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JOINT SUBMISSION TO THE UN SPECIAL RAPPORTEUR ON TORTURE BY ASSOCIAZIONE ANTIGONE AND PHYSICIANS FOR HUMAN RIGHTS ISRAEL ON

THE INTERNATIONAL GUIDING STATEMENT ON ALTERNATIVES TO SOLITARY CONFINEMENT

Current issues and good practices in prison management

Thematic report of the Special Rapporteur on Torture

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About the submitting organizations:

ASSOCIAZIONE ANTIGONE

Founded in 1991, Antigone is an Italian organization dealing with human rights protection in penal and penitentiary systems. It carries on a cultural work on public opinion through campaigns, education, media, publications and its self-titled academic review. An Observatory on Italian prisons, involving around 80 people, has been active since 1998, when Antigone received from the Ministry of Justice special authorizations to visit prisons with the same power that the law gives to parliamentarians. Every year Antigone's Observatory publishes a Report on the Italian penitentiary system. Since 2008, Antigone is allowed to enter also in all Italian juvenile prison facilities. Through a prison Ombudsman to which it gave birth, Antigone also collects complaints from prisons and police stations and mediates with the Administration in order to solve specific problems. Furthermore, Antigone's lawyers and physicians operate in some Italian prisons giving suggestions and monitoring life conditions. Antigone carries on investigations about ill-treatments and is formally involved in criminal trials for torture in prison. Antigone is also the leading organization of the European Prison Observatory, involving 13 European countries[1].

PHYSICIANS FOR HUMAN RIGHTS ISRAEL (PHRI)

Physicians for Human Rights Israel (PHRI) stands at the forefront of the struggle for human rights –the right to health in particular– in Israel and the occupied Palestinian territory. Founded in 1988 by a group of Palestinian and Jewish physicians, PHRI works to promote a just society where the right to health is granted equally to all people under Israel's responsibility. PHRI employs a multi-faceted approach to achieve its goals through the provision of humanitarian aid and work promoting policy change. Through our open and mobile clinics, volunteer medical professionals provide services free of charge to people with limited or no access to health care (primarily migrants, asylum seekers, and Palestinian residents of the West Bank and Gaza). At the same time, PHRI works to change discriminatory and abusive structures and policies towards Palestinians in the Occupied Territory, prisoners and detainees, migrant workers, refugees, undocumented persons, and Israeli residents. Our methodology includes data collection, casework, legal action, local and international advocacy, education, and mobilization of the medical community. PHRI is supported by more than 3500 members and volunteers, and each year we serve more than 20000 people by providing medical care or assistance in accessing the right to health. The principles of human rights, medical ethics, and social justice are at the core of our worldview. It is our position that the medical community is sometimes complicit –passively or actively– in oppressive practices that undermine equality and health[2].

[1] For further information see https://www.antigone.it (accessed on 24.10.2023).
[2] For further information see https://www.phr.org.il/en/ (accessed on 24.10.2023)

Introduction

In light of the call for input launched by the Special Rapporteur "Current issues and good practices in prison management-Thematic report of the Special Rapporteur on Torture", and of the Special Rapporteur's expression of interest on receiving information regarding "Measures taken to mitigate the use and impact of solitary confinement and the development of alternative approaches for both disciplinary and non-disciplinary segregation", Associazione Antigone & Physicians for Human Rights Israel (PHRI) wish to bring the attention of the Special Rapporteur on the *International Guiding Statement on Alternatives to Solitary Confinement* (IGS). Based on the reflections of a multidisciplinary group of international experts, which has been promoted and coordinated by Associazione Antigone and PHRI, the IGS aims to offer world-wide consensus guidelines for reducing and hopefully abolishing the use of solitary confinement in prisons.

This submission is composed of preliminary remarks on the definition and practice of solitary confinement, to give context to the urgent need for a consensus statement on alternatives to the practice, as well as a summary of the recommendations within the IGS. The IGS aims to place solitary confinement at the forefront of the discourse on human rights within prison systems.

While former Special Rapporteur Juan Méndez broke new ground in outlining solitary confinement above 15 days as a possible form of cruel, inhuman, or degrading treatment punishment or even torture in his 2011 report[3], there is a need for a re-invigorated conversation around solitary confinement and additional momentum for reducing the practice.

We hope that the recommendations elaborated in the IGS can guide States towards increasing the use of alternatives to solitary confinement, including through the use of the IGS as a reference point by international human rights bodies.

Preliminary remarks

There is international consensus that solitary confinement is extremely harmful to the mental and physical health of individuals. Increasingly, international law seeks to limit the use of solitary confinement for vulnerable groups[4]. Yet individuals worldwide continue to be held in solitary confinement.

[3] A/66/268.

[4] In 2007, at the International Psychological trauma Symposium the *Istanbul Statement on the Use and Effects of Solitary Confinement* was adopted, banning the practice for various groups, including mentally ill individuals in incarceration and those suffering from mental disabilities. The Istanbul Statement on the Use and Effects of Solitary Confinement was annexed to the former Special Rapporteur's 2008 interim report to the General Assembly (A/63/175, annex).

According to the Mandela Rules nº 44, solitary confinement means "the confinement of prisoners for 22 hours or more a day without meaningful human contact". And prolonged solitary confinement refers to "confinement for a time period in excess of 15 consecutive days[5]", which amounts to a form of torture and ill-treatment[6]. Therefore, prolonged solitary confinement is strictly prohibited by international standards.

Probably, the paradigmatic example of the use of solitary confinement is the US *Supermax* phenomenon. The following statistics provided by Solitary Watch & the Unlock the Box Campaign[7] underscore the alarming extent of solitary confinement in the US. In fact, the US federal and state adult prisons and local and federal jails reported on a given day in 2019 locking approximately 122840 people -constituting 6,08% of the total prison and jail population- in solitary confinement 22 or more hours a day. Nevertheless, this figure still undoubtedly undercounts the number of individuals who experience solitary confinement[8].
As for as the length of solitary confinement, according to data provided by the CLA and the Liman Center in 2021[9], a snapshot revealed that between 41,000 and 48,000 individuals experienced prolonged solitary confinement for an average of 22 or more hours a day, lasting at least 15 continuous days. On this, the even more alarming figure is that nearly a quarter of these individuals had endured solitary confinement for years, with almost 4% spending more than a decade in such conditions[10].

As for the dimension of solitary confinement in Europe, there is a lack of complete data that prevents a true understanding of the extent of the phenomenon. However, the CPT has always paid particular attention to individuals in incarceration held in solitary confinement because of the damaging effects it can produce. On this regard, the most significant indicator of the damage which solitary confinement can inflict is the considerably higher rate of suicide among prisoners subjected to it than that among the general prison population. Clearly, therefore, solitary confinement on its own potentially raises issues in relation to the

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[5]The Report of the Special Rapporteur on Torture, Juan Méndez, published in 2011, states that the choice of 15 days stems from a review of the literature indicating that beyond this point "some of the harmful psychological effects of solitary confinement may become irreversible" (A/66/268, §§19, 26, 60, 79). The research evidence for this is well summarised in Sharon Shalev's "A Sourcebook on Solitary Confinement" (Mannheim Centre for Criminology, London, 2008), available at www.solitaryconfinement.org (accessed on 24.10.23).

