Protocol on medico-legal documentation of solitary confinement

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Key points of interest

- This Protocol summarises the relevant conceptual (legal and health) factors regarding solitary confinement, and it formulates questions for its medico-legal documentation.
- The Protocol is general in scope, with additional specific elements for populations particularly vulnerable to solitary confinement pending to be further developed in future editions after pilot testing.
- This Protocol is a supplement to the Istanbul Protocol.

Abstract

Introduction. This Protocol originates from a joint project regarding documentation of psychological torture initiated by the Public Committee against Torture in Israel (PCATI), REDRESS and DIGNITY - Danish Institute Against Torture (DIGNITY) in 2015 after the Copenhagen Conference on Psychological Torture. The project is a vehicle to establish a common understanding between health and legal professions as to how to best ensure the most accurate documentation of torture.

The aim of the Protocol is to improve documentation of solitary confinement and therefore to clarify the facts of the case so that stronger legal claims can subsequently be submitted to local and international complaints mechanisms. The Protocol has been developed based on a methodology involving a compilation and review of legal and health knowledge on solitary confinement and discussions among the authors and in a group of international experts.

Methods and Results. This Protocol is cognisant of the significance of the specific social, cultural and political contexts in which solitary confinement is used. We hope that this Protocol will assist in the discussions between the various stakeholders and provide guidance on what can be documented and how to document torture.

Keywords: solitary confinement, documentation, psychological torture, Istanbul Protocol

Introduction

Building on the Istanbul Protocol (IP) and experience among the authors, the aim of this

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Protocol is to improve medico-legal documentation of solitary confinement as torture or ill-treatment so that – inter alia – legal claims submitted to courts and complaints mechanisms can be better corroborated by medical evidence. This Protocol focuses on solitary confinement when used in different settings and forms within national criminal justice systems. The Protocol aims at clarifying the facts of solitary confinement from a multidisciplinary perspective so that stronger legal claims can subsequently be submitted to local and international authorities.

Although it can be used as a stand-alone tool, the Protocol should be better viewed as a supplement to the *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Therefore, some questions related to describing the events might overlap with those of the IP.

Within a criminal justice system, solitary confinement is applied in places of detention from the moment of police arrest and later during pre-trial stages and criminal investigation and/or during imprisonment. Some countries use solitary confinement towards prisoners who await sentencing and the execution of a death sentence. Solitary confinement is also used during administrative immigration detention, typically for the same reasons as within the criminal justice system, and in care institutions such as psychiatric hospitals, juvenile and child protection centres[1]. These latter institutions fall outside the scope of this Protocol, but its recommendations may still be of value when documenting and assessing solitary confinement used in those contexts.

Methodology

This Protocol has been developed based on an interdisciplinary methodology developed by DIGNITY – Danish Institute against Torture, Public Committee Against Torture in Israel (PCATI) and REDRESS involving the following steps: compilation and review of existing legal norms and standards; review of knowledge found in legal and health practice and research regarding forms and effects of solitary confinement; and discussion in a group of international experts.[2] This follows the same methodology as per the Protocol on Medico-Legal Documentation of Sleep Deprivation (Peréz-Sales et al., 2019) and the Protocol on Medico-Legal Documentation of Threats. This Protocol has not yet been pilot-tested in cases, but the authors encourage the testing of the Protocol in different contexts and would be happy to collaborate on this in the future.

1 Although both the Convention on the Rights of the Child and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty state that solitary confinement is strictly forbidden, it is used in many jurisdictions as a sanction for misbehaviours or allegedly as part of behaviour modification programs. Quite often solitary confinement is camouflaged in "stay-in-room" and other similar measures of isolation. In those cases where the local legislation allows it, further elements should be considered and explored related to (a) specific health effects on children (b) developmental and neurodevelopmental consequences (c) negative consequences in attachment (d) negative consequences of the use of reward/punishment methods as allegedly pedagogical methods. (Gagnon et al., 2022; McCall-smith, 2022; Royal College of Paediatrics and Child Health (RCPCH);Royal College of Psychiatrists;British Medical Association (BMA), 2018; UN General Assembly, 1990)

2 The method is described in Søndergaard, E., Skilbeck, R., & Shir, E. (2019). Development of interdisciplinary protocols on medico-legal documentation of torture: Sleep deprivation. *Torture Journal*, *29*(2), 23-27.

Conceptual, legal and medical/ psychological considerations

(1) Conceptual aspects

The Protocol refers to the following concepts and definitions:

Solitary confinement: Solitary confinement is defined internationally by Rule 44 of the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (Mandela Rules) as: *'the confinement of prisoners for 22 hours or more a day without meaningful human contact'*.[3] This refers to the situation in which a detaining authority has imposed a measure on a prisoner who is forced to spend at least a minimum of 22 hours alone ("solitary") in a cell without any meaningful contact with other prisoners or prison staff. Three central elements in this definition are *confinement, duration,* and *the lack of meaningful human contact*:

- ***Confinement:*** The prisoner is typically placed in a confined space (most often a cell) for solitary confinement. This could be for example in a special wing of the detention facility or in their everyday cell. The conditions of this cell vary greatly from one country to another and even from one detention facility to another, for example in terms of size, ventilation, lighting, furniture, etc. (see the Protocol, section 3). The regime around solitary confinement also varies, for example in terms of access to outdoor space etc.
- ***Duration*:** It refers to the total time from the beginning to the end of the confinement and it will be measured in hours, days up to weeks, months and even years in the worst cases. Depending upon the form of solitary confinement there might be a fixed duration of the isolation whereas in other regimes it may be indefinite or open-ended. Note that duration also relates to multiple consecutive or near-consecutive stays in solitary confinement (see the Protocol, section 3).
- ***Without meaningful human contact:*** Despite its centrality to the international definition of solitary confinement, there is limited guidance in international human rights instruments. The Istanbul Statement on Solitary Confinement and the Essex Expert Group defined it as "the amount and quality of social interaction and psychological stimulation which human beings require for their mental health and well-being" (Istanbul Statement, 2007; Essex Paper 3, 2017).[4]
- **The term "solitary confinement".** National prison legislation may specifically refer to "solitary confinement", but such measures may also be referred to under other names such as 'isolation', 'segregation', 'ex-

3 Whilst the international definition of solitary confinement is useful for documentation purposes, as described in this Protocol, it remains important to bear in mind that some national and regional frameworks can differ in the definition of solitary confinement. The European Prison Rules (2020) adopts this same definition however (Rule 60.6.a).

