

30 years of solitary confinement: What has changed, and what still needs to happen

Sharon Shalev

Abstract

Solitary confinement cells are where those considered to be too dangerous to themselves or to others, too troublesome, too mentally unwell, or simply different, will be locked away, spending 22-24 hours a day alone, out of sight and out of mind.

Solitary confinement is an extreme and harmful practice on the cusp of prohibited treatment of people deprived of their liberty, with potentially grave consequences for the individuals concerned and the societies to which they eventually return.

This article reflects on some of the achievements, and remaining challenges, around the use and regulation of solitary confinement practices internationally in the last 30 years, drawing on recent developments and the author's work in the area.

Introduction

Solitary confinement is regularly and commonly practiced in closed institutions, including prisons; psychiatric hospitals (where it is sometimes called 'seclusion' or 'isolation'); police detention; jails holding pre-trial detainees and people undergoing interrogation; and immigration detention facilities.

Solitary confinement is often the precursor to torture, as well as being a form of ill treatment, and sometimes torture, in itself. Solitary

confinement cells are where those undergoing coercive interrogation will be housed, and to which they will be returned once the interrogation is over. It is where, in countries still practicing the death penalty, people awaiting execution will typically be held, and where spies and 'enemies of the state' may spend years and decades. It is where prisoners who committed an offence in prison, or broke a prison rule, will serve the punishment of being banished from the prison society- usually as a short, but 'hard', punishment. It is where those considered to be too dangerous to themselves or to others, too troublesome or too mentally unwell will be housed. In all these instances solitary confinement means being locked away and apart from other human beings in a small cell where the individual will have to sleep, eat, defecate, and spend 22-24 hours alone, out of sight and out of mind.

Solitary confinement is an extreme practice on the cusp of prohibited treatment of people deprived of their liberty, with potentially extreme consequences for the individuals concerned and the societies to which they eventually return.

This article reflects on some of the achievements, and remaining challenges, around the use and regulation of solitary confinement practices internationally in the last 30 years. I have been researching and active in this field for most of the lifespan of this journal, and as

the editors have been generous in their remit, I thought that I would use this opportunity to reflect on these developments from the perspective of my own work in the area.

Shining a light on solitary

My interest in solitary confinement dates back to the early 1990's and my work as Complaints Coordinator for Israeli-Palestinian Physicians for Human Rights. In the course of our work, we encountered people who were isolated during their interrogation by the security services, often with dire health consequences. The purpose of solitary confinement in the context of coercive interrogation is set out in an FBI manual on interrogation techniques as follows:

“Isolation of the detainee not only ensures the safety of other detainees but also prevents the individual detainee from drawing strength from the support and companionship of other detainees. It also prevents collusion on cover stories between detainees. A large part of the Interrogators [sic] advantage is the natural fear of the unknown that the detainee will be experiencing. Exposure to other detainees will mitigate that fear. if the policy of the facility permits consider having your detainee placed in an individual cell several days before you begin interrogation”

FBI, 2010.

From the interrogator's perspective, the supposed advantages of solitary confinement as an interrogation technique are obvious- it does not require any physical contact with the detainee – no electric shocks, beatings or other torturing of the body are required. And it does not leave broken bones and physical scars.

Putting aside though the questionable quality of information obtained through such methods and the concerns around the detain-

ee's access to justice (O'Mara, 2015; Ginbar, 2008; Physicians for Human Rights, 2007), the hope and expectation of adverse psychological effects as a result of being isolated from others set out in the FBI's interrogation manual, hints at why solitary confinement is a controversial and problematic practice.

Solitary confinement 'attacks' the isolated individual in two ways: it places them in highly stressful conditions, and it takes away the usual coping mechanisms- access to human company, nature, and things to do. Perhaps unsurprisingly, the documented adverse health effects of solitary confinement are both psychological and physiological, and wide ranging (World Health Organisation, 2014. See also Haney, 2018). Neuroscientific research demonstrate that solitary confinement and the reduced sensory input associated with it affect not only brain function, but also brain architecture, resulting in irreversible changes (Akil, 2019; See also Coppola, 2019).

Solitary confinement may not leave physical scars, but as the title of an article written by Hernan Reyes MD, a colleague and long-time collaborator in efforts to reduce the use of solitary confinement, asserted, the worst scars are in the mind (Reyes, 2007. See also Perez-Sales, 2016). The literature on the health effects of solitary confinement as well as personal accounts by incarcerated and formerly incarcerated people (Casella, Ridgeway and Shroud, 2016), make it clear that solitary confinement has a devastating effect on the human mind, making it- at least arguably – a form of psychological torture.

