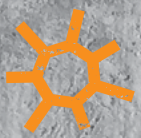

PHYSICIANS FOR HUMAN RIGHTS
רופאים לזכויות אדם
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PER I DIRITTI E LE GARANZIE NEL SISTEMA PENALE

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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