beds in prisons. Section 87 of the Act¹³ states:

“A mechanical restraint may not be used for any disciplinary purpose: It must be used in a manner that minimises harm and discomfort to the prisoner. A prison manager may authorise the use of a mechanical restraint on a prisoner for more than 24 hours, only if, in the opinion of a medical officer, continued restraint is necessary to protect the prisoner from self-harm.”

Thus, for mechanical restraint to occur in New Zealand prisons, a health professional must be made aware of this and for prolonged mechanical restraint to occur, a health professional must direct or approve it.

We outline three cases where mechanical restraints were used in New Zealand prisons. Though these cases are specific to particular prisons, the use of mechanical restraints in response to mental distress is widespread with 57 episodes of ‘tie down’ having been used (at Auckland Prison, Rimutaka Prison, Waikeria Prison and Christchurch Prison) over the past three years. In 44 of these incidents, people were ‘tied down’ for longer than 12 hours.²

The three cases from the Ombudsman’s report are summarised in Table 1. The full circumstances of each case are beyond the scope of this article. However, this summary illustrates the key issues. For a fuller understanding, readers are encouraged to read the Ombudsman’s report.²

As a result of the Ombudsman’s concerns, Corrections initiated an investigation by the Chief Inspector of Corrections (the Inspector) into the management of Person A. The Inspector concluded that the decision to place the prisoner on the ‘tie down’ bed was

Table 1: Three cases from the Ombudsmen's findings on the use of mechanical restraint in New Zealand prisons.

Person A
<p>In March 2016, the Ombudsman's Office became aware of a person, hereafter known as Person A, who was being repeatedly restrained on a 'tie-down' bed in prison. They were strapped to a restraint bed by their ankles, wrists and waist, following several episodes of self-harm. Corrections had stated the reason for them being secured on the 'tie-down' bed was serious self-harming behaviour. Person A had been referred to the Regional Forensic Service but was declined admission.</p> <p>Person A had self-harmed on three occasions, requiring hospital treatment as a result. Following this they spent 37 consecutive nights secured on the 'tie-down' bed from 28 February to 5 April 2016. Video footage provided evidence of a spit-hood applied to their head on at least one occasion.</p> <p>Each day, Person A was observed in their 'safe' cell from approximately 8.30am to 4pm, with a corrections officer sitting outside looking through a window, with the door locked. At 4pm, to coincide with reduced staffing ratios, they were secured on the 'tie-down bed' until 8.30am the following day (approximately 16 hours each day/night) for the 37 consecutive nights.</p> <p>In total, Person A spent approximately 592 hours on the 'tie-down' bed. They were naked for two of the four observed restraints, having been restrained in their 'safe' cell and then forcibly moved into a cell with a 'tie-down' bed. Under the Corrections Regulations (Reg 80b), a medical officer must be notified promptly when any person is placed under a mechanical restraint (unless the medical officer has recommended the use of the restraint). Additionally, under Corrections' own tie-down bed instructions, mechanical restraint can only be used with medical approval. In response to Person A's self-harming and subsequent restraint, a multidisciplinary team was established, consisting of medical staff, psychological services, custodial staff and DHB forensic psychiatric services liaison staff. Approval to tie them to the bed was given by the medical officer, in accordance with a decision by the multi-disciplinary team (inclusive of the forensic team).</p> <p>The forensic mental health section of the Person A's management plan suggested the 'tie-down' bed was being used as a behaviour modification tool (as opposed to managing imminent risk of self-harm) stating:</p> <p><i>"...[We] felt it best to target two sets of behaviours that [they] would need to manage in order to gain a reduction of time on the tie-down bed. We considered the following to be situationally important:</i></p> <ul style="list-style-type: none"> • <i>Access to [their] wound and the concomitant need for hygiene (showers).</i> • <i>[Them] wrestling [their] wrist loose from the restraints in the middle of the night (effectively seen as self-harm in itself).</i> <p><i>Compliance with each of these will result in the benefit of 20 mins less on the tie-down bed at the beginning of the tie-down for the first behaviour and 20 mins at the end of the tie-down for the second behaviour. It means that [they don't] have to do both to get both; [they] only has to comply with one to get the reward. The rewards are also incremental: it becomes 40 mins, then 60 mins, then 80 mins and so on, ie, an extra 20 min."</i></p> <p>During a visit to the prison on 11 April 2016, OPCAT Inspectors spoke with Person A, the prison director, unit staff, the prison chaplain, the Health Services Manager, the psychiatrist, the prison psychologist, the visiting justice and the medical officer. Inspectors also observed video footage of Person A on the 'tie-down' bed and had serious concerns.</p> <p>It appeared that Person A was successfully managed with constant observations during the day with no significant episodes of self-harm. Restraining Person A on a 'tie-down' bed each day at 4.00pm was not responsive to their individual medical situation but appeared to relate to prison routines, resources and convenience.</p> <p>Neither the psychiatrist, who had signed off on Person A's management plan, nor the prison psychologist, had observed Person A being secured on the 'tie-down' bed or visited Person A during any of the 16-hour confinements on the bed. Corrections failed to follow their own procedures, as the required paperwork was not signed by the prison director. Furthermore, Corrections' 'tie-down' bed instructions require that, if on release from a 'tie-down' bed, the individual exhibits behaviour that warrants restraint using a 'tie-down' bed, this requires a new approval and advice. Person A's 'tie-down' for 37 nights was based on the one approval.</p> <p>Concerns regarding the repeated use of the 'tie-down' bed were raised with the Chief Inspector of Corrections on 14 March 2016. Investigation of Person A's management was undertaken by a Corrections inspector. On 21 March 2016 the Corrections Inspectorate reported to the Ombudsman that they were "happy with the measures taken" in respect of Person A's management.²</p>