William Blake, a man who at the time was serving his 25th year in solitary confinement in a US supermax prison, wrote:

I've read of the studies done regarding the effects of long-term isolation in soli-

tary confinement on inmates, seen how researchers say it can ruin a man's mind, and I've watched with my own eyes the slow descent of men into madness- sometimes not so slow. What I've never seen the experts write about, though, is what year after year of abject isolation can do to that immaterial part in our middle where hopes survive or die, and the spirit resides. So please allow me to speak to you of what I've seen and felt during some of the harder times of my twenty-five-year SHU odyssey. I've experienced times so difficult and felt boredom and loneliness to such a degree that it seemed to be a physical thing inside so thick it felt like it was choking me, trying to squeeze the sanity from my mind, the spirit from my soul, and the life from my body."

Blake, 2016:29.

Serving and former prisoners who have spent long stretches in solitary confinement have told me about times when they provoked guards, knowing that they would be wrestled down to the ground, just to be touched by another human being, or times when they cut themselves just to see the blood flow, affirming they were still alive. Others described solitary confinement like being in a pressure cooker, waiting to explode, or being in a coffin.

Research has shown that the harms of solitary confinement can also continue to affect individuals after their release from prison. People who have previously spent time in solitary confinement describe how, even many years later, they are unable to form intimate relationships and are uncomfortable in social settings, preferring instead to lead a life of solitude. Some opt for more extreme options. One study found an association between solitary confinement and elevated mortality due

to non-natural causes in individuals who had previously spent time in solitary confinement (Wildeman & Andersen, 2020).

Solitary confinement and human rights law pre-2015

Despite a recognition of the damaging effects of solitary confinement and the obvious contradiction between these and the proclaimed wish of most prison systems¹ to 'rehabilitate' 'reform' or 'reintegrate' those in their custody, until recently there was little reference to the practice in the international arena. The UN Standard Minimum Rules for the Treatment of Prisoners (SMR) from 1955 only address the more obviously torturous, or medieval aspects of the practice. Not mentioning solitary confinement by name, Rule 31 stipulates only that:

Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.

Rule 32 places the burden of supervising punishments on the prison doctor, requiring that

32. (1) Punishment by close confinement or reduction of diet shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

(2) The same shall apply to any other punishment that may be prejudicial to the physical or mental health of a prisoner. In no case may such punishment be contrary to or depart from the principle stated in rule 31.

1 The discussion which follows centres around the use of solitary confinement in prisons, though, as noted, it is practiced in other closed institutions too.

(3) The medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical or mental health.

Just before the birth of this Journal, in December 1990, the United Nations Basic Principles for the Treatment of Prisoners were adopted. These principles included a call on Member States to ensure that,

Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged (Principle 7).

Whilst this represented, at least on paper, a step forward, the call to abolish solitary confinement fell largely on deaf ears and did little to stem its use across the world. The United States in particular saw in fact a massive increase in the use of solitary confinement. From the mid-1990s and throughout the 2000s, supermaximum security (or 'supermax') prisons, designed specifically to hold many hundreds of people each in strict and prolonged solitary confinement, proliferated across the United States. At their peak, across the US, they housed an estimated 80,000 people, typically in 8x8 foot boxes, containing an open toilet/basin combination, a concrete plinth for a bed and a small concrete table/stall unit, for 23+ hours a day, separated from the world at large as well as their peers, and completely dependent on prison staff for the provision of all their basic daily needs.

Access to these prisons from outsiders was (and is- the UN Special Rapporteur on Torture's repeated requests to visit have been refused), extraordinarily tightly controlled, feeding into a myth of super-predatory indi-

viduals locked up in these 'supermax' prisons, and from whom society allegedly needed protecting.² With big economic advantages to rural communities from the large high-tech prisons and pressure from prison guard unions to minimise the risk that their members were said to face in their places of work by isolating all prisoners in single cells, the spread of supermaxes proceeded largely unchecked.

Perhaps unsurprisingly when- following the events of September 11th 2001, and the launch of its declared 'war on terror'- the US needed somewhere to place people suspected of terrorism who were apprehended by its armed forces in Afghanistan, it looked to its own prisons for inspiration. The Supermax model was deemed to be suitable for detaining (without charge) 'enemy combatants', and the now notorious Guantanamo Bay prison was directly modelled on a US Supermax (Miami Correctional Facility in Indianapolis).

As conditions and practices at Guantanamo Bay and the legal status of those detained there became more widely discussed, calls to close it became more widespread (Cohn, 2011; Smith, 2007). Interestingly, though, highlighting of practices in Guantanamo Bay did not translate into a greater focus on supermax prisons in the US itself.³ In

2 Shalev, 2009. I had the dubious good fortune of visiting two supermax prisons in the course of making a documentary film in 1999 for an American TV network, which meant that doors (and a great number of them need to be unlocked to get in the guts of a supermax- I counted ten doors and gates from entering the prison site to a cell) were miraculously opened. The days we spent in Pelican Bay Secure Housing Unit in California and the Special Management Unit in Arizona remain perhaps the most memorable days of fieldwork in my many years of visiting solitary confinement units.