4 It is debatable whether double-celling would amount to 'meaningful human contact' according to the Mandela Rules. It is instructive to note that the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment (CPT) holds its standards on solitary confinement to equally apply to situations where a prisoner is placed together with 'one or two other prisoners' (CPT, European Standards, 'Substantive sections of the CPT's General Reports', CPT/Inf/E (2002) 1 - Rev. 2015, p. 29, para. 54). Haney argues that 'double-celling' may even exacerbate instead of mitigate the impact of isolation as a prisoner is not only isolated from the general population but also 'crowded' in with another person, with whom they may not be compatible. (Haney, Craig, Expert Report in Ashker v. Governor of California, Civil Action No. 4:09-cv-05796-CW (N.D. California, 2012, p. 22).

clusion', 'separation', and 'cellular'. This Protocol uses the two terms "solitary confinement" or "isolation" interchangeably.

- **Typical use of solitary confinement**: Within a national criminal justice system, solitary confinement is usually imposed by detaining authorities for the following reasons:

1. To preserve evidence in the interests of the criminal investigation
2. Disciplinary reasons (e.g., for punishment for breach of prison rules)
3. Security reasons (e.g., maintaining prison order and security against danger and disruptions); or
4. Preventive or protective reasons (e.g., separating prisoners at risk of harm from or to others which may even be requested by the prisoner him- or herself).

The rationale and legal basis for using solitary confinement in these situations may differ. Solitary confinement may also occur outside the above-mentioned situations, for example, *de facto* solitary confinement in the absence of a formal decision, or as a result of quarantine/isolation during an outbreak of an infectious disease where community standards of care are not being complied with (Cloud DH et al., 2020).

Categories of vulnerable prisoners: Vulnerability may relate to the risk of more severe reactions to solitary confinement of certain groups of prisoners. The Mandela Rules (Rule 45 (2)) refer to three such groups:

1. *Prisoners with physical or mental disabilities*
2. *Children:* defined as a person under the age of 18.
3. *Women who are pregnant, with infants or breastfeeding*[5]*:* This refers to women prisoners who are pregnant or who have recently given birth and who are now the main caregiver for their young child (breastfeeding or not).

Vulnerability may also relate to the likelihood of a prisoner being placed in solitary confinement. For example, a detainee with a cognitive impairment may be more likely to not understand prison rules and thus more likely to break them leading to punishment. Socio-cultural factors such as indigeneity have also been recognised as amplifying the risk of death in solitary confinement.[6]

(2) Legal norms

The Mandela Rules, which reflect international consensus around prison management and treatment of inmates, provide for a legal definition of all forms of solitary confinement in which deprivation of "meaningful human contact" for a specific period of time is key.[7]

5 The Bangkok Rules include specific provisions against the use of solitary confinement in women (rules 23 and 24) in order *to avoid causing possible health complications to those who are pregnant or penalizing their children in prison by separating them from their mothers*. (*The Bangkok Rules. United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders with Their Commentary. A/RES/65/229*, 2011)

6 For an example from Australia, see Royal Commission into Aboriginal deaths in custody, Volume 3 [1991] AURoyalC 3,15 April 1991, para. 25.7.12: "The extreme anxiety suffered by Aboriginal prisoners committed to solitary confinement should be recognised."

7 See for example British Columbia Civil Liberties Association and John Howard Society v. Attorney General of Canada, 2018, B.C.J. No. 53, 2018 BCSC 62, para 61: I am satisfied based on the evidence that the Mandela Rules represent an international consensus of proper principles and practices in the management of prisons and the treatment of those confined.

The legal interpretation of this aspect of the definition and the maximum duration entails that social interactions cannot be limited to those determined by prison routines, the course of (criminal) investigations or medical necessity. Thus, the notion of meaningful excludes situations in which for example 1) prison staff deliver a food tray, mail or medication to the cell door (Essex Paper 3); 2) investigators or legal representatives incidental and limited to their professional duties and routine matters interact with the inmate; and 3) prisoners have means of communication less than direct and personal (such as where prisoners are able to shout at each other through cell walls or communication solely via technological means such as telephones or computers). It is crucial that the contact provides the stimuli necessary for human well-being and this implies an empathetic exchange and sustained, social interaction (Essex Paper 3). Assessments of the level and quality of contact must be made on a case-by-case basis.

The Mandela Rules provide for prohibitions of solitary confinement in cases of indefinite solitary confinement, i.e., without an end date (Rule 43), prolonged periods (Rule 43) and when used towards specifically children, pregnant women or women with infants or breastfeeding and prisoners with mental or physical disabilities 'when their conditions would be exacerbated by such measures' (Rule 45(2)).[8] The last prohibition, which reflects principles stipulated in the United Nations Convention on the Rights of Persons with Disabilities and in the European Prison Rules (Rule 60.6.b), requires prison staff to consider whether prisoners suffer from any disabilities and if so, whether their conditions would be worsened by isolation. Regarding children, there are specific international regulations that forbid the use of solitary confinement in juveniles (McCall-smith, 2022; UN General Assembly, 1990), with also recommendations by medical and psychiatric international bodies (Gagnon et al., 2022; Royal College of Paediatrics and Child Health (RCPCH);Royal College of Psychiatrists;British Medical Association (BMA), 2018).

Importantly, the Mandela Rules introduce a time limit for all forms of solitary confinement and ban placing prisoners in solitary confinement for longer than 15 consecutive days (Rule 44). The (prison) authorities' decision becomes unlawful on day 16 when the prisoner should have been released. This also refers to a situation of solitary confinement for shorter periods than 15 days but where the solitary confinement is repeated frequently. This could happen for example if a prisoner is placed in solitary confinement three consecutive times of seven days as the total duration in solitary confinement exceeds 15 days.[9]

Solitary confinement may cause serious harm, amounting to torture or cruel, inhuman and degrading treatment or punishment (CIDTP). The legal assessment in relation to torture needs to be based on the four elements found in the definition of torture (Article 1 (1) UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment

8 See case law from Australia, for example Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children & Others [No 2] (2017) 52 VR 441, 554.