[6] A/HRC/43/49 §57.

[7]Solitary Watch & The Unlock Box Campaign (2023), *Calculating Torture*, https://solitarywatch.org/calculating-torture/ (consulted on 03.10.2023).

[8] To begin with, this figure is based on self-reported data from correctional departments. It reflects only those held in solitary for 22 hours a day or more and omits shorter numbers of hours in solitary, units that amount to solitary by another name, and informal or transient forms of solitary such as lockdowns or quarantines. It also does not include individuals held in isolation in immigrant or juvenile facilities. In addition, the figure represents a snapshot of the number of people in solitary at a given time, while many times that number are locked in solitary during the course of a year (Ibid).

[9]Correctional Leaders Association and Liman Center, (2021), *Time-In-Cell*, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4206981#:~:text=This%20study%2C%20Time%2DIn%2D,together%20to%20generate%20the%20only (accessed on 03.10.23).

[10]Ibid.

prohibition of torture and inhuman or degrading treatment or punishment[11] also in European penitentiary systems.

Moreover, thanks to remarkable research conducted by Professor Sharon Shalev, some data regarding New Zealand are available. In the year to 30 Nov 2016, there were 16,370 recorded instances of solitary confinement in New Zealand. With an average prison population of 9,798 people, this equals 167.1 instances of segregation per 100 prisoners. To put these numbers in context, in England and Wales the rate was 36.9 segregation instances per 100 prisoners, 24 meaning that, on average, New Zealand segregated prisoners over four times more often than England and Wales. For Professor Shalev this was a surprising finding, especially considering that the use of segregation in England and Wales itself was found to be high[12].

Although comprehensive data for Latin America is not available, solitary confinement represents one of the issues of greatest concern to human rights organizations operating in some South American states. In fact, in 2021, Chilean and Argentinian organizations published a specific protocol both to monitor solitary confinement in prisons and to offer guidelines for intervention on the matter[13]. In relation to Argentina, from 2010 to 2019, 71% of the disciplinary sanctions imposed were solitary confinement[14]. Of particular concern in Chile is the duration of prolonged solitary confinement, with OVIC data for 2021 showing an average of 224 days (approximately 7 months)[15].

However, prison authorities commonly claim that, in response to certain individual cases, there are no alternatives, except to place that individual in solitary confinement, including people belonging to underprivileged groups. The criminalization of vulnerable populations is directly linked with the prison overcrowding phenomenon. In fact, mass incarceration has emerged as a system of racialized social control disproportionately affecting underprivileged groups, resulting in their unbalanced representation in prison worldwide. These communities are also over-represented in solitary confinement.

Furthermore, in the last years it has been observed that prison administrations are increasingly resorting to solitary confinement to manage individuals with mental health issues and even mental disabilities, even though this is totally contrary to international standards on the subject. The high presence of mental distress among individuals in

[11] CPT/Inf(2011)28-part2 §53.

[12] Shalev, S., (2017), *Thinking outside the box? A review of seclusion and restraint practices in New Zealand*, https://www.solitaryconfinement.org/solitary-confinement-in-new-zealand (accessed on 08.11.23).

[13] Instituto Nacional de Derechos Humanos & Procuración penitenciaria de la Nación (2021), *Protocolo de actuación para organismos de derechos humanos ante la detección de prácticas de aislamiento en establecimientos penitenciarios*, available at https://bibliotecadigital.indh.cl/server/api/core/bitstreams/e6983794-ffbb-42b7-9651-f7dd1ddb6b22/content (accessed on 08.11.23).

[14] Ibid., p.13.

[15] Observatorio de Violencia Institucional en Chile (2022), *El aislamiento penitenciario prolongado: La llegalidad del Régimen Especial en las Cárceles Chilenas*, https://www.ovic.cl/storage/app/uploads/public/62b/f23/b62/62bf23b622d08029963736.pdf (accessed on 08.11.23).

incarcerations, as well as the lack of insufficient mental health services, contribute to the deterioration of mental health problems, and lead to more rule-breaking and violence[16], and therefore to an increased use of solitary confinement. Hence, solitary confinement units are moving away from the rehabilitative ideal -which represents the main legitimation of all penitentiary systems- towards a mere warehousing approach, ascending to one of the main modalities of management in the prison universe.

The International Guiding Statement on Alternatives to Solitary Confinement

For all these reasons, in January 2022, PHRI and Associazione Antigone convened an international group of experts with multidisciplinary skills to develop a set of guidelines regarding the overcoming of solitary confinement at a global level. Specifically, the experts involved were prison administrators, mental health professionals, correctional staff, and academics, who have either implemented alternatives to solitary confinement or proposed alternatives to the practice.

The result of this process is the *International Guiding Statement on Alternatives to Solitary confinement*[17] (IGS) published in May 2023. The IGS seeks to bridge the gap between international law and medical agreement on the harm caused by solitary confinement, by presenting a consensus on measures that can help reduce and ultimately abolish this practice. The IGS is accompanied by a *Background Brief: Alternatives to Solitary confinement*[18] aimed at providing additional background information. In both documents the signatures of international experts collected so far also can be reviewed[19].

The experts' view in reasoning about the IGS does not look at the phenomenon of solitary confinement as something isolated, but rather as the consequence of broader shortcomings that afflict the prison system[20]. Indeed, in order to fully understand the underlying reasons for the application of solitary confinement, it is necessary to analyse the systemic problems that plague prisons. The solitary confinement pipeline includes both conditions within prisons -such as overcrowding, lack of adequate mental health care, a punitive approach to prison management- and broader structural issues, such as mass incarceration, criminalisation of underprivilege groups, as well as insufficient mental health care in the community, and the use of prisons as places of detention for individuals with mental health issues, as has been pointed out earlier. Nevertheless, according to the IGS, until these structural changes are addressed, short-term measures must be implemented to ensure that individuals currently

[16]Kupers, T., (2015), A Community Mental Health Model in Corrections, *Stanford Law & Policy Review*, 26 (119).
[17]See Annex 1 or access to https://www.antigone.it/upload/5298_SolitaryStetement_paper_Eng_24.08.23.pdf (consulted on 02.10.23).
[18]See Annex 2 or access to https://www.antigone.it/upload/5298_SolitaryBrief_paper_Eng_24.08.23.pdf (consulted on 02.10.23).
[19]The document boasts the signature of the former Special Rapporteur on Torture (2010-2016), Professor Juan Méndez, and the former President of the CPT and Italian NPM, Professor Mauro Palma.
[20]See the *Appendix*.

held in solitary confinement can be taken out. As stakeholders increasingly implement the recommendations of the IGS, more tools and alternatives to solitary confinement will be available for use.