Table 1: Three cases from the Ombudsmen’s findings on the use of mechanical restraint in New Zealand prisons (continued).

Person B
<p>Person B was ‘tied down’ by restraints on their wrists, torso and ankles. This contravenes Schedule 5 of Corrections Regulations, which states that “tie-down beds may only be used in conjunction with one or both of the following: a wrist bed restraint; a torso restraint”²⁶</p> <p>The use of restraints for the seven days from 5 May to 11 May 2016 had been approved by a medical officer. The rationale for the approval of Person B’s waist restraint was unclear. Specified medical advice was not sought to permit ankle restraint. OPCAT Inspectors were unable to ascertain from Person B’s notes any form of meaningful therapeutic intervention to address their self-harming.</p>
Person C
<p>For more than three months in 2016, Person C was almost continuously kept in a waist restraint with their hands cuffed behind their back due to self-harming. This intensive restraint lasted for approximately 12 weeks (1,764 hours) prior to their release from prison.</p> <p>According to the report, a prison nurse visited Person C at least three times a day in order to monitor their wounds. In the opinion of the OPCAT inspectors however, their mental healthcare was inadequately managed. A psychiatrist assessed Person C approximately one month after they were put into the restraints, recommending interventions including psychotherapy and counselling. Following review of Person C’s file, along with interviewing them and prison staff, it was found that they had not received any counselling or psychotherapy during their 12-week restraint, or prior to being released. The DHB regional forensic psychiatric services’ liaison nurse attended weekly MDT meetings but did not have regular sessions with Person C. In summary, there was no evidence of any therapeutic intervention or psychological support having taken place.</p> <p>Person C reported that they had been on medication for a mental health condition before being incarcerated but on admission to prison the medication was stopped. According to the healthcare manager this medication can only be prescribed by a psychiatrist, and the wait to see a psychiatrist can be several weeks. Person C’s mental health deteriorated as a direct result of discontinuing their medication.</p>

justified, but noted there was “confusion specifically in relation to the medical and health practitioners’ responsibilities in accordance with the legislation and delegations, and how that translated to the national policies and procedures regarding the application of the [‘tie-down’ bed]”.²⁷ The investigation also found:

“...a lack of clarity around what decision the medical officer is being asked to make in relation to the use of mechanical restraint and whether processes to make such decisions are reflective of safe clinical practice that supports a medical practitioner’s professional accountability...[and that] there does not appear to be any current support or mechanism for the medical officer to peer review these decisions.”²⁷

The Inspector was also of the view that the use of ‘tie-down’ for Person A “...was a last resort for prison management who believed [they] would be admitted to the [forensic unit] as had occurred in similar circumstances five months earlier. However, when [they were] assessed as “not mentally ill” by the psychiatrist, the pressure was placed back on custodial and health staff to manage [their] self-harm risk behaviours”.²⁷

This statement raises questions about why the mental health team remained involved, given that the person was deemed not mentally unwell, and illustrates the ambiguity around the role of health professionals in such situations.