9 It is also CPT's practice to require an interruption of several days between such periods (CPT, Report on the Visit to Spain in 2011, CPT/Inf (2013) 6, p. 75). See also CPT 21st General Report, CPT/Inf (2011) 28, p. 56: "there should be a prohibition of sequential disciplinary sentences resulting in an uninterrupted period of solitary confinement in excess of the maximum period".

or Punishment (UNCAT)), i.e., severity of physical or mental pain or suffering, some involvement of authorities, purpose, and intentionality. Three of these elements under the definition emerge to be particularly significant: *purpose, intentionality,* and *severity* of physical or mental pain or suffering. If these elements cannot be identified, the measure cannot be considered torture, but may still amount to CIDTP. This is explored below when reviewing jurisprudence. Specifically with regards to solitary confinement, it is important to note that the infliction of mental pain can constitute torture on its own and need not be coupled with physical pain.

CIDTP, as stipulated in article 16 UNCAT, is also absolutely prohibited under binding international law. It presupposes some involvement of a person with official capacity, with the act falling short on one or more of the three other elements of the definition of torture (severity, intention, and purpose). By way of example, if solitary confinement causes severe pain or suffering, but is not intentional or purposeful, it may constitute CIDTP, rather than torture. Similarly, if such an act is purposeful and intentional, but does not cause "severe" pain or suffering it will not amount to torture but to CIDTP.

The nexus between solitary confinement and torture/CIDTP has become well-established in international and regional jurisprudence:

The European Court of Human Rights (ECtHR) has stated that solitary confinement can ultimately destroy the personality of the detainee and his/her social abilities (Ramirez Sanchez v. France) and that "solitary confinement without appropriate mental and physical stimulation is likely, in the long-term, to have damaging effects, resulting in deterioration of mental faculties and social abilities" (A.B. v. Russia). The ECtHR has ruled on the excessive use of solitary confinement in numerous cases.[10] The ECtHR has referred to the principle of proportionality in cases when assessing solitary confinement used as disciplinary punishment. By way of example, in *Ramishvili and Kokhreidze v. Georgia,* the applicant who had been sentenced to four years in prison, was placed in solitary confinement as a disciplinary punishment for using a mobile telephone. The court first observed that, amongst the available disciplinary sanctions, the administration chose the most severe one – confinement in a punishment cell. No consideration was given to such facts as, for example, the nature of the applicant's wrongdoing and the fact that it was his first such breach. The court found this to be CIDTP with reference to the conditions of the punishment cell (insufficient cell space (5.65 sq. m for two prisoners)); no outdoor exercise; no privacy; shared bed; and inadequate sanitary conditions.[11]

National courts have also recognised that duration is an important factor when assessing solitary confinement.[12]

Both the Inter-American Commission on Human Rights (IACommHR) and the Inter-American Court on Human Rights (IACtHR) have similarly recognised the profound effects of prolonged isolation and

10 Mathew v. the Netherlands, 24919/03, 29 September 2005; A.B. v. Russia, 1439/06, 14 October 2010; Piechowicz v. Poland, 20071/07, 17 May 2012; Gorbulya v. Russia, 31535/09, 6 March 2014; and N.T. v. Russia, 4727/11, 2 June 2020.

11 For criticism of the use of solitary confinement as a disciplinary punishment for possessing a mobile phone in Danish prisons, see Conference Report 2017 (DIGNITY, Copenhagen), on-line at: conference-report-solitary-confinement.pdf (dignity.dk)

12 Ashker v. Governor of California, Civil Action No. 4:09-cv-05796-CW (N.D. California) and the settlement of the case 1 September 2015. See also dissenting Judge Breyer in Ruiz v. Texas, 137 S. Ct. 1246, 1247 (2017).

deprivation of communication. The IACommHR has absolutely and consistently proscribed prolonged and indefinite detention as a "form of cruel, inhuman or degrading treatment under Article 5 of the American Convention on Human Rights".[13] The IACtHR ruled that these measures were "in themselves cruel and inhuman treatment, harmful to the psychological and moral integrity of the person and a violation of the right of any detainee to respect for his inherent dignity as a human being".[14] Over the years, IACtHR has handed down strong condemnations on solitary confinement.[15]

The African Commission on Human and Peoples' Rights (ACHPR) has too had occasion to consider solitary confinement. On one occasion, three political prisoners were held in 'almost complete solitary confinement, given extremely poor food, inadequate medical care, shackled for long periods of time within their cells and prevented from seeing each other for years' and it was held that the breadth of this treatment constituted, amongst other things, violations of article 5.[16] In another, the ACHPR found a violation in a case involving a journalist who was detained for 147 days, physically restrained and kept in solitary confinement for some periods.[17] It is difficult to discern the legitimate bounds of solitary confinement from the Commission's conflated reasoning in these cases.

The UN Committee Against Torture (CAT)[18] and the UN Human Rights Committee (HRC)[19] have interpreted their respective binding conventions in the context of solitary confinement.

To avoid harm generally, the use of solitary confinement – when not prohibited according to hard or soft law (see above) - should be limited to exceptional cases as a last resort and for as short a time as possible (Rule 45 (1) Mandela Rules). Thus, authorities are obliged to, first, consider alternative and less restrictive measures and, second, if these are rejected, ensure that the duration of the solitary confinement be as short as possible. The harm caused by solitary confinement was recognised by a trial court in Canada (the British Columbia Supreme Court) that found that "it causes some inmates physical harm and that it places all inmates subject to it in Canada at significant risk of serious psychological harm, including mental pain and suffering, and increased incidence of self-harm and suicide" (Lobel and Smith, 2020).[20] The European and

13 Castillo Petruzzi et al. v. Peru, Series C, No. 52, judgement of 30 May 1999.

14 Velázquez-Rodríguez v. Honduras, Series C, No. 4, judgement of 29 July 1988, p. 156.

15 Loayza-Tamayo v. Peru, Series C, No. 33, judgement of 17 September 1997, p. 58; Miguel Castro-Castro Prison v. Peru, Series C, No. 160, judgement of 25 November 2006; Cantoral-Benavides v. Peru, Series C, No. 69, judgement of18 August 2000, p. 62 and 104.

16 Krishna Achuthan and Amnesty International (on behalf of Aleke Banda and Orton and Vera Chirwa) v. Malawi, African Commission on Human and Peoples' Rights, No. 64/92, 68/92 and 78/92, judgement of 22 March 1995, p. 7.

17 Media Rights Agenda (on behalf of Niran Malaolu) v. Nigeria, African Commission on Human and Peoples' Rights, No. 224/98, judgement of 6 November 2000, p. 70 and 72.

18 Bouabdallah Ltaief v. Tunisia, CAT/C/31/D/189/2001, 14 November 2003; Imed Abdelli v. Tunisia, CAT/C/31/D/188/2001, 14 November 2003; CAT, Report of the Inquiry on Turkey, A/48/44/ADD.1, 15 November 1993), p. 52.