3 Although a small but persistent and group of US based colleagues have worked tirelessly to

fact, supermax prisons remained in such high use that when the then US President Barack Obama announced that he intended to close Guantanamo, the idea of transferring the detainees to the Federal Supermax in Denver, Colorado, was mooted and rejected, as the prison was reportedly ‘too full’ (Finely, 2009).

The US courts, while on occasion clearly outraged by some of the practices in supermax prisons, have stopped short of declaring that the strict and prolonged solitary confinement experienced by prisoners is, in itself and for all prisoners, cruel, inhuman, or degrading treatment or punishment. Despite some successful class action lawsuits ordering significant modifications in their operation,⁴ supermax prisons are still in use across the United States, with solitary confinement remaining the key mode of incarceration in them. The compact and rigid

architectural design of supermax prisons, which is entirely centred around the single solitary cell and allows for little or no communal spaces, means that changing their function would in any case be near impossible (Shalev, 2009).

The specific brand of supermax confinement as exercised in the US did not cross the Atlantic into Europe where most jurisdictions, by and large, rejected the worst excesses of the US prisons and ‘resisted punitiveness’ (Snacken, 2010). But, as Committee for the Prevention of Torture (CPT) reports show time and time again, the (mis)use of solitary confinement in closed institutions remains a problem in many European jurisdictions too. The European Court on Human Rights has stated that:

Complete sensory isolation, coupled with total social isolation, can destroy the personality and constitutes a form of inhuman treatment which cannot be justified by the requirements of security or any other reason.

Ramirez Sanchez, 2006.

Yet, when asked to determine whether solitary confinement was a form of torture, inhuman and degrading treatment, in violation of Article 3 of the European Convention on Human Rights, the Court has found that, although undesirable, “the prohibition of contact with other prisoners for security, disciplinary or protective reasons does not in itself amount to inhuman treatment or punishment” (Ibid. § 123. See also Rodley & Pollard, 2009; Morgan & Evans, 2002; Shalev, 2011).

It was not until the adoption by the UN General Assembly of the Istanbul Statement on the Use and Effects of Solitary Confinement in 2007, and the revision of the UN Standard Minimum Rules in 2015 (renamed as the Nelson Mandela Rules), that the age-old practice of solitary confinement begun receiving

stem the spread of the solitary confinement, attest to its harms and advocate against its use in supermax prisons since their early days. Dr Stuart Grassian, a Boston based psychiatrist, Prof. Craig Haney, a social-psychologist from Santa Cruz, California, Dr Terry Kupers, a psychiatrist, Amy Fettig and David Fathi from the American Civil Liberties Union and the Stop Solitary Campaign, Don Spector from the Prison Law Office Bonnie Kerness of American Friends Service Committee, Jamie Fellner from Human Rights Watch, scholars and lawyers including Jim Boston, Alan Miles, Lorna Rhodes, Margo Schlanger, Laura Rovner, Jules Lobel and the late Hans Toch, journalists Lance Tapley, Alan Prendergast, Susan Greene, and Jean Casella and the late James Ridgway, who later set up Solitary Watch (a key resource on all things solitary in the United States), and former Corrections leaders Jerome Miller and Chase Riveland, are some of the key individuals associated with the early days of the push back against the spread of supermax prisons. Many others have joined since.

4 For example, ending the use of indeterminate solitary confinement in California (Ashker, 2012) and prohibiting the solitary confinement of youth in Mississippi (C.B., et al., 2012).

concentrated attention in the human rights world, including the first ever international law definition of what ‘solitary confinement’ actually means.

The Istanbul Statement on the Use and Effects of Solitary Confinement was initially drafted by Peter Scharff-Smith and me and then expanded, revised, and introduced to participants of the International Psychological Trauma Symposium in Istanbul in 2007. Peter has written an article for this very journal providing background on the Istanbul Statement, so I shall not elaborate here, other than to note that much of the ensuing language around the use and regulation of solitary confinement dates back to the Istanbul meeting.

A crucial actor at the Istanbul meeting and later efforts to promote a reform of solitary confinement practices was the then UN Special Rapporteur on Torture (SRT), Manfred Nowak. He engaged in quiet but energetic diplomacy throughout the conference – for example, being the go-between when our Turkish hosts who wanted so-called ‘small-group isolation’, such as that practiced in the infamous F-Type prisons in Turkey (Human Rights Watch, 2001) to be included in the definition of solitary confinement, whereas others, myself included, thought that ‘solitary confinement’ should mean exactly that. The final text of the Istanbul Statement was presented to conference participants and endorsed by them. In 2008, the SRT introduced the Statement to the UN General Assembly and gained endorsement for it. Later that year, my ‘Sourcebook on Solitary Confinement’ (Shalev, 2018), which brought together for the first-time various aspects of solitary confinement, including its health effects and medical ethics in prison health work, was published. The Sourcebook filled an important gap and helped to stimulate and inform a public and professional debate on

solitary confinement and international efforts to reform the practice.