In April 2017, OPCAT Inspectors acting under delegation of the National Preventive Mechanisms in the Crimes of Torture Act 1989, visited Christchurch Prison and reviewed a number of reported incidents involving mechanical restraints.¹ A person had been mechanically restrained on the ‘tie-down’ bed in the At Risk Unit (ARU) on for 15 hours. The reasons for its use were deemed inappropriate as the records did not indicate a life-threatening situation, nor was the incident recorded in the prison’s ‘Use of Force’ register. There was no record of attempts by staff to engage with the person to establish why they were distressed.¹ Additionally, several other incidents were reported where people claimed to have been the subject of use of force or mechanical restraints that were unrecorded, with their complaints ignored by prison staff. Two people requested that the use of force against them be referred to

the Police as they believed they had been assaulted during the incidents. According to the Ombudsman's report, the Police did not interview either person prior to deciding there was no merit to their complaint.¹

The cases reported by OPCAT Inspectors are not isolated, nor is this the first time Corrections has had issues highlighted to them. These inspections were undertaken partly in response to recommendations made following the United Nations (UN) 2014 *Report on the visit of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment to New Zealand*. The UN highlights a number of examples whereby "... order and security prevailed too easily over dignity and fairness; specifically, the care and treatment of adult prisoners considered to be at risk of suicide and self-harm".²⁸

Discussion

Corrections' legislated role is to administer sentences in a safe, secure, humane and effective manner and to provide healthcare of a standard that is reasonably equivalent to the standard of that available to the public.¹³ In addition, the Bill of Rights Act 1990 states "everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment" and that "everyone deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person".²⁹

In response to the criticisms from the UN, the Ombudsman and Correction's own Inspectorate,³⁰ there has been increased investment into mental health services in prisons. There has also been an undertaking by Corrections to "work closely with those committed to delivering better mental health services, including the Ministry of Health and District Health Boards, particularly forensic units such as the Mason Clinic, the Ombudsman, service providers and our justice sector colleagues".³¹

A review of ARUs has been undertaken and a new model of care will be piloted at three prisons.³¹ This involves a multidisciplinary team approach where mental health and cultural assessment professionals will screen, assess and treat people with moderate to severe mental health conditions. While these are potentially

positive changes, there is no commitment by Corrections to end the use of 'tie-down' as demonstrated in the most recent Briefing to the Incoming Minister:

*"Corrections recognises that changes were needed to the policies and practices governing the use of restraints. The changes have been made, reaffirming the use of tie-down beds in particular as a measure of last resort."*³²

The State has a broader 'duty of care', exercised through the institutions of the Ministry of Health and DHBs. At a minimum there should be sufficient mental health service beds for all acutely unwell people in prison, particularly those at risk of suicide or self-harm. There is a chronic waiting list for forensic beds and most particularly, acute beds. As at 31 August 2018, there were 18 prisoners on a forensic mental health waiting list. Of these, 12 were on an acute waiting list.³³

For health professionals, there is an additional 'duty of care' to provide humane and evidence-based treatment, and to uphold human rights. These obligations are enshrined and explicit in various declarations and codes of ethics for different professional groups. For doctors, the World Medical Association *Declaration of Geneva* includes the clause, "I will respect the autonomy and dignity of my patient".¹⁴ The New Zealand Medical Council's *Good Medical Practice* discusses the treatment of patients with respect and the adherence of medical doctors to relevant professional standards.³⁴ In addition, the New Zealand Medical Association's *Code of Ethics for the New Zealand Medical Profession* (NZMA Code) highlights core principles of ethical behaviour. These include "consider[ation of] the health and well-being of the patient to be [the] first priority, respect[ing] the rights, autonomy and freedom of choice of the patient, and practic[ing] the science and art of medicine...with moral integrity, compassion and respect for human dignity".³⁵