The recommendations in the IGS are divided into 4 sections and the *Appendix*. The following is a summary of each one:

Section A – Documentation, oversight, and accountability measures:

Understanding the way in which and the extent to which solitary confinement is carried out, as well as the individuals most likely to be targeted, is a necessary step in reducing and ultimately abolishing this practice. In this vein, the IGS suggests implementing urgent legislative action to ban solitary confinement in incarceration settings for all individuals, as well as a specific regulation and judicial review of all forms of solitary confinement until its abolition. Despite often taking part in prolonging solitary confinement measures, judges rarely conduct on-site visits to verify the accuracy of data given by prison authorities. As such, the IGS recommends the institutionalisation and regularisation of on-site visits by judges involved in solitary confinement cases.
Also, comprehensive incident reports of any use of force (including mechanical restraint) should be provided by prison staff in order to fully understand the violent dynamics that usually leads to the imposition of solitary confinement or even are used to manage critical situations within the solitary confinement's units.
In addition, for the purpose of documenting the phenomenon as broadly as possible, it is recommended to get comprehensive, anonymized and individual records which include whether the individual belongs to a vulnerable population, the official reason for placement in solitary confinement, steps taken to avoid using the measure, and a schedule for removal from confinement.

Section B – Preventing placements in solitary confinement, alternative measures:

Around the world, prison authorities cite several justifications for using solitary confinement, including to minimise friction, to respond to violent acts, as a disciplinary sanction, to prevent self-harm, to address security concerns, and upon the request of an individual. The IGS provides recommendations on how to remove people who are currently placed in solitary confinement, how to deal differently in the situations outlined above, and on the role of physicians and prison staff within such contexts.
According to the IGS, which echoes international recommendations, as for the pivotal role of health professionals in incarceration settings, they should always recommend removal from solitary confinement in all cases and should be prohibited from participating in any decision-making resulting in solitary confinement. Moreover, in any situation where individuals experience a mental health crisis and acts of self-harm, the IGS recommends an immediate assessment by mental health professionals, an individualised care plan[21], and that de-escalation measures be put in place by prison staff.

[21] See Section C.

The establishment of an independent body of mental health professionals, which will be authorised to suggest a person's release from prison, is also a recommendation emphasised in the IGS. In addition, the latter discourages the imposition of solitary confinement even in cases where it is requested by the incarcerated people themselves, submitting a different arrangement, having carried out a process to understand the underlying reasons behind that request.
Furthermore, in the IGS it is stated that regularly reviewed, evidence-based risks and needs assessments (also by an independent body), as well as identifying a suitable arrangement to ensure an individual deemed a security risk is not isolated from the general prison population may contribute to the prevention of the imposition of solitary confinement especially for purported security reasons.

Section C – Individualised care plans:

The IGS recommends that individuals be offered a tailor-made care plan, developed in collaboration with health professionals, that addresses their unique circumstances in a transparent, responsive, and compassionate way. In this regard, current incarceration settings are characterised by a one-size-first-all approach that negatively impacts the health of individuals in incarceration. People placed in solitary confinement often struggle with the homogenous order of prison systems, demonstrating a connection between solitary confinement and failure to develop individualised care programs. According to the group of experts participating in the IGS, with very limited resources, meaningful individualised care plans could be provided, with the aim of promoting an incisive change in the situation of the individual held in solitary confinement.
Care plans should encompass regular appointments with therapeutic professionals, as well as opportunities to connect with friends, family, and qualified prison staff. These care plans must have defined timeframes and should be reassessed if there are any modifications that could affect the individual's care. To avoid the typical infantilization process in prison settings and in order to fully respect the dignity of the person held in solitary confinement, their wishes should be reflected in the process of planning, managing, and reviewing the care plan. In the same vein, personal resources relating to the individual's field of chosen interest, e.g., literature, music, and art, must be included in the care plans.
Although the care plan' s urgent objective is to re-integrate the individual into less restrictive conditions of confinement, the ultimate and most important goal is to prepare them for life post confinement.

Section D – Measures to ensure staff competency and well-being:

The approach and decisions taken by staff are key factors in determining whether individuals are placed in solitary confinement. Lack of appropriate training and tools too often results in the use of punitive approaches and the misinterpretation of individual behaviour, such as terming self-harm as "attention seeking". According to the IGS, training and support for prison staff should encompass instruction in de-escalation methods and early intervention procedures, provisions for secondary trauma care for the well-being of the staff, and an enhanced comprehension of the effects of solitary confinement on the individuals under

their care. In this sense, the IGS includes recommendations on what should be included in training for prison staff, how it should be evaluated, and who should deliver that training and supervision.

Appendix – Steps for stopping the solitary confinement pipeline:

In the belief that the IGS moves within extremely complex issues, the *Appendix* proposes the horizon to which it is necessary to move to overcome solitary confinement. Therefore, this section provides the comprehensive and holistic view that is a necessary accompaniment to the short-term and medium-term measures.
The holistic view is declined as follows:

1. Reduce the prison population;
2. Prevent undue and disproportionate criminalization of vulnerable populations;
3. Implement health and welfare safeguards;
4. Mainstream the normalisation principle;
5. Ensure the right to health for all.

To conclude, the IGS aims to be a consensus statement that prison authorities, policy makers and civil society organizations can support, enabling collaborative efforts towards its implementation. Aware that some recommendations can be executed immediately, while others will require a concerted effort to ensure local and international implementation, Associazione Antigone and PHRI hope that the IGS will be an approach shifting, a tool to think differently on these matters, and a useful roadmap towards the reduction and eventual abolition of solitary confinement all over the world.

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INTERNATIONAL GUIDING STATEMENT ON

ALTERNATIVES TO SOLITARY CONFINEMENT

MAY 2023

Preamble[1]

Solitary confinement[2] has devastating psychological, physical, and social impacts on individuals in incarceration settings, particularly vulnerable populations.[3] While the UN Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules) already prohibit the use of solitary confinement for longer than fifteen days and with respect to vulnerable populations,[4] the devastating effects of this penal practice demand its abolition in all forms.

Due to the current lack of alternatives for addressing the challenges of incarceration systems, individuals in prison,[5] including underprivileged groups[6] and vulnerable populations, continue to be placed in solitary

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[1] For the supplementary *Background Brief: Alternatives to Solitary Confinement*, which further discusses each of the recommendations in this statement, see: https://www.phr.org.il/en/statement-on-alternatives-to-solitary-confinement/ or here https://www.antigone.it/upload2/uploads/docs/International%20Guiding%20Statement%20-%20April%202023.pdf

[2] We refer to solitary confinement as practiced in prisons and outlined in the UN Standard Minimum Rules for the Treatment of Prisoners, art. 44, as the confinement of individuals in incarceration settings for 22 hours or more a day without meaningful human contact. The Essex Paper 3 provides guidance regarding the nature of such contact, requiring it to be "face to face and direct (without physical barriers) and more than fleeting or incidental, enabling empathetic interpersonal communication. Contact must not be limited to those interactions determined by prison routines, the course of (criminal) investigations, or medical necessity." While solitary confinement also exists in other settings, including in immigration detention, military occupation, mental health facilities in the community, and other contexts, these remain beyond the scope of this International Guiding Statement and Background Brief, due to the specific circumstances that require special considerations. However, the principles and spirit of the documents likewise apply in such settings.