The excellent work of the UN Special Rapporteur on Torture advocating against the extensive use of solitary confinement around the world continued and intensified with the appointment of the next Special Rapporteur on Torture, Juan Mendez. His influential 2011 report on solitary confinement and ongoing engagement with reform efforts spurred on and fed into the eventual revision of the UN SMR (UN, 2011).

The revision of the UN SMR was formalised at the Crime Commission’s meeting in Cape Town, South Africa in March 2015, where a consensus was reached on the text of the Rules, which were renamed the Nelson Mandela Rules (for background see Huber, 2016).

Solitary confinement and the Mandela Rules: achievements and some remaining issues

The Mandela Rules, with a new section focusing entirely on solitary confinement practices, prohibiting the use of indeterminate or prolonged (defined as longer than 15 days) solitary confinement, calling for a reduction in its use to an absolute minimum, and placing a strict limit on its duration, present a tremendous achievement which many people worked hard to achieve.⁵ The revised Rules help focus

5 Of particular note are efforts led first by Penal Reform International’s Policy Director, Mary Murphy, and later by Andrea Huber who replaced her and, alongside Olivia Rope, energetically took forward work on revising the SMR. Starting in 2010, PRI convened a series of expert meetings, which I took part in, to discuss the proposed revisions and help draft the new SMR sections, one of which was to address solitary confinement. In consultation with Hernan Reyes and Jonathan Beynon, I drafted some suggestions for the solitary confinement related text. The proposed revisions were discussed, modified, and put forward to the

minds on the harms of solitary confinement, and the fine line between permissible treatment and inhuman treatment. But the Rules leave open some questions and issues, including the role of health professionals in solitary confinement units.

The remainder of this article examines the contribution of the Mandela Rules, some open questions, and some of the shortcomings of the Rules, with regard to provisions related to the use of solitary confinement.

Defining solitary confinement

One of the key contributions of the Mandela Rules is the offer of a definition of ‘solitary confinement’. According to Rule 44:

For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact.

This definition may seem obvious, but one of the most persistent issues around the use of solitary confinement, ever since the early days of its use in the 19th century and to date, is one of definition.

first experts meeting arranged jointly by PRI and the Human Rights Centre at Essex university in 2012 to “provide recommendations on possible wording for revised Rules” (PRI, 2017:5). The text was further discussed in two subsequent meetings, chaired by the late Professor Sir Nigel Rodley who imparted his immense knowledge, experience, and humour to proceedings, and were followed up by email exchanges between the working group on solitary confinement. “The deliberations of the group of experts – which have become known informally as the ‘Essex papers’ – were submitted to the Inter-governmental Expert Group Meeting (IEGM) established at the UN level to negotiate a review of the Rules (PRI, 2017:5). A final meeting was held in 2016 to propose guidance on the implementation of the Mandela Rules, published as Essex Paper 3 (PRI, 2017).

Prison authorities in particular are not keen on the term, and throughout its long history solitary confinement has been known by a variety of names, typically indicative of the purpose that the name-giver wanted to ascribe to the unit- ‘Intervention and Support Unit’; ‘Special Management Unit’; ‘Structured Interventions Unit’; ‘Control Unit’ and so on.⁶ The physical space bearing all these different names has though, throughout the years, remained remarkably similar.

There is a reason for this. Renaming solitary confinement enables the name-givers to distance themselves from the damages of solitary confinement and present their (solitary confinement-like) practices, to themselves and to others- as something completely different. It also enables prison authorities to respond to legal challenges and judicial interventions condemning their solitary confinement practices by saying that they no longer practice solitary confinement, and therefore any criticisms are no longer valid.

A recent example of this is the introduction of Structured Intervention Units (SIUs) in Canada as an alternative to the much criticised ‘Administrative Segregation Units’ to resolve ongoing legal challenges to practices amounting to solitary confinement. Informed critics note, however, that the change of name and declared intentions have not in fact been

6 For example, see a tweet accompanying a video issued by New Zealand’s Department of Corrections in October 2017 which read: “We don’t use solitary confinement - but sometimes we have to restrict prisoners’ contact to keep everyone safe. We call this segregation.” (<https://twitter.com/CorrectionsNZ/status/925579921677737984>). Having written three reports about practices in New Zealand’s prisons, I can categorically say that practices there absolutely constitute solitary confinement as defined in the Mandela Rules (See my reports at: www.solitaryconfinement.org/new-zealand).

reflected in any change in practices on the ground (Wright, 2019).