The Royal Australian and New Zealand College of Psychiatrists' *Code of Ethics* (RANZCP Code) requires that psychiatrists use up-to-date, evidence-based treatments wherever possible, and provide an adequate standard of care. This is regardless of patient legal status or the type of setting in which they are treated.¹⁵ Furthermore, it states psychiatrists should not participate

in the practice of torture or cruel, inhuman or degrading interrogation, treatment or punishment. It advises psychiatrists who become aware of these situations in practice to raise concerns with relevant authorities and/or publicly. The RANZCP Code emphasises that a psychiatrist's primary responsibility is to their patients, stating:

*"...particular care is needed when this conflicts with responsibility to an employer or government. If clinical services fall below acceptable standards, psychiatrists have a duty to advocate for services and take appropriate action. Exceptionally, they may have to dissociate themselves from such services."*¹⁵

The RANZCP code is consistent with the World Psychiatric Association *Madrid Declaration of Ethical Standards for Psychiatric Practice* which states that "no treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or the life of others".³⁶ Furthermore, it stipulates that psychiatrists should not "take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts" and that "professional independence to apply best practice guidelines and clinical wisdom in upholding the welfare of the patient should be the primary considerations for the psychiatrist".³⁶

Corrections are providing healthcare in a coercive, harsh and punitive setting. In the community, an equivalent standard for a person at serious risk of suicide or self-harm is that of comprehensive mental health assessment. This may also include transfer to a hospital or other safe, therapeutic environment for monitoring, support and evidence-based treatment. A person and their whānau in this setting have the right to appropriate treatment options and to services that comply with legal, professional, ethical and other relevant standards. They also have recourse to the Health & Disability Commissioner if there is any failure to maintain standards and rights.³⁷

Best practice for this population includes trauma-informed care.³⁸ This requires compassionate, knowledgeable and responsive care that upholds the dignity, values and beliefs of people and their cultural identities.³⁹

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) highlight that if a person's psychiatric symptoms are so severe that involuntary treatment is necessary, that person should receive treatment in a hospital, not a prison. They note "involuntary mental health treatment in custodial settings compromises clinical care, encourages inappropriate management of prisoners, and breaches human rights".⁴⁰

The proposed move to mental health beds in prisons is thus fraught. The World Health Organization (WHO) highlights the numerous challenges, pointing out "prisons are sometimes used as dumping grounds for people with mental disorders".⁴¹ The WHO advises:

*"people with mental disorders [should be diverted] towards the mental health system... Prisons are the wrong place for many people in need of mental health treatment, since the criminal justice system emphasises deterrence and punishment rather than treatment and care."*⁴¹

There is an opportunity with the Corrections Amendment Bill before parliament to include legislative change that abolish the use of 'tie-down' in prisons. Of concern, however, are the proposed changes that include allowance for those being transferred from prison to hospitals to be mechanically restrained for prolonged periods over 24 hours.⁴²

Conclusion

We highlight a number of important ethical and policy concerns around the use of 'tie down' in New Zealand prisons. With the knowledge that many similar jurisdictions and indeed other prisons in New Zealand manage people in situations of mental distress without resorting to 'tie down',² we call for this practice to be abolished.

More specific guidance is needed for all health professionals working in coercive environments, emphasising their obligation to uphold patients' rights and provide humane, effective and compassionate care in these settings. The RANZCP has recently updated relevant policy and standards and the current review of the NZMA Code provides an opportunity for leadership in developing specific guidance for doctors.

However, all regulatory and professional bodies need to attend to the issues raised. We call for all health professionals to refuse to participate in the inhumane practice of 'tie down' and to advocate for legislative change to end its use in New Zealand prisons.

Looking to the future, Government must make provision for sufficient forensic

mental health capacity and capability in the health sector, and ensure timely, equitable access to services that are high-quality, trauma-informed and culturally safe.

Note: Since the time of writing the Department of Corrections has announced all existing tie-down beds would be removed completely from prisons.

Competing interests:

Nil.

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