19 Daley v. Jamaica, CCPR/C/63/D/750/1997. 3 August 1998; Evans v. Trinidad and Tobago, CCPR/C/77/D/908/2000, 5 May 2003; Yong-Joo Kang v. Republic of South Korea, CCPR/C/78/D/878/1999, 16 July 2003, See also HRC, General Comment 7, Article 7 (1982), p. 2.

20 See British Columbia Civil Liberties Association

Inter-American jurisprudence also require that solitary confinement be used exceptionally[21] and, even then, proportionately.[22]

Additional requirements are stipulated in the Mandela Rules, including strict medical supervision of detainees in solitary confinement: "health care personnel… shall… pay particular attention to the health of prisoners held under any form of involuntary separation, including by visiting such prisoners on a daily basis and providing prompt medical assistance and treatment at the request of such prisoners or prison staff" (Rule 46(1)). The World Medical Association has noted that, "the provision of medical care should take place upon medical need or the request of the prisoner. Physicians should be guaranteed daily access to prisoners in solitary confinement, upon their own initiative" (World Medical Association, 2019). [23]

Solitary confinement should take place in cells that meet the minimum conditions according to the international standards, e.g., the Mandela Rules. There are further requirements related to solitary confinement imposed as a disciplinary measure, e.g., regarding the right to complain and judicial review (Rules 36 – 53 Mandela Rules).

Specifically with regards to the right to family life (and private communication etc.), as recognised pursuant to e.g., the International Covenant on Civil and Political Rights (ICCPR), the Mandela Rules require that contact with families cannot be prohibited during solitary confinement and punitive limitations of family contact are prohibited, especially with children (Rule 43(3)).[24] This means that the prisoners must be allowed to maintain some degree of contact with their family and friends through visits, as well as through adequate and frequent correspondence. However, due to security concerns, the prison authorities are afforded a degree of control over who is admitted for visits (Rule 60) and communication with family and friends can be 'under necessary supervision', usually by visual control (Rule 58 (1)). Moreover, while family contact cannot be prohibited, it can however be restricted for 'a limited time period and as strictly required for the maintenance of security and order' (Rule 43 (3)) (see ECtHR, Piechowicz v. Poland).

States are obligated under international human rights law to treat all persons equally and without discrimination. This is enshrined in several core international instruments in-

and John Howard Society v. Attorney General of Canada, 2018, B.C.J. No. 53, 2018 BCSC 62. The case has been appealed to the Supreme Court of Canada.

21 Inter-American Commission on Human Rights, Resolution 1/08, *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas*, 13 March 2008: 'Solitary confinement shall only be permitted as a disposition of last resort and for a strictly limited time, when it is evident that it is necessary to ensure legitimate interests relating to the institution's internal security, and to protect fundamental rights, such as the right to life and integrity of persons deprived of liberty or the personnel.'

22 Case of Montero-Aranguren et al. (Detention Center of Catia) v. Venezuela, Series C No. 150, Judgement of 5 July 2006.

23 The IACtHR views independent and autonomous monitoring as to the suitability of an individual to solitary confinement as essential (IACHR, Report on the Human Rights of Persons Deprived of Liberty in the Americas, OEA/Ser.L/V/II. Doc. 64, 31 December 2011, p. 417 and 418.

24 Mandela Rules (43 (3)) also provides that "the means of family contact may only be restricted for a limited time period and as strictly required for the maintenance of security and order". See also ECtHR, *Ilaşcu and others v. Moldova and Russia,* No. 48787/99, 8 July 2004, §438. With regards to women, see also Rule 23 of the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules) (2010).

cluding article 2 of the Universal Declaration of Human Rights and article 2(2) of both the ICCPR and the International Covenant on Economic, Social and Cultural Rights. These provisions explicitly prohibit discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status. This is firmly established in the jurisprudence with respect to children,[25] LGTB prisoners,[26] and prisoners with disabilities.[27]

(3) Medical/psychological aspects

Solitary confinement has been shown to have serious and often long-lasting effects on mental health and psychological and social functioning (Grassian, 2006; Craig Haney, 2018; S. Shalev & Lloyd, 2015; Shalev, 2008, 2022; Siennick et al., 2021; The Lancet, 2018). Physical symptoms may also be seen. The consequences described are surprisingly consistent across a wide range of studies, time, types of prisons, categories of detainees, and locations. This overview aims at highlighting some of the most relevant studies, both the earlier or historic ones and more recent studies.

A range of reactions has been described following isolation in detention facilities. Some relate to changes in mood, some reactions are somatic, and others are similar to or indicative of serious mental distress and illness. Across studies there is strong indication that the longer the isolation, the likelier the adverse reactions.

A few lessons learned from studies on sensory deprivation in experimental settings will be included, as solitary confinement in its strictest forms may to some extent resemble sensory deprivation, given the potential for solitary confinement to limit sensory stimulation including to light, sound and touch by other humans. Deprivation of stimuli can be depicted as a continuum, where different forms of stimulation or sensory input are present to varying degrees and intensities.

Consequences of isolation

The well-known but today highly contested experiments on sensory deprivation carried out in the 1950s showed that after only a few days of severely limited sensory inputs (light, sound and touch), the participants in the research, who were volunteers, well-prepared, and able to stop the experiment at any time, reported inability to think clearly, less control over their thinking, and loss of ability to judge time. They also showed temporary mental impairment, lowered concentration, reduced academic per-

25 The UN Committee for the Rights of the Child has consistently and on a number of occasions emphasised that all forms of solitary confinement of children should be abolished: Concluding Observations on El Salvador, CRC/C/15/Add.232, 30 June 2004, p. 36(a); Concluding Observations on Singapore, CRC/C/15/Add.220, 27 October 2003, p. 45(d); General Comment No. 10, CRC/C/GC/10, 25 April 2007, p. 89). The IACtHR has noted that a vast majority of member States have continued to apply solitary confinement as punishment towards children (IACtHR, Rapporteurship on the Rights of the Child, Juvenile Justice and Human Rights in the Americas, OEA/Ser.L/V/II. Doc. 78 (2011), p. 559) and reiterated in the same report the prohibition of 'any state practice that involves solitary confinement of children held in police premises.', p. 263. See also case law from Australia, for example Certain Children by their Litigation Guardian Sister Marie Brigid Arthur v Minister for Families and Children & Others [No 2] (2017) 52 VR 441, 554.