Meaningful human contact

The origins of the term ‘meaningful human contact’ can be traced back to the Istanbul Statement. It is interesting to note that, originally, we did not intend for the term ‘meaningful human contact’ to define solitary confinement. Rather we attempted to describe what solitary confinement looks like in practice across jurisdictions, regardless of what it was called, or the official reasons for imposing it. This is an important point, because, as discussed below, the term has proven to be problematic.

The Istanbul Statement defines solitary confinement as:

Solitary confinement is the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic.

In the Mandela Rules, the term ‘meaningful human contact’ becomes part of what distinguishes between permissible and prohibited practice. Rule 44 states: “solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact.”

The drafting of the Mandela Rules suggests that, so long as the isolated individual can enjoy some ‘meaningful human contact’, and so long as their solitary confinement does not

become prolonged (longer than 15 days) and hence prohibited, their solitary confinement is permissible. Further, the term ‘meaningful human contact’ has proven to be problematic and difficult to demonstrate or disprove. Even in jurisdictions keen to adhere to the Rules, the term has led to what I can only describe as petty accountancy, with prison authorities documenting every interaction, even ones lasting a few minutes, in the hope that these will amount to sufficient, demonstrable ‘meaningful human contact’.

The Essex Expert Group, which convened for the purpose of providing guidance on the interpretation and implementation of the Mandela Rules, suggested that, for contact to be ‘meaningful’,

Such interaction requires the human contact 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.

PRI, 2017:88-89

This precludes strictly utilitarian interactions such as giving a prisoner their food tray or escorting them to the exercise yard, although these activities may well involve ‘meaningful interaction’. Indeed, in some prisons I found that yard time was used by segregation unit staff to interact with segregated prisoners and gauge their state of health and wellbeing, whereas in others cell and yard doors are operated remotely, eliminating the need for face-to-face interaction altogether.

But how do you measure and assess ‘meaningful human contact’? what constitutes ‘meaningful human contact’? how long does the contact have to last for it to be ‘meaningful’?

ful'? who does it need to be meaningful to? and importantly, is 'meaningful human contact', whatever it is, sufficient to maintain the health and wellbeing of someone in solitary confinement? I am not convinced that it is.

Is there an 'acceptable' duration in solitary confinement, and if so, what is it?

The Mandela Rules, following the Istanbul Statement, set the time frame for a practice to fall under the definition of 'solitary confinement' at '22 hours or more a day'. As noted above, the inclusion of this timeframe reflected the Istanbul Statement's attempt to describe what solitary confinement entailed in practice, and many jurisdictions allow even isolated individuals to spend an hour or so outside the cell. We felt that not specifying a timeframe might lead to any practice which is short of 24 hours alone in cell being not deemed to be solitary confinement.

But this definition raises some issues: first, it focuses the mind on this artificial cut-point of 22 hours, rather than on the practice itself. Secondly, it puts into question practices that look and feel like solitary confinement but involve less than 22 hours in the cell. Where do you draw the line? 21.5 hours in cell? Third, this definition does not allow for nuance, reflecting the fact that different individuals react differently to solitary confinement, and that some are more susceptible to its damages.

Measuring psychosocial pain and who should be excluded from solitary confinement

Texas's administrative segregation units are virtual incubators of psychoses-seeding illness in otherwise healthy inmates

Federal Judge in Ruiz, 1999:37

Proponents of solitary confinement often point to attempts to quantify its adverse effects as showing that the pain of solitary confinement is no worse than the pain of prison more generally (Morgan et al., 2016), or, in one case, suggesting that solitary confinement may even be beneficial to health (O'Keefe et al., 2013, but see Haney, 2018; Shalev & Lloyd, 2011). Others point out to those who survived long periods in solitary confinement seemingly unscathed (O'Donnell, 2014) and to the ability of human spirit to thrive even in the darkest of places (Jeffreys, 2013).

Whilst it is true that human beings can survive the most unimaginable experiences, I think that we should be careful not to hold the strength of the human spirit as 'proof' that locking up another human being in a small cell, alone, for weeks, months or years, can be anything but painful and damaging.

Recognising the particular vulnerabilities of certain categories of people, Mandela Rule 45(2) stipulates that:

The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice, continues to apply.⁷

7 Rule 22 of the Bangkok Rules (United Nations, 2010) states that "Punishment by close confinement or disciplinary segregation shall not be applied to pregnant women, women with infants and breastfeeding mothers in prison". Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990) states that "disciplinary measures constituting cruel, inhuman or

These prohibitions are based on the knowledge that the effects of solitary confinement on children, young people, people with disabilities, and those who are mentally unwell, can be particularly harmful. A US Federal judge noted that prolonged solitary confinement in a ‘supermax’ prison “may press the outer bounds of what most humans can psychologically tolerate”, and for those with pre-existing psychiatric disorders it was “the mental equivalent of putting an asthmatic in a place with little air to breathe” (Madrid, 1995).