[3] For the purposes of this statement, this includes individuals with mental and physical disabilities, minors, and women.

[4] UN Standard Minimum Rules for the Treatment of Prisoners, art. 43, 44. Article 45 prohibits any placement in solitary confinement in the case of women, children, and individuals with mental or physical disabilities when such measures would exacerbate their conditions. Additional international instruments confirm the need to prohibit solitary confinement for individuals with mental and physical disabilities, such as the WMA Declaration on Solitary Confinement and the 2007 Istanbul Statement on the Use and Effects of Solitary Confinement.

[5] For the purpose of the International Guiding Statement and Background Brief, we refer to prisons interchangeably as incarceration settings.

[6] For the purposes of this statement, underprivileged groups are defined as groups experiencing increased rates of poverty, social exclusion, discrimination, and violence, including but not limited to people of African descent, indigenous persons, Roma, Sinti, and travellers, persons belonging to national, ethnic, and linguistic minorities, migrants, asylum seekers, refugees, internally displaced people, and LGBTQI+ people. For more, see the Background Brief, section A.

confinement worldwide. The impact of overcrowding, inadequate health care, and other unavailable services within incarceration settings promote the reliance of prison authorities on solitary confinement. Eliminating its use, therefore, requires broader systemic reform of the criminal legal system and community mental health services.

This statement is the outcome of an international working group of prison administrators, correctional staff, and experts on prison reform, solitary confinement, and mental health, convened by Physicians for Human Rights Israel (PHRI) and Antigone in January 2022. It offers concrete alternatives and interim steps for removing individuals from solitary confinement and is accompanied by the Background Brief, which provides additional context and background. Adopting these suggested measures will help national authorities, prison administrators, and health professionals reduce and ultimately abolish this harmful practice.

Section A:
Documentation, oversight, and accountability measures

Exposing how solitary confinement is practiced and impacts individuals in incarceration settings is the starting point for reducing and eliminating its use (see Background Brief, section B, page 5).

1. **Urgent legislative action** to ban solitary confinement in incarceration settings for **all** individuals.
2. **Regulation and judicial review** of all formal and informal forms of solitary confinement until its use is abolished.
3. **Comprehensive, anonymized, and individual records,** which include the following:

a. Identifying details of the individual in question, available only to monitoring bodies

b. Indication whether the individual belongs to a vulnerable population or an underprivileged group

c. Official reason for placement in solitary confinement

d. Steps taken to avoid using the measure

e. Review(s) of the decision by a court or relevant body

f. An individualized care plan, including a schedule for removal from confinement

g. All other restrictions and the justifications for their use

4. **The collection of data, made available to the public**, on the number of persons in solitary confinement (including psychiatric units), reasons for confinement, duration, indication whether individuals belong to a vulnerable population or underprivileged group, and earlier steps to prevent placement. The information should include all instances and forms of movement restriction, including the use of restraints or shackles, and be published by prison authorities on a quarterly basis.

5. **Regular review of individual records by independent national and international bodies**. National prison monitoring bodies must follow internationally accepted standards, such as OPCAT. The solitary confinement monitoring process should include the following:

a. Continuous free access to prisons for scheduled and un-announced visits
b. Private meetings with individuals in incarceration settings in different units
c. Publication of visit reports and policy recommendations to relevant authorities
d. Multidisciplinary monitoring teams that include attorneys and health professionals

6. **Comprehensive incident reports** provided by prison staff on any use of force, including mechanical restraints. Reports should include the following information:

a. The type of force or mechanical restraint used
b. Alternative measures that were attempted before the use of force
c. Any available video recordings relating to the incident
d. The duration of the coercive measure(s) and steps taken to end their use
e. Recorded or written statements by prison staff and the individual in question
f. Indication whether the individual belongs to an underprivileged group or vulnerable population.

7. **Tracking the use of all coercive measures** on underprivileged groups and vulnerable populations in incarceration settings by a state-appointed independent committee led by civil society representatives. Findings must be made available publicly and utilized to develop an action plan to reduce the measures' use.
8. **Routine on-site visits by judges** reviewing solitary confinement cases. Judicial activities should include scheduled and unannounced visits in incarceration settings and personal meetings with individuals in solitary confinement.

9. **Clear clinical criteria to distinguish solitary confinement from** medical isolation (due to a communicable disease) or medical quarantine (due to exposure to a communicable disease). Medical isolation extending beyond fifteen days must be subjected to the same monitoring measures required for solitary confinement.
10. **Inform individuals in solitary confinement of their rights**, both verbally and in written form, in a language they understand, and with reasonable accommodations for persons with disabilities. Information on available remedies must be provided.

Section B: Preventing placements in solitary confinement: Alternative Measures

Prison authorities cite various justifications for using solitary confinement, including minimizing friction between individuals, disciplinary sanctions, self-harm prevention, security concerns, and response to individuals' requests. To eventually eliminate the practice of solitary confinement, the context for its deployment must be addressed, including the behavioral effects of the extreme conditions of incarceration settings (see appendix and Background Brief, section A). Simultaneously, the following safeguards and alternatives will help prison officials (recommendations 1-3, 8) and national authorities (recommendations 4-7) reduce and ultimately abolish the practice of solitary confinement:

1. **Ensure a time-limited schedule for removal** from solitary confinement that complies, at the very least, with the fifteen-day limit and the prohibition on the application of solitary confinement for vulnerable groups dictated by the Mandela Rules, regardless of the stated reason for using the measure.
2. **Provide information to a monitoring body** with the formal power to file complaints to a national authority when the solitary confinement prohibition is violated (see section A on documentation, oversight, and accountability measures).

3. **Implement measures to reduce friction, violence, and self-harm, including the following:**

a. Concrete steps to reduce overcrowding (see appendix).

b. Ensuring all individuals in incarceration settings have the maximum out-of-cell time and access to purposeful activities.

c. A personalized care plan for all individuals in solitary confinement, which must function as an intermediary step and provide personal resources to help with removal from solitary confinement. This plan must include an urgent timeline for reintegration into the general prison population (see section C on individualized care plans).

d. Providing programming to promote socialization skills and build stronger relationships and interactions, particularly for individuals who asked to be placed in confinement.

e. Training prison staff to recognize underlying motives for particular behaviors and reduce them through de-escalation, therapeutic, and non-punitive approaches (see section D on measures to ensure staff competency and well-being).

f. Training frontline staff to de-escalate incidents of self-harm and prevent mischaracterization (see section D on measures to ensure staff competency and well-being).

g. Periodic review of the responses of health professionals and prison staff to incidents of self-harm and suicide attempts by a body of health professionals independent of the prison and criminal legal system.

h. Establishing a mechanism for individuals to report human rights violations by other individuals or prison staff.

4. **Ensure that health professionals in incarceration settings:**[7]

a. Are prohibited from participating in any part of the decision-making process resulting in solitary confinement.

b. Recommend removal from solitary confinement in all cases.

c. Provide only medically necessary drugs and treatment.