26 ECtHR, X v. Turkey. The UN Sub-Committee on the Prevention of Torture has also drawn attention to the plight of LGBT prisoners in isolation observing that they were 'not only likely to serve their sentences in isolation, but also more likely to serve longer time.' (SPT, Ninth annual report of the SPT, CAT/C/57/4, 22 March 2016, p. 64.

27 IACtHR, Víctor Rosario Congo v. Ecuador, Case 11.427, Report No. 12/97, IACtHR, OEA/Ser.L/V/II.95 Doc. 7 rev. at 257, judgement of 12 March 1997.

formance and more restlessness. Some developed hallucinations, anxiety and even panic (Heron, 1957; Leiderman et al., 1958).

Learning may also be drawn from emergent fields of neuro-research that have linked loneliness with among others poorer cognitive performance, faster cognitive decline and depressive cognition (as an example, see Cacioppo & Hawkley, 2009). The need for sensory stimulation for human functioning is well documented also in other types of studies. In one randomised clinical trial a group of prisoners was allocated to solitary confinement for seven days and another group to normal treatment. The former group had decreased electroencephalogram activity and visual evoked potentials latency (impacts to electrical activity in the brain and visual pathways), both indicators of neurological dysfunction. Similar findings are seen in sensory deprivation (O'Mara, 2015). Recent neuropsychological studies further indicate that extended solitary confinement can cause brain damage (Akil, 2019), even irreversible ones (Coppola, 2019, Kupers, 2017).

Psychological reactions: Frequently observed psychological reactions in prison studies, even after shorter periods of solitary confinement, are anxiety, fear, feeling low, depression, and concentration problems (Stang et al., 2003). In one study, as many as 91% were found to suffer from anxiety and nervousness, and 70% described themselves "on the verge of an emotional breakdown" (Haney, 2003). Furthermore, 77% were in a state of chronic depression and two-thirds were suffering from more than one symptom at the same time (Haney, 2003; Smith, 2006). Higher levels of aggression and anger, hostility and withdrawal from other people during and after long-term solitary confinement, have also been described (Jackson, 1983; Miller, 1997). Many report feelings of estrangement from self and others, and experiences of confusion (Perez-Sales, 2017; Sveaass, 2009).

Physical symptoms: In a study on the use of solitary confinement during pre-trial detention, 94% were found to suffer both psychological and psychosomatic adverse symptoms after four weeks (Gamman, 2001; Smith, 2011), and in another study, prisoners in solitary confinement complained about more health problems than those in regular custody, in particular headache, pain in the neck, shoulders and stomach, anxiety and depression (Gamman, 1995). Those with somatic diseases prior to seclusion deteriorated. The complaints lasted throughout the period of seclusion, but most prisoners recovered when seclusion ended. Skin reactions such as itching and rashes have also been observed in people in solitary confinement (Strong et al., 2020), as have apathy, dizziness and loss of weight (Korn, 1988).

Psychiatric disorders: The relation between isolation and psychiatric disorders is complex. During the first few months of detention, isolated detainees with a pre-existing mental health disorder have been found to maintain their level of disorder, whereas non-isolated detainees improved their situation (Andersen et al., 2003).

In one study following prisoners over time, a significantly higher percentage of prisoners in solitary confinement (28 % vs 15%) developed symptoms, the most common being related to adjustment disorders with difficulty in concentrating, insomnia, irritability, depression and sadness, anxiety, anergia and passivity as common symptoms. Typically, a mixture of anxiety, depressive and psychosomatic symptomatology was seen (Andersen et al., 2000). Uncontrolled thought processes and hallucinations have also frequently been described (Jackson, 1983).

In one study, the proportion of detainees suffering from schizophrenia, bipolar disorder,

generalised anxiety disorder, antisocial personality disorder, posttraumatic stress disorder (PTSD) and panic disorder was higher in the isolated prisoners than in the general population of detainees and the non-incarcerated groups (Hodgins et al., 1991). Detainees hospitalised in a psychiatric clinic have had an overrepresentation of those who had experienced solitary confinement (Volkart et al., 1983), and prisoners kept in solitary confinement for 4 weeks were found 20 times more likely to be admitted on a psychiatric indication compared to those who had not been in any form of solitary confinement (Sestoft et al., 1998).

Suicide and self-harm: Suicide and self-harm are frequently observed among those in solitary confinement. 13 % of one group in solitary confinement were found to engage in self-harming acts (Gamman, 2001), and in another study, those in solitary confinement were almost seven times as likely to self-harm and over six times as likely to potentially fatally self-harm as compared to those not in solitary confinement (Kaba et al, 2014). The risk of suicide has been found to increase considerably when comparing isolated with non-isolated detainees (Roma et al., 2013). Even in the first years after release, those who have been in solitary confinement/punishment cell (one form of isolation) have been found to have a higher mortality (Wildeman and Andersen 2020; Brinkley-Rubinstein et al., 2019).

Factors impacting the effect of solitary confinement

The detrimental effects of solitary confinement may be found in most persons who have endured forms of isolation, but several factors may influence the outcome (Haney, 2003; Shalev, 2008).

These factors include individual aspects like age, gender, prior health condition, cultural background, personality, former stress exposure/trauma, former placement(s) in solitary confinement, as well as preparedness, motivation and background. They also include factors related to the circumstances under which solitary confinement occurs, and aspects such as duration, general conditions in the cell, sensory inputs, mitigating factors like access to radio, television, or newspapers, activities and communication. Furthermore, information or knowledge about duration and the degree of control over the duration is important, and the lack of information about duration may affect the person more than the duration itself. Furthermore, the lack of cues to enable orientation was noted as salient (Ruff et al., 1961). Finally lack of access to services, complaints mechanisms etc., must also be considered factors impacting the effect of solitary confinement.

II. Protocol

This is a generic Protocol to guide the part of an interview that relates to documentation of solitary confinement. As such, this Protocol complements the Istanbul Protocol when specific documentation of solitary confinement is required. However, it is worth noting that ill-treatment and torture are often not based on single individual techniques (which may or may not be damaging if considered one by one) but are the result of the combined interaction of methods. Cumulative effects of the general detention and interrogation context and the various methods used are of importance and should be documented according to the Istanbul Protocol. The same is the case for cumulative effects over time of certain methods including solitary confinement.

The Protocol is designed to be used by lawyers and health professionals during interviews in a detention facility or after release. While some information may be collected by both health and legal professionals (i.e., sections 1-4), two sections of the Protocol require specific qualifications (i.e., sections 5 and 6).