With regard to children, as a joint statement from the British Medical Association (BMA), the Royal College of Psychiatrists (RCPsych) and the Royal College of Paediatrics and Child Health (RCPCH) asserted, “children are still in the crucial stages of developing socially, psychologically, and neurologically, and there are serious risks of solitary confinement causing long-term psychiatric and developmental harm”. The Statement called for children and young people in detention to never be subject to solitary confinement (BMA, RCPsych, RCPCH, 2018). Yet, children and young people are regularly isolated in prisons across the world. In Australia, for example, children as young as 15 were reportedly routinely held in solitary confinement (Victorian Ombudsman, 2019). An inspection report from England and Wales made similar findings (HMIP, 2019).

Mothers and pregnant women are also routinely segregated. My study of the use

of solitary confinement in women’s prisons in New Zealand, for example, found that despite being a highly vulnerable population with high levels of trauma and multiple and complex needs, women (mostly Māori) were segregated significantly (73%) more often than men, including stays lasting several months (Shalev, 2021). My research suggests that women may experience the pains of solitary confinement even more acutely than men, and the rate of self-harm amongst segregated women is particularly high (ibid.).

People suffering mental illness are similarly placed in solitary confinement in prisons worldwide – because there are no other institutional solutions for them, or because they disturb other prisoners in the prison’s general population, or because they are awaiting a bed in a psychiatric hospital. This is the case despite wide consensus that solitary confinement is even more painful for people who are mentally unwell. Mandela Rule 45(2) excludes from solitary confinement people with disabilities “where their conditions would be exacerbated by such measures” (Rule 45(2)). But this, in my view, is problematic. Is it right to wait until someone, who may have had no previous mental health issues, develops a psychiatric disorder before asserting that they must not continue being subjected to a practice known to cause mental illness?

I would have liked to see the Mandela Rules mandate a complete prohibition on the use of solitary confinement for people with mental illness, for children and young people, and for women.

Who should review solitary confinement placements?

Nelson Mandela Rule 45 requires for solitary confinement placements to be subject to ‘independent review’.

degrading treatment . . . including . . . solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile.”

The UN Committee on the Rights of the Child (CRC) has stated in its General comment No. 10 (United Nations CRC, 2007) that solitary confinement of children is strictly forbidden under Article 37.

But who this ‘independent reviewer’ should be, and the degree of authority they have in the process, remains open to national interpretation and application. International experience with various forms of independent reviews shows that these often leave something to be desired.

For example, in 2000, as part of efforts to limit the use of solitary confinement, Israel introduced a law requiring any extension of solitary confinement stays for longer than 6 months (already a very prolonged time, of course) to be authorised by a judge (Dagan & Shalev, 2021). However, an analysis of 354 court decisions made in the course of 20 years found that whilst judges recognised the harms and particular pains of solitary confinement, they nonetheless approved 93% of requests to extend solitary confinement stays, including very prolonged ones. The study suggests that structural factors and the use of ‘techniques of neutralisation’ and forms of denial⁸ allowed judges to “explain away the ‘pains of solitary confinement,’ and diminish their own role in authorising and inflicting those pains”

8 The term ‘techniques of neutralisation’ was coined by American criminologists Gresham Sykes and David Matza (1957) to explain the way in which people rationalise their criminal conduct and its associated guilt. The five main ‘techniques’ are: denial of responsibility; denial of injury; denial of the victim; condemnation of the condemner; and appeal to higher loyalties. This was further developed by Stanley Cohen’s (2001) framework for understanding the manner in which human suffering can be either denied or acknowledged, including: Literal denial (it didn’t happen); Interpretive denial (the facts themselves are not denied but are given a different interpretation or ‘spin’); and implicative denial (the implications of what happened are denied). These forms of denial allow the individual to avoid fully acknowledging the reality of human suffering and thus to feel no compulsion to act to mitigate this suffering.

(Dagan & Shalev, p. 16) potentially hampering their effectiveness as independent reviewers.

Canada opted for a system of Independent External Decision Makers (IEDMs) for deciding on extended solitary confinement placements, but a study of the work of the IEDMs found that they approved the prison authorities’ decisions in the vast majority (87%) of cases (Sprott, Dobb and Ifene, 2021). Further, an ‘Implementation Advisory Panel’ set up for the specific purpose of monitoring the newly set-up Structured Interventions Units in 2019 was dissolved a year later as the Canadian Department of Corrections failed to allow members access to the units or to data, casting doubt on the utility of this form of independent review.

Even given good access to prisons, prisoners, and prison administrative records, an independent reviewer needs good knowledge and understanding of prison procedures and practices. They also need maintain a relationship which is co-operative, but not too close, with prison staff, as well as gaining the trust of prisoners. This is not always an easy balance to achieve. Even when access is provided and a cordial distance is maintained, follow up is often poor, and adherence to recommendations difficult to monitor, as the Canadian experience demonstrates.