[7] For recommendations 4a, c, d, g, and h, see the WMA Statement on Solitary Confinement (2014). https://www.wma.net/policies-post/wma-statement-on-solitary-confinement/

d. Be guaranteed daily access to individuals in solitary confinement, upon their own initiative. If the attending physicians deem it necessary, more frequent access should be granted.

e. Adhere to the same ethical codes and principles they are bound by in other medical settings.

f. Provide an individualized care plan (see section C).

g. Be employed and supervised by a body independent of the prison and criminal legal system.

h. Provide relevant information to monitoring bodies, including the health impact of solitary confinement on individuals.

5. **Regulate** the use of force against individuals in incarceration settings, including those committing violent acts or self-harm, through:

a. Legislation prohibiting the use of extreme coercive measures, including restraint chairs and riot guns.

b. Documenting all instances of coercive measures (see section A, recommendation 6)

c. Reducing and working towards the abolition of physical and mechanical restraints by adopting a prevention and early intervention framework in incarceration settings to reduce risk factors for aggression or violence (see appendix and section D on measures to ensure staff competency and well-being).

6. **In any situation where individuals experience a mental health crisis and acts of violence and self-harm** in incarceration settings, including in solitary confinement, the following steps must be taken:

a. An immediate assessment by mental health professionals.

b. An exhaustive investigation by an independent body of mental health professionals and complete documentation of the case (see section A, recommendation 6).

c. The investigating body must have the power to recommend transferring the individual out of prison.

7. **Prevent the imposition of solitary confinement for purported security reasons** by:

a. Conducting regularly reviewed, evidence-based risks and needs assessments for individuals in incarceration settings.
b. Identifying a suitable arrangement to ensure an individual deemed a security risk is not isolated from the general prison population.
c. External assessment of the risks and needs assessment and the appropriate arrangement by an independent body (see section A, recommendation 5).

8. Reduce and ultimately prevent the imposition of solitary confinement **upon request by an individual through:**

a. Ensuring the person requesting solitary confinement undergoes a mental health assessment by mental health personnel and prison staff to examine the reasons for making the request.
b. Identifying a suitable alternative to solitary confinement by prison staff and mental health professionals together with the individual to address the individual's concerns, including their safety.

Section C: Individualized care plans

Current incarceration settings are characterized by a one-size-fits-all approach that negatively impacts the health of individuals in incarceration. Individuals placed in solitary confinement often struggle with the homogenous order of prison systems, demonstrating a connection between solitary confinement and failure to develop individualized care programs (see Background Brief, section C).

1. **Individualized, interdisciplinary mental and physical health care plans** developed by health professionals and implemented by prison authorities. Plans must account for gender, sexual orientation, cultural, ethnic, socio-economic, and linguistic backgrounds, and any barriers distancing the individual from the custodial, educational, and health professionals.
2. Care plans must include **scheduled meetings** with therapeutic providers, friends, family, and trained prison personnel.

3. **Detailed records of individualized care plans and follow-up steps**. The care plans must be time-limited and reevaluated in case of any changes that may impact the care.
4. **Care plans must be regularly reviewed** by health professionals and independent monitoring bodies (see section A).
5. **Individual care plans must guarantee**:

a. The individual's wishes are reflected in the process of planning, managing, and reviewing the plan
b. The individual has access to their care plan
c. The individual has the capacity and ability to consent to the care plan
d. Staff responsiveness to changes in the individual's needs or preferences
e. Documentation of any disagreements concerning the care plan
f. The provision of personal resources relating to the individual's field of chosen interest.

6. **Care plans for individuals in solitary confinement** must include:

a. Personal resources relating to the individual's field of chosen interest, e.g., literature, music, and art.
b. Urgent steps and a concrete timeline for reintegration into the general prison population that, at the very least, comply with the fifteen-day limit dictated by the Mandela Rules.
c. A review of the plan by relevant monitoring mechanisms (see section A, recommendation 5).

7. To provide further support to the individual and only if they agree, health care staff should consider **sharing the care plan with relevant family members,** excluding any information the individual deems confidential.

Section D:
Measures to ensure staff competency and well-being

Prison staff often lack professional support and training, leading to increased stress, decreased use of de-escalation practices, and a tendency to adopt a punitive approach, including placement in solitary confinement (see Background Brief, section D).

1. **Support and supervision** for all prison staff by health professionals to process their experiences in incarceration settings, including secondary trauma care.
2. **Training for prison staff at every level** in the following:

a. The impact of trauma on individuals in incarceration settings and minimizing re-traumatization caused by incarceration

b. The severe and damaging effects of solitary confinement

c. The social circumstances of individuals in incarceration and the specific needs of vulnerable populations and underprivileged groups

d. Preventive intervention and de-escalation mechanisms, including conflict resolution, peer support, and restorative justice methods

e. Training personnel must include independent mental health professionals not employed by the prison or the criminal legal system

3. **Training, professional support, and guidance for working with underprivileged groups** and understanding the unique social circumstances of people in prison.
4. **Assessment and accreditation of the training curriculum** by an independent body with no financial links to the prison system.
5. **Assessment of the training program's long-term benefits over time** by an independent monitoring body.

Appendix:
Steps for stopping the solitary confinement pipeline

1. **Reduce the prison population**

   The use of solitary confinement is partly the result of broader structural problems within the criminal legal system. The following preventative steps must be taken to reduce the number of individuals placed in prisons (see Background Brief, section A):

a. Shorter sentences, adjudication for most crimes, parole opportunities, incarceration alternatives for petty crimes, and creating and expanding restorative justice programs.

b. Limiting the use of pre-trial incarceration through non-custodial measures.

c. Alternatives to incarceration for people with mental disabilities, including housing and social and mental health services in a community setting, under the supervision of health services.

2. **Prevent undue and disproportionate criminalization of underprivileged groups**

   Globally, underprivileged groups are overrepresented in prisons and solitary confinement. The following measures are required to end these disparities (see Background Brief, p. 4-5):

a. Providing reports on underprivileged backgrounds in pre-sentencing and bail hearings, including cruel, inhuman, or degrading treatment, torture, and trauma history.

b. Conducting in-depth examinations by state-appointed independent committees led by civil society representatives. The committees should assess the causes of the overrepresentation of underprivileged groups in prisons, the coercive measures used against them, and steps to address these inequalities.

3. **Implement health and welfare safeguards**

   Prisons should not be used as holding facilities for individuals with mental disabilities (who are often also placed in solitary confinement). National authorities should implement the following professional responses:

a. Providing and expanding access to trauma services, public mental health programs, substance abuse recovery programs, supportive housing, income assistance, vocational training, and post-incarceration community reintegration programs.

b. Adjusting community programs to meet the needs of underprivileged groups, including the needs of individuals with intersecting identities and language and cultural barriers.

4. Mainstream the normalization principle

Individuals in prisons often face additional deprivation of rights other than the right to liberty. The following steps must be taken to ensure their rights are protected (see Background Brief, p. 7):

a. To the greatest extent, prison systems should reflect the conditions of life outside the prison walls and uphold the rights of individuals in incarceration settings.

b. All rights other than the right to liberty must be protected while in prison, including access to health care, phone calls, visits, personal resources, and the possibility to activate effective remedies.

c. Prison authorities must justify and document actions violating the normalization principle.