The Istanbul Protocol stipulates a number of important general considerations for documentation interviews, including in relation to security concerns. If the prisoner is still held in detention, it is important to remember the person's precarious situation, assess security concerns and adopt mitigating measures if necessary. The Istanbul Protocol also stipulates general considerations for documentation interviews with particularly vulnerable groups, e.g., children. These considerations should be taken into account also when documenting solitary confinement. Moreover, when interviewing a prisoner who has been subjected to solitary confinement – and perhaps even for a prolonged period of time - it is important to remember measures to avoid triggering adverse reactions.

Interviews with children are particularly difficult. Adaptation of the questions will be required depending on the age of the child, and the child's behaviour, cognition and emotion need to be interpreted in light of its age and development. Interviews with children should therefore only be carried out by interviewers with particular expertise, experience and training so that an adequate assessment can be made of which parts of the protocol to use.

It is presupposed that the interviewer has collected personal information about the person, including age, gender etc. This information will assist in the assessment of whether the person falls within one of the categories in relation to which solitary confinement should not be used according to the Mandela Rules (see above and section 6 below) and which specific considerations need to be taken into account during the interview.

The Protocol contains six sections:

1. Informed consent
2. Subjective experience
3. Conditions and circumstances of the solitary confinement
4. Assessing health and functioning prior to detention *and* to solitary confinement
5. Assessing medical and psychological consequences, and
6. Legal assessment of solitary confinement

Section 1. Informed consent

Informed consent involves making sure that when someone consents to an interview (and to the subsequent use of the information that has been provided), the person is fully informed of and has understood the potential benefits and risks of the proposed course of action. The interviewer should obtain informed consent according to the guidelines mentioned in the Istanbul Protocol (Chapter II).

Section 2. Subjective experience

This section includes questions to be asked during the interview in order to obtain the person's description of his/her experience of solitary confinement. The answers should be collected as verbatim as possible. It presupposes that first, the interviewer asks the person to confirm that s/he has been held in a cell or other place without contact with others for a certain length of time (solitary confinement).

If this is the case, follow-up questions should be asked. The following questions may serve as inspiration, but other topics of relevance may arise during the interview.

- Why do you think you were held in solitary confinement?
- *What do you remember from the period you spent in solitary confinement?* Include additional questions about what the person saw, heard, felt, smelled, or thoughts he/she had.
- *How do you think the solitary confinement affected you when it happened and immediately afterwards?*
- If some time has passed since the person was released from solitary confinement: *Does it still affect you today? If yes, can you explain how?*

Section 3. Circumstances and conditions of solitary confinement

With a view to supplement what has already been described in the previous section, this section presents questions that can be asked during the interview to obtain an account of what happened as objectively and concretely as possible. Note that there may be some gaps in the information, but the interview should aim at collecting the facts in as detailed a manner as possible.

a. The events leading up to the solitary confinement
   - *How were you moved into solitary confinement?*
   - *What was the process leading up to the solitary confinement?* (e.g., if solitary confinement was a disciplinary sanction)
   - *What information were you given and when?* (e.g., about the reason for solitary confinement, expected duration, regime, complaint options, reviews and medical visits)
   - *Do you have any pre-existing health conditions that might affect you during solitary confinement, and if so, were the detaining authorities aware of those, and did they take them into account? (e.g., claustrophobia, anxiety, depression)*

b. Duration
   - *How many days/weeks/months/years have you been in solitary confinement in total?*

- *Was this one consecutive period, did you have any breaks from the solitary confinement during this time, or did you have multiple stays in solitary confinement? (i.e., a description of length of different stays and breaks)*

c. Contact with others during solitary confinement
   - *Who were you in contact with during your time in solitary confinement?*
   - *How often were you in contact with these people, and for how long?*
   - *What was the purpose of this contact? (e.g., bringing person to the bathroom, serving food, check-in by staff, visits from outside)*
   - *How were you in contact with these people? (e.g., by phone, through door, visit in the cell, access to others outside of cell)*
   - *What was the purpose of the different types of contact you had?*
   - *Did you get a chance to speak with them, were they silent all the time, or were you expected to keep silent?*

d. Conditions under which the solitary confinement took place

Try to collect as much information as possible about the room in which the solitary confinement took place and about the general conditions during solitary confinement. This may include:

- *Size and condition of the room*
- *Type and condition of bed and other furniture*
- *Access to outdoor air and light in the room (presence and size of windows, doors, ventilation openings)*
- *Artificial light and switches*
- *Temperature, dampness and air quality*
- *Sounds – noise – silence, incl. changes during the day*
- *Possibilities to indicate time, e.g., clock, watch, prayer calls*
- *Level of cleanliness including presence of dirt, mould, insects or other animals*
- *Access to clothes, footwear, covers/blankets*
- *Access to food, water, and toilet facilities (how often, time between, on demand?)*
- *Access to warning button/alarm or other means to notify staff in case of need*
- *Use of restraints (when, which types)*
- *Access to reading materials, radio, TV, or other activities in the room*
- *Access to work, open air exercise or other activities outside of the room (what, how often, for how long?)*

e. Contact with health professionals during solitary confinement
   - *Did you receive unsolicited visits by a health professional during solitary confinement?*
   - *If yes, how often did these visits happen? How long did the visits take, and what did the health professional do? Were you able to speak to the health professional in private?*
   - *Did you yourself request to see a doctor or other health professional during the solitary confinement, and was your request granted?*

f. Access to legal safeguards during solitary confinement
   - *Were you able to file a complaint about being placed in solitary confinement or the conditions of the confinement?*
   - *Did you have access to free legal aid or to see a lawyer?*
   - *Did regular reviews of the decision to place you in solitary confinement take place, and did you get a chance to be heard during these reviews? How often did these reviews happen?*

Section 4. Assessing health and functioning prior to detention and solitary confinement
This section is intended to gain information about the person's health status and functioning prior to detention and to solitary confinement. This serves three main purposes:

- Identifying any pre-existing conditions may help when arguing that the person should not have been placed in solitary confinement due to particular vulnerabilities.
- Comparing the person's health status pre and post solitary confinement may assist in assessing the impact that the isolation may have had.
- Determining in court proceedings whether the plaintiff has the burden of proof (see section 6).

Before asking the below questions, the interview should clarify whether previously, the person has spent time in solitary confinement as well as reactions experienced. For each instance, information should be collected about when, where and under which conditions.

Please collect the answers as verbatim as possible.