What role should physicians and other health professionals have in solitary confinement units?

In many jurisdictions a doctor or a nurse need to sign a form asserting that a person is able to withstand isolation. Indeed, this is considered to be a safeguard against ill treatment. The original text of the UN SMR of 1955 stipulated that

Rule 32

- (1) Punishment by close confinement or reduction of diet shall never be inflicted

unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.

The Mandela Rules attempt to walk a tightrope between, on the one hand, a wish to ensure that detainees always have access to a doctor and, on the other hand, the ethical requirement for health professionals not to take part in practices which are not geared towards maintaining and improving their patients' health, and, specifically, not to participate in assessing their 'fitness for isolation'.⁹

Nelson Mandela Rule 46

1. Health-care personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures. They shall, however, 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.

2. Health-care personnel shall report to the director, without delay, any adverse effect of disciplinary sanctions or other restrictive measures on the physical or mental health of a prisoner subjected to such sanctions or measures and shall advise the director if they consider it necessary to terminate or alter them for physical or mental health reasons.

3. Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.

The Mandela Rules make clear that medical staff have an important role to play in safeguarding the wellbeing of prisoners who are isolated, but how is 'keeping a close eye' different to 'certifying fitness' for isolation? This is an unresolved, and a difficult, issue. Whilst we would not want to advocate less human contact, and certainly not with doctors, I think that we should be clearer about what exactly it is that health professionals are asked to do, and how does that square with their broader role. It is important that doctors are associated with healing and cure, and not seen as facilitators of ill treatment to those perceived as able to withstand it.

The future: is the tide turning?

In the United States, the birthplace of the use of prolonged solitary confinement for mass warehousing of people in prison, there are signs that the tide of solitary confinement may have started turning (Washington Post, 2014). Several States have now successfully implemented significant reforms to their use of solitary confinement – for example, Colorado banned the use of solitary confinement for longer than 15 days in 2017 (Raemisch, 2019), and policy changes in North Dakota achieved a 74.28% reduction in the use of solitary confinement between 2016 and 2020, with no associated increase in prison misconduct (Cloud et al. 2021).

It is not clear to me that this reversal will be sustained in the United States, and it is unclear whether other countries will follow.

⁹ For example, the World Medical Association's Statement on Solitary Confinement (2014) sets out in Principle 9 that 'physicians should never participate in any part of the decision-making process resulting in solitary confinement.' For a comprehensive discussion of medical ethics in solitary confinement units, see Sourcebook on Solitary Confinement (op cit.)

It is in any case unlikely that prison authorities across the world would give up entirely the legal right and physical space to segregate a prisoner from their peers. But the more examples of successful alternatives there are, the more likely prison authorities are to consider using this extreme tool in a different way. Rather than being places of deprivation and punishment, the units where the prison's most vulnerable and most challenging individuals are housed can become places of investment and growth, of trauma informed practice and a focus on meeting individual needs.

We should also take comfort in the fact that the term 'solitary confinement' is now widely used, and is associated with negative, painful practices. This, in itself, is an achievement.

But, in my view, we need to push for further, and more radical, change.

Having studied solitary confinement for close to three decades, and having visited numerous places of detention where people were held in small concrete or metal cubes with few personal belongings, with little personal autonomy and control over their daily lives, and with incredibly limited access to the outside world, it is increasingly clear to me that as well as being immensely harmful to health and wellbeing and inefficient in dealing with prison violence, prolonged solitary confinement is morally and ethically wrong. It should be abolished.