5. Ensure the right to health for all

The adverse health outcomes of incarceration settings and low health care standards harm the mental and physical well-being of individuals in incarceration. This is particularly damaging to vulnerable populations and can result in their placement in solitary confinement (see Background Brief, p. 7). The following steps must be taken to ensure their right to health is protected:

a. National health authorities should be responsible for physical and mental health services in incarceration settings.

b. Continuity of care between community health services and health services in incarceration settings, including (consensual) transfer of relevant medical information.

c. Provision of physical and mental health services tailored to the specific needs of individuals in incarceration settings.

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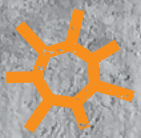

PHYSICIANS FOR HUMAN RIGHTS
רופאים לזכויות אדם
أطباء لحقوق الإنسان
ISRAEL

ANTIGONE
30 ANNI
PER I DIRITTI E LE GARANZIE NEL SISTEMA PENALE

BACKGROUND BRIEF: ALTERNATIVES TO SOLITARY CONFINEMENT

MAY 2023

Introduction

Despite international restrictions, individuals in incarceration settings worldwide, including vulnerable populations,[1] are still regularly placed in solitary confinement. The continued use of this harmful practice is partly rooted in the lack of alternatives for confronting the challenges of contemporary incarceration settings.

In January 2022, Physicians for Human Rights Israel (PHRI) and Antigone convened an international group of prison[2] reform, solitary confinement, and mental health experts to bridge this gap and develop concrete alternatives to solitary confinement.

The resulting International Guiding Statement on Alternatives to Solitary Confinement[3] addresses the conditions driving the use of solitary confinement in incarceration settings. The Statement includes recommendations for ending the solitary confinement pipeline, accountability and oversight measures, and guidelines for individualized care and staff training.

The recommendations in the Statement offer national authorities, prison administrators, and health professionals practical measures and interim steps to reduce and ultimately abolish this harmful practice.

This Background Brief is intended to be read alongside the Guiding Statement and offers its readers additional context on the suggested alternatives.

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[1] For the purposes of this statement, this includes individuals with mental and physical disabilities, minors, and women.

[2] For the purposes of the International Guiding Statement and Background Brief, we refer to prisons interchangeably as incarceration settings.

[3] For the International Guiding Statement on Alternatives to Solitary Confinement, see https://www.phr.org.il/en/statement-on-alternatives-to-solitary-confinement/ or here https://www.antigone.it/upload2/uploads/docs/Background%20Brief%20-%20April%202023.pdf

The Impact of Solitary Confinement [4]

The psychological impacts of solitary confinement range from a state of confusion and inability to concentrate to disturbing hallucinations and paranoia, depression and anxiety, post-traumatic stress disorder (PTSD), increased suicidal ideation, self-harm, and suicide (Shalev, 2008, p. 20; Haney & Lynch, 1997; Haney, 2003, p.134; Kaba et al., 2014; Reiter et al., 2020). Physiological symptoms include cardiovascular and gastrointestinal complications, migraines, deteriorating eyesight, fatigue, and muscle pain (Smith, 2006, p. 477, Strong et al., 2021). Solitary confinement both manufactures and aggravates mental disabilities (Raemisch, 2017).

The effects of solitary confinement depend on individual and environmental factors and may only begin to appear after several days. They can continue to impact individuals long after they are released from solitary confinement and may remain chronic for many years (Wildeman & Andersen, 2020; Kupers, 2016, 2017).

International covenants and human rights standards increasingly limit the use of solitary confinement and, in the case of vulnerable populations, prohibit it altogether. The United Nations Standard Minimum Rules for the Treatment of Prisoners (2015), also known as the Mandela Rules, have prohibited solitary confinement lasting longer than 15 days. In 2008, the UN General Assembly adopted the Istanbul Statement on the Use and Effects of Solitary Confinement, banning the practice for various groups, including those suffering from mental disabilities. The prohibition was reinforced by the 2019 World Medical Association Statement on Solitary Confinement (2019) and the Consensus Statement from the Santa Cruz Summit on Solitary Confinement and Health (2020). The way in which solitary confinement

[4] Solitary confinement is the practice of confining individuals in incarceration settings for 22 hours or more a day without meaningful human contact, as practiced worldwide and as defined in the United Nations Standard Minimum Rules for the Treatment of Prisoners. While solitary confinement also exists in other settings, including in immigration detention, military occupation, mental health facilities in the community, and other contexts, these remain beyond the scope of this International Guiding Statement and Background Brief, due to the specific circumstances that require special considerations. However, the principles and spirit of the documents likewise apply in such settings.

may constitute cruel, inhuman, and degrading treatment has been confirmed by jurisprudence, e.g., Inter-American court rulings that solitary confinement violates personal integrity (Inter-American Court of Human Rights, Cantoral Benavides v. Colombia, 2000).

Despite international standards restricting this practice, individuals in incarceration settings, including vulnerable populations, are still regularly placed in solitary confinement, sometimes for prolonged periods, due to a lack of alternatives for facing the challenges of contemporary incarceration settings.

The International Guiding Statement and its accompanying Background Brief aim to bridge this gap and provide measures for national authorities, prison administrators, and other bodies to phase out and ultimately abolish the practice of solitary confinement.

Section A: The solitary confinement pipeline

Prison overcrowding

Recent growth in the number of individuals in incarceration settings has contributed to the overuse of solitary confinement worldwide.[5] The overcrowding due to mass incarceration increases stress and friction among people living in prisons. Existing prison resources - including insufficient or unavailable health care - inadequately address and resolve these frictions, leading prison authorities to resort to punitive measures, including solitary confinement.

Among the leading drivers of mass incarceration is the criminal legal system's preservation of racial, gender, health, and socio-economic inequalities, along with over-policing and the criminalization of

[5] Globally, since 2000, there has been an increase of 24%, a rate slightly less than the estimated growth in the world's general population. (Penal Reform International & Thailand Institute of Justice, 2022, p. 6).

underprivileged groups.[6] Mass incarceration has emerged as a system of racialized social control disproportionately affecting underprivileged groups (Alexander, 2010), resulting in their disproportionate representation in prisons worldwide.[7] These communities are also over-represented in solitary confinement, to which they are sent more often and for longer intervals (Correctional Leaders Association, 2020).[8] Another significant driver of mass incarceration is excessive pre-trial detention, accounting for one-third of the global prison population (Penal Reform International & Thailand Institute of Justice, 2022, p. 6).

Social disparities in the community have also resulted in the over-representation of vulnerable populations in incarceration settings, including individuals with mental disabilities. The prison system's failure to meet their needs later results in overrepresentation in solitary confinement, where they are placed more frequently and for longer durations (Correctional Leaders Association & Yale Law School, 2020).

The factors contributing to their increased representation in prisons include a lack of access to mental health care, underdeveloped trauma services, and scarce social support due to underfunded community mental health programs. Consequently, prisons have become default holding facilities for those with mental disabilities.[9] Individuals with mental disabilities also face a higher risk of being held in pre-trial detention.