1. Physical and mental health related problems prior to detention and prior to experiencing solitary confinement *(preferably to be asked by a health professional)*.
2. If the person has spent time in detention prior to solitary confinement, ask also about physical and mental health related problems prior to solitary confinement *(preferably to be asked by a health professional)*.
3. General level of functioning prior to detention. Issues may include living conditions, educational background, work and other forms of daily activities, financial situation, family situation, plans and aims.
4. If the person has spent time in detention prior to solitary confinement, ask also about the level of functioning in detention prior to be placed in solitary confinement. Issues may include relations to other detainees and staff, and work or other activities.

Section 5. Assessing physical and psychological consequences
This section of the Protocol should be used either by a medical or psychological expert. The following questions serve as inspiration as to what would be relevant to ask to assess physical and psychological consequences, bearing in mind that the specifics of the person and the situation in which the interview takes place should always be taken into account. Please provide a detailed description of the person's responses.

If an interviewer without medical or psychological expertise is not available, and taking into account the experience of the interviewer, the first four questions below might still be asked, but caution should be exercised to avoid intimidating the person interviewed.

- *Did you experience any physical symptoms while being in solitary confinement (e.g., pain, sleeping problems, nausea, dizziness, bodily tension)?* Please describe in detail.
- *Did you experience any mental health problems while being in solitary confinement?* Please describe in detail.
- *Have you ever required medical or psychological treatment for these problems?*
- *Do you currently experience any mental health or social problems that you attribute to having been in solitary confinement?*

Further details about the person's reactions to solitary confinement can be collected using the below two checklists and the additional questions related to the person's interaction with others. The elements of the checklists and the questions are designed to be used after solitary confinement has been terminated. They may also serve as inspiration while interviewing someone who is still in solitary confinement, but the precarious situation and the mental state of the person needs to be taken into account when deciding on the level of detail of the questions asked.

1: Checklist of cognitive symptoms:
This checklist assesses the person's cognitive symptoms during solitary confinement and afterwards. [28] When asking questions, please seek details of any of the below items (e.g., circumstances, symptoms, subjective experience or whatever can help to understand the item).

Table 1. Checklist of cognitive symptoms:

	Did any of these symptoms occur while in solitary confinement, and how often?	What was the situation after solitary confinement?
	1. Never 2. Sometimes 3. Often 4. All the time	1. Not applicable 2. Improved 3. Unchanged 4. Worsened
1. Did you ever lose **consciousness**?		
If yes: Reasons for losing consciousness: (a) Beatings to the head or other head trauma (b) Suffocation/asphyxia (c) Emotional fainting due to anxiety or fear (d) Other forms of pain (e) Other		
2. Orientation. Were you able to say more or less how much time you had been detained in solitary confinement?		
3. Orientation. Did you usually know, approximately, the time of the day? (morning, afternoon, evening or night)		
4. Awareness. Did you feel sleepy most of the day?		

28 Items selected and adapted from MOCA and Brief Neuropsychological Assessment questionnaires to a context of detention and solitary confinement.

5. **Concentration and Memory**. Did you ever notice that you could not remember basic information about yourself (e.g., the name of very close family members, details from your childhood)?		
6. **Concentration and Memory**. Did it happen that you were not able to understand even simple questions from others?		
7. **Concentration and Memory**. Were you able to recall, immediately after having been in solitary confinement, how your cell was (do not use if the person was blindfolded)?		
8. **Concentration and Memory**. Did you notice any difficulties in concentrating on tasks or activities you were engaged in?		
9. **Perception**. Did you perceive your surroundings altered (e.g., walls, ceiling as moving or as falling upon you?)		
10. **Perception**. Did you hear voices or see figures outside your head and later you realised that they were unreal?		
11. Judgement. Did you experience any situation where you tried to talk but found it difficult to find the right words and/or you felt blocked?		
12. **Judgement**. Were your legal rights explained to you, but you were not able to understand the contents of the conversation?		
13. **Judgement**. Were you presented with documents (e.g., confession, statement, etc.) that you were not able to understand?		
14. **Subjective Self-Assessment**. Do you think you were fit to make decisions of any kind?		

2: Checklist of emotional symptoms:

This checklist assesses the emotions during solitary confinement and afterwards. [29]

Questions related to the person's interactions with others:

- *After having been in solitary confinement, have you experienced any changes in your desire to be with others?* (e.g., wanting more or less contact, withdrawing from others or avoiding others altogether)
- *Do you experience any problems when being with others?* (e.g., concentration problems, lack of trust, disturbing thoughts, disturbing emotions (e.g., anger or disappointment), or psychosomatic reactions (e.g., sweating, dry mouth, shaking, or dizziness))
- *Do you feel that being with others can help you?*
- *Is there a difference in your reactions depending on who you are with?* (e.g., family, friends, colleagues)
- *Do you feel that your reactions to being with others make things difficult for you?* (e.g., influences how the person fulfils his/her role in the family or the ability to work or study)

29 Items selected and adapted from the Positive and Negative Affect Schedule (PANAS) and Profile of Mood States (POMS) to a context of detention and solitary confinement.

Table 2. Checklist of emotional symptoms.

	Did any of these emotions occur while in solitary confinement, and how often?	What was the situation after solitary confinement?
	1. Never 2. Sometimes 3. Often 4. All the time	1. Not applicable 2. Improved 3. Unchanged 4. Worsened
Emotions, Feelings and Somatisation		
1. **Sadness**		
2. **Anger** (at yourself or others)		
3. **Terror, Fear**		
4. **Anxiety** including problems breathing, or panic attacks		
5. **Pain** without apparent reason (e.g., stomachache, headaches or other reactions)		

Acting emotions		
6. Self-Harm. Urge to harm yourself (e.g., cutting or hitting)		
7. Suicide ideation. Thoughts about taking your own life		
8. Suicide plans or actions. You had a defined plan or even tried to kill yourself		
9. Apathy. Feeling abandoned and without hope		
Secondary Emotions – Emotions related to others		
10. Shame. Intense humiliation or degradation		
11. Guilt. Self-accusation or intense remorse		
Detaching emotions		
12. Dissociation. Feeling that everything was unreal. Dazed, as if everything did not really happen to you.		
Positive Emotions		
13. Control. Calm, feeling in charge		
14. Happiness. Moments of joy despite everything		

Further assessments:
Annex A includes a selection of clinical scales that may be used for the full assessment of the person as per the Istanbul Protocol. These scales may be used also *in relation to solitary confinement.* For instance, if the PCL-C-V is used to assess symptoms of post-traumatic stress disorder, explain to the person that each item (flashbacks, avoidance behaviours, intruding thoughts) should be considered in relation to solitary confinement (i.e., flashbacks or recurrent thoughts on the time in solitary confinement, avoidance of being alone etc). When doing the assessment, use the most recent and validated versions of the clinical scales available.

