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INTERNATIONAL GUIDING STATEMENT ON

# ALTERNATIVES TO SOLITARY CONFINEMENT

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# 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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