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[6] For the purposes of the Background Brief and International Guiding Statement, underprivileged groups are defined as those who experience a higher risk of poverty, social exclusion, discrimination, and violence, including but not limited to people of African descent, indigenous persons, Roma, Sinti and travelers, persons belonging to national/ethnic/linguistic minorities, migrants, asylum seekers, and refugees, internally displaced people, and LGBTQ+ people.

[7] This can be seen in, e.g., the disproportionate incarceration of Black and Latino men in the US (Carson, 2014) and the imprisonment of indigenous people in Canada. Women with intersecting identities are particularly marginalized by the state, criminalized, and blamed for the conditions that frame their violent experiences (Richie, 2012).

[8] This is contrary, e.g., to the position of the European Committee for the Prevention of Torture, which, based on the jurisprudence of the European Court of Human Rights, established five critical categories for assessing whether the imposition of solitary confinement is justified or not: proportionality, legality, accountability, necessity, and non-discrimination. See European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2011).

[9] In several countries, the closure of psychiatric facilities has led to the use of prisons for holding people with mental disabilities. For more, see Prison Insider (2021).

Once inside, the stress of life in incarceration settings exacerbates preexisting mental health struggles (Prison Insider, 2021). This is particularly true for individuals in pre-trial detention, for whom the suicide rate is three times higher than convicted people (Open Society Justice Initiative, 2014).

The impact of overcrowding on available services and programming

Due to mass incarceration, overcrowding severely impairs the quality of sanitation, hygiene, health services, and programming in incarceration settings. Unavailable services harm the prison population, which suffers from higher rates of mental disabilities and physical illness than the general population (Enggist et al., 2014).

Due to overcrowding, vulnerable populations, including those with mental disabilities, are not adequately screened upon arrival and thereby prevented from receiving the limited support available (Contrôleur Général des Lieux de Privation de Liberté, 2020).[10] Crowded conditions worsen the already severe cognitive strain of prison life by increasing uncertainty and interpersonal instability among individuals in incarceration settings (Haney, 2006).

The use of solitary confinement is linked to unavailable or low-quality psychiatric and psychological treatment and a lack of rehabilitation and education programming. Insufficient health services contribute to the deterioration of mental health problems, while lacking programming leads to idleness, the inability to release tensions, and feelings of despair regarding post-release prospects. These consequences lead to more rule-breaking and violence (Kupers, 2015).

[10] As a result, individuals entering incarceration settings with pre-existing mental disabilities often remain untreated. For more, see Haney (2006).

Violation of the normalization principle and the impact of the prison health system structure

Unavailable services lead to the severe deprivation of rights of individuals in incarceration settings, including the right to health, and violate the internationally enshrined normalization principle (Committee of Ministers, 2020, par. 5).[11] The lack of resources also forces prison staff to resort to authoritarian tactics, including solitary confinement and "mental health observation," often used as a whitewashed term for de-facto solitary confinement.

Placing health care responsibilities on prison authorities rather than a national medical body contributes to poor health services, the prioritization of security needs, and increased dual loyalty concerns.[12] The latter – namely, the conflict between the professional clinical duties of practitioners and their obligations, expressed or implied, to the interests of the prison administration and state authorities – correlates with the use of solitary confinement (J. Pont et al., 2012; Barragan et al., 2022).

Health professionals caring for individuals in incarceration settings are often forced to support the practice of solitary confinement. Such conduct contrasts with international standards stating that health professionals "shall not have any role in the imposition of disciplinary sanctions or other restrictive measures" (World Medical Association, 2019). Nevertheless, health professionals continue to normalize solitary confinement in various ways, including determining if patients are medically "fit" for solitary confinement.[13] This is more likely to occur when they are subordinated to non-health-related governmental ministries, including security ministries (Pont et al., 2012).

[11] We refer to the principle of normalization as that whereby individuals in detention settings must retain their rights, except those taken away by the necessary implication of incarceration.

[12] For an example in Israel, see Michaeli (2020).

[13] For an example in Serbia, see Council of Europe & Lietuva (2014, p. 35).

Section B: Documentation, oversight, and accountability measures

Alongside stopping the solitary confinement pipeline, exposing how solitary confinement is practiced and how it impacts individuals in prison is a necessary step toward reducing and ultimately eliminating it.

Individuals in incarceration settings are restricted in their movement and ability to communicate with the outside world, particularly those in solitary confinement. These restrictions increase the likelihood of additional human rights violations beyond the use of solitary confinement. A robust, coordinated, and proactive framework for documentation, monitoring, and oversight is therefore needed to protect the well-being and safety of those entirely dependent on others and who have limited capacity to advocate for themselves.

Often, prison systems do not accurately document their justifications for using solitary confinement or its conditions. The little documentation they maintain does not include an action plan for removal from solitary confinement (Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2019, par. 79). This lack of documentation complicates the work of judicial and monitoring bodies assessing solitary confinement measures and leads prisons to adopt informal practices that lack transparency, oversight, and safeguarding (United Kingdom's National Preventive Mechanism, 2015, pp. 27–29).

Furthermore, those placed in solitary confinement are often unaware of why they were sent there and what remedies are available to them to end their confinement. This is especially true for people with mental disabilities, who may lack the capacity to exercise their rights (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2011, p. 43).

Judges approving and prolonging solitary confinement rarely conduct in-person visits to meet the individuals under review (European

Committee for the Prevention of Torture, 2010, p. 49). As a result, they cannot accurately evaluate the evidence and justifications of prison authorities for using solitary confinement (Cunliffe, 2014), contributing to frequent judiciary approval of the measure (Dagan & Shalev, 2021).

Section C: Individualized care plans

Aside from the exposure of the way in which solitary confinement is practiced, individualized care must be provided. Most incarceration settings operate according to uniform rules that help them run smoothly, often due to insufficient resources. Yet a one-size-fits-all approach to health care and other prison aspects is highly damaging to individuals in incarceration settings, particularly those in solitary confinement (Reiter & Blair, 2018).

Those placed in solitary confinement are often persons who are unable to function within the existing prison system rules and require individualized care (Reiter & Blair, 2018; Reiter et al., 2021; Augustine et al., 2021; Barragan et al., 2022). Bearing in mind the negative health consequences of solitary confinement, individuals placed therein have an even greater need for individual resources. Resources relating to the individual's field of interest such as literature, music, and art can help meet their unique needs, ease the mental harm of solitary confinement, and prepare them for reintegration with the general population.

Once placed in solitary confinement, individuals are deprived of meaningful social contact, which has been shown to constitute a form of trauma (Consensus Statement from the Santa Cruz Summit on Solitary Confinement and Health, 2020). Social interaction is necessary for reality testing, defining one's personality, and evaluating one's behavioral and emotional responses to external stimuli. Meaningful social contact is, therefore, vital to countering the impact of solitary confinement (Brioschi & Paterniti Martello, 2021, p. 25).