Conclusion:
You should end your assessment with summarizing the findings, if possible using the ICD or DSM diagnostic systems.

Section 6. Legal assessment of solitary confinement

This section of the Protocol should be used by a legal professional. Try during the interview to seek the below mentioned information that will be useful for the legal assessment of the case.

When assessing the measure in light of international law, there are different questions to be considered:

- What type of solitary confinement was imposed in the specific case and why?
- Did the person belong to one of the vulnerable groups who should not be subjected to solitary confinement according to the Mandela Rules?

- Did the measure violate other principles of the Mandela Rules?
- E.g., was the measure in violation of an absolute prohibition?
- Did the measure amount to torture or ill-treatment (Articles 1 or 16 UNCAT)?
- Did solitary confinement violate other human rights norms? This legal assessment would relate to, *inter alia*, freedom from non-discrimination i.e., whether the instance was imposed discriminatorily.

At a procedural level, it is worth remembering that the general rule across jurisdictions is that the plaintiff has the obligation to prove his claims. However, if the plaintiff can document good health when detained whereas this was no longer the case when released, then the burden of proof may change to the defending state, as it happens in European jurisprudence (ECtHR, *Ribitsch v Austria*). If you have managed to collect information about the person's health prior to detention and to solitary confinement (see above), this may prove of relevance for procedural questions.

Interpreting and using medical and psychological assessment results

In light of the above legal discussion, it is likely that argumentation could be supported by assessments undertaken by health professionals.

When assessing the outcomes of such assessments, guidance can be sought in the Istanbul Protocol and the following questions should be raised:

- Do the findings suggest that solitary confinement has led to physical and/or mental health problems?
- May pre-existing mental health problems have increased the risk of exacerbating mental health problems while in solitary confinement?
- May pre-existing mental health problems have led to solitary confinement?

Annex 1. Solitary Confinement. Quick Interviewing Guide.

Quick interviewing guide.

1. Ask openly about the alleged victim's **subjective experience** of solitary confinement. Collect answers as verbatim as possible.

   - Why were you held in solitary confinement?
   - What do you remember from the time spent in solitary confinement?
   - How did it affect you when it happened and immediately afterwards?
   - Does it still affect you today? If yes, how?

2. **Circumstances and conditions.**

   - What were the events leading up to solitary confinement?
   - How much time did you spend in solitary confinement? One or several episodes?
   - Who were you in contact with during the time in solitary confinement, how; how often; and for what purpose?
   - How were the conditions under which solitary confinement took place, e.g. conditions of the cell and access to a toilet; use of restraints; access to work and activities?
   - Did you have access to a health professional?
   - Did you have access to a lawyer and was the decision of solitary confinement reviewed regularly?
   - Were you able to file a complaint?

3. **Health and functioning prior to detention and solitary confinement.** This section serves to:
   - Identify pre-existing health-conditions that indicate particular vulnerabilities
   - compare health status pre and post solitary confinement
   - determine whether the plaintiff has the burden of proof

   Collect information about:

   - Previous solitary confinement and reactions
   - Physical and mental health related problems prior to detention
   - Physical and mental health problems prior to solitary confinement
   - General level of functioning prior to detention, incl. living conditions; financial situation; family situation; plans and aims
   - Level of functioning while in detention but prior to solitary confinement, incl. relation to other detainees and staff; work and other activities

4. **Physical and psychological consequences of solitary confinement.**

   - Did you experience any physical symptoms while being in solitary confinement?
   - Did you experience any mental health problems while being in solitary confinement?
   - Have you ever required medical or psychological treatment for these problems?
   - Do you currently experience any mental health or social problems that you attribute to having been in solitary confinement?
   - In addition to these questions, checklists to explore in depth potential cognitive and emotional reactions can be used by health professionals.

5. **Legal assessment** (not part of the interview):

   - What type of solitary confinement was imposed?
   - Did the person belong to a vulnerable group who should not be subjected to solitary confinement?
   - Did the measure violate other principles of the Mandela Rules?
   - Did the measure amount to torture or ill-treatment?
   - Were other human rights norms violated?
   - How does the medical/psychological assessment contribute to conclusions?

Annex 2. Additional questionnaires

This Protocol can be complemented with the following assessment tools. Some of these are referenced in the Protocol, others included for information.

Posttraumatic Stress Disorder (PTSD): The Posttraumatic Checklist Civilian Version 5 (PCL-C-5), a 20-item questionnaire that provides a diagnosis of PTSD according to DSM-V Criteria. There are also short screening versions available. The International Trauma Questionnaire is a 12-item measure that provides diagnoses of PTSD and Complex PTSD according to ICD-11. The Dissociative Experiences Scale (DES-II) provides a measure of states of dissociation. Can be tailored to reaction within detention periods.

Daily Functioning: Consider measures that assess the autonomy of the person after release from detention (e.g., work, study, community and family life).

Montreal Cognitive Assessment (MOCA). 30 items assessing neurocognitive functioning. Administration takes around 15'. Ziad S. Nasreddine MD, et al, The Montreal Cognitive

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Brief Neuropsychological Assessment – Mini Mental State Examination. 30 items measure that screen for cognitive impairment linked to medical conditions. Folstein MF, Folstein SE, McHugh PR. "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res. 1975;12:189-19.

Positive and Negative Affect Schedule (PANAS). Short scale that consists of two 10-item mood scales to measure emotional reactions to a given situation. D. Watson, L.A. Clark, and A. Tellegen (1988). Development and Validation of Brief Measures of Positive and Negative Affect: The PANAS Scales. Journal of Personality and Social Psychology, 54, 1063-1070.

Profile of Mood States (POMS). 65 items assessing 7 different mood domains. McNair, D., Lorr, M., & Droppleman, L. (1971). *Manual for the Profile of Mood States*. San Diego: Educational and Industrial Testing Service.

Intentionality Assessment Checklist (IAC). This is an aid to assess the alleged torture perpetrator's intent. It helps to systematically assess all potentially pertinent elements, without aiming to provide a score but an overall perspective of elements relevant to intentionality. Pau Pérez-Sales, *Psychological Torture*, Routledge. p. 375

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