Section D:
Measures to ensure staff competency and well-being

To ensure prison staff have the necessary skills to face the challenges of incarceration settings, they must receive proper professional training (Mandela Rules, art. 75). A lack of support and relevant training has been proven to compound the adverse effects of stress and exacerbate the inherent tension in any prison environment (European Committee on Crime Problems, 2019). Amid limited resources and a sense of fear and anxiety, individuals working in corrections may tend to assert control forcibly. This, in turn, impacts individuals in incarceration settings, who mirror and re-enact personal histories, including oppressive relations in the family, community, and state. At the same time, prison staff risk vicarious traumatization (Brooker & Monteiro, 2021).

To minimize triggers, reduce dangerous incidents, de-escalate situations, and avoid the use of restraints (including solitary confinement), it is crucial to offer prison staff training, guidance, and professional support, including secondary trauma care. Interaction between staff and people in prison is the day-to-day fabric of both trauma recovery and re-traumatization (Miller & Najavits, 2012). De-escalation strategies aim to validate the individual's feelings, minimize the invasion of their personal space, and promote their capacity to choose from various behavioral actions, thereby supporting interpersonal relationships and promoting the safety of others (Levenson & Willis, 2019).

Section E:
Measures to prevent placement in solitary confinement

Prison authorities cite various justifications for using solitary confinement, including response to violence, disciplinary sanctions, security concerns, self-harm prevention, and responding to the requests of individuals. To reduce and eliminate the practice of solitary confinement, the context for its deployment must be addressed, including the behavioral effects of the extreme conditions in incarceration settings.

Response to violence and friction

Violence in prison is widespread for various reasons – ranging from inhumane incarceration conditions to stress caused by incarceration, with a link between overcrowding, friction, and acts of violence in prison settings (Baggio et al., 2020). In such instances, prison staff often resort to solitary confinement to keep individuals "under control" and attempt to reduce violence. Solitary confinement is used to deal with violence even though there is no evidence to prove its effectiveness and despite studies demonstrating that restricting solitary confinement decreases violence and aggression in prisons (Shames, Wilcox & Subramanian, 2015).

Prison staff often fail to identify when violent acts are committed due to mental disabilities. Even when recognized, they may still place the individual in solitary confinement and use other coercive measures to ensure obedience (Prison Insider, 2021). Such tactics are often employed rather than allowing qualified professionals to handle cases using therapeutic approaches.

Disciplinary sanctions and punishment

Contrary to the Mandela Rules, solitary confinement is often used as a form of punishment rather than a preventative or preemptive means (Dignity Danish institute against torture, 2017; Penal Reform International, 2022, Mandela Rules, art. 43). Individuals in incarceration settings are more likely to be placed in solitary confinement as a disciplinary sanction if they are seen as belonging to a gang or if they are deemed dangerous, including if they were classified as such due to previous placement in solitary confinement (Dignity Danish institute against torture, 2017).

Placement for purported security considerations

Prison administrators often cite security concerns to justify placement in solitary confinement. Individuals may be placed in solitary confinement because of the crime they were imprisoned for or because they are

assumed to present a severe risk to prison safety. These individuals are often placed in solitary confinement without an in-depth evaluation of the security risk they are purported to pose.

In such cases, individuals are placed in high-security facilities that entail formal or de-facto solitary confinement. Contrary to Mandela Rules restrictions (European Committee for the Prevention of Torture, 2011, p. 43), their placement there can last for years and often entails additional restrictions, including visitation rights, keeping books or a television in the cell, and access to activities (European Court of Human Rights, Piechowicz v. Poland, 2007).

Response to self-harm

Acts of self-harm in incarceration settings are frequent and vary in lethality and suicidal intent.[14] Individuals in prisons are three to nine times more likely to die from suicide.[15] Self-harm in prisons results from individual and environmental factors such as the characteristics of people living in incarceration settings, the prevalence of mental disabilities, vulnerability to self-harm, and the interaction of these factors with the stressors of the prison environment. Moreover, studies have indicated a link between self-harm and placement in solitary confinement (Favril et al., 2020).

Individuals in solitary confinement are nearly seven times more likely to commit acts of self-harm than others in prison (Kaba et al., 2014). The increased risk persists even after release from prison, as individuals in solitary confinement are often released directly back into the community. For individuals with mental disabilities who are placed in solitary confinement and deprived of means of communicating and resisting a perceived oppressive situation, non-lethal self-harm may be a final resort of self-expression (Kupers, 2017a). Paradoxically, individuals

[14] According to several studies, the annual prevalence of self-harm is estimated at 5–6% in men and 20–24% in women. For more, see Favril et al. (2020).

[15] One study revealed that the risk of suicide increases at least three-fold for men in incarceration settings compared to the general male population. Females in incarceration settings are at least nine times more likely to die from suicide compared to the general female population. For more, see Taanvi Ramesh (2018).

with mental disabilities are often placed in solitary confinement as a means of self-harm prevention (Shalev, 2014).

Lacking the necessary professional training, prison staff often perceive self-harm as 'manipulative' or 'attention-seeking,' leading to increased hostility and the use of restraints. Furthermore, prison staff frequently express low confidence in understanding, managing, and preventing self-harm, including suicides (Hewson et al., 2022).

Requests to be placed in solitary confinement

Individuals in incarceration settings sometimes ask to be placed in solitary confinement (Shalev, 2008). Such requests may be motivated by a need for protection by individuals experiencing victimization, including individuals convicted of charges that carry a stigma, LGBTQI+ individuals, individuals with particular political views or ethnic backgrounds, individuals with mental disabilities, and others without a support network within the prison (Vera Institute of Justice, 2021). In other cases, individuals may ask to be isolated because they believe it will improve their mental state and help them avoid some of the stressors of prison life (Shalev & Edgar, 2015). However, due to the negative health impacts of solitary confinement, such requests ultimately lead to further deterioration in the mental well-being of these individuals.

Background Brief Conclusion

Prison authorities continue to rely on solitary confinement despite consensus on its harm, primarily due to a lack of alternatives for addressing the challenges of contemporary incarceration settings.

These challenges include what we refer to above as the solitary confinement pipeline, rooted in overcrowding, the presence of vulnerable populations in incarceration settings, and the impact of incarceration on physical and mental health. These challenges are met by a prison system lacking accountability and oversight over the way and extent that solitary confinement is practiced. Simultaneously, incarceration settings operate as uniform and one-size-fits-all systems that do not meet the needs of the individuals held within them. Due to the mental and physical harm of living in these settings, individuals in incarceration require greater support and resources than those outside of it. Prison staff, meanwhile, receive insufficient guidance and training to face these challenges, resulting in reliance on punitive measures, including placement in solitary confinement.

In response to these challenges, prison authorities continue to place individuals, including vulnerable populations, in solitary confinement, whether as a means of responding to violence among individuals, as a form of punishment, for security considerations, to prevent self-harm, or upon the request of individuals.

This document provides the background and context for these challenges. It is intended to be read alongside the International Guiding Statement on Alternatives to Solitary Confinement, which offers concrete recommendations and provides a roadmap for reducing and ultimately abolishing solitary confinement.

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