References

- Akil, H. (2019). The Brain in Isolation. In: Lobel, J., & Smith, P. S. (Eds.). (2019). Solitary confinement: Effects, practices, and pathways toward reform. Oxford University Press. pp 199-2019. DOI:10.1093/oso/9780190947927.001.0001
- Blake, W. (2016), A sentence worse than death. In: Casella, J., Ridgeway, J., and Shourd, S. (Eds.) *Hell Is a Very Small Place:Voices from Solitary Confinement*. (2016) The New Press, New York London.
- British Medical Association (BMA), Royal College of Psychiatrists (RCPsych) and Royal College of Paediatrics and Child Health (RCPCH). *Joint position statement on solitary confinement of children and young people*. September 2018. <https://www.bma.org.uk/media/1859/bma-solitary-confinement-in-youth-detention-joint-statement-2018.pdf>
- Casella, J., Ridgeway, J., and Shourd, S. (Eds.) *Hell Is a Very Small Place:Voices from Solitary Confinement*. (2016) The New Press, New York London.
- Cloud, D. H., Augustine, D., Ahalt, C., Haney, C., Peterson, L., Braun, C., & Williams, B. (2021). "We just needed to open the door": a case study of the quest to end solitary confinement in North Dakota. *Health Justice*, 9(1), 28. <https://doi.org/10.1186/s40352-021-00155-5>
- Cohen, S., (2001) *States of Denial: Knowing about Atrocities and Suffering*. Polity Press: Cambridge.
- Cohn, M. (Ed.). (2011). *The United States and torture: Interrogation, incarceration, and abuse*. NYU Press
- Coppola, F., *The Brain in Solitude: An(other) Eighth Amendment Challenge to Solitary Confinement*, *Journal of Law and the Biosciences*, 1-42 (2019) DOI:10.1093/jlb/lisz014
- Dagan N., Shalev S., *The role of Israeli judges in authorising solitary confinement placements: Balancing human rights and risk, or neutralising responsibility? Punishment & Society*. May 2021. doi:10.1177/14624745211019112 (open access)
- European Committee for the Prevention of Torture (CPT) Country Reports and Standards. Available at <https://www.coe.int/en/web/portal/human-rights>.
- Federal Bureau of Investigations (FBI) Primer on "Cross Cultural Rapport-Based Interrogation", 18/1/2010, released to the American Civil Liberties Union in May 2012 (unpublished).
- Finely, B. (2009). Supermax too full for Guantanamo detainees. *Denver Post*, 21 May 2009 <https://www.denverpost.com/2009/05/21/supermax-too-full-for-guantanamo-detainees>
- Ginbar, Y. (2008) *Why not torture terrorists? moral, practical, and legal aspects of the "ticking bomb" justification for torture*. Oxford University Press on Demand. DOI:10.1093/acprof:oso/9780199540914.001.0001
- Haney, C. (2018) Restricting the use of solitary confinement. *Annual Review of Criminology* 1(1): 285-310. doi 10.1146/annurev-criminol-032317-092326
- Haney, C. (2018). The psychological effects of solitary confinement: A systematic critique.

- Crime and Justice, 47(1), 365-416. <https://doi.org/10.1086/696041>
- Her Majesty's Inspectorate of Prisons. *Thematic report on the Separation of children in young offender institutions*, January 2020. <https://www.justiceinspectors.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2020/01/Separation-of-children-thematic-Web-2019.pdf>
- Huber, A. The relevance of the Mandela Rules in Europe. *ERA Forum* 17, 299-310 (2016). <https://doi.org/10.1007/s12027-016-0427-2>
- Human Rights Watch, Turkey: Small Group Isolation in F-type Prisons and the Violent Transfers of Prisoners to Sincan, Kandira, and Edirne Prisons on December 19, 2000, 5 April 2001, D1302, available at: <https://www.refworld.org/docid/3bd023992.html> [accessed 18 November 2021]
- Jeffreys, D. (2013). *Spirituality in Dark Places: the ethics of solitary confinement*. Springer.
- Morgan, R., & Evans, M. (2002). Combating torture in Europe: the work and standards of the European Committee for the Prevention of Torture (CPT). Council of Europe.
- Morgan, R. D., Gendreau, P., Smith, P., Gray, A. L., Labrecque, R. M., MacLean, N., Van Horn, S. A., Bolanos, A. D., Batastini, A. B., & Mills, J. F. (2016). Quantitative syntheses of the effects of administrative segregation on inmates' well-being. *Psychology, Public Policy, and Law*, 22(4), 439-461. <https://doi.org/10.1037/law0000089>
- O'Donnell, I. (2014). Prisoners, solitude, and time. Oxford University Press.
- O'Keefe, M. L., Klebe, K. J., Metzner, J., Dvoskin, J., Fellner, J., & Stucker, A. (2013). A longitudinal study of administrative segregation. *Journal of the American Academy of Psychiatry and the Law Online*, 41(1), 49-60.
- O'Mara, S. (2015) *Why torture doesn't work: the neuroscience of interrogation*, Harvard University Press. <https://doi.org/10.4159/9780674915510>
- Penal Reform International (2017). Essex paper 3: Initial guidance on the interpretation and implementation of the Nelson Mandela Rules. Online: <https://www.penalreform.org/resource/guidance-on-implementation-the-nelson-mandela-rules/>
- Perez-Sales P. (2016). Psychological Torture: Definition, evaluation and measurement. Routledge Books. London <https://doi.org/10.4324/9781315616940>
- Physicians for Human Rights (2007) Leave No Marks: Enhanced interrogation techniques and the risk of criminality. Physicians For Human Rights, Boston, NJ.
- Raemisch, R. (2019). Colorado Ends Prolonged, Indeterminate Solitary Confinement. In: Lobel & Scharff Smith, op cit., at 311.
- Reyes, H. (2007) The worst scars are in the mind: psychological torture. International Review of the Red Cross Volume 89 Number 867 September 2007. Online at: <https://international-review.icrc.org/sites/default/files/irrc-867-5.pdf> DOI: <https://doi.org/10.1017/S1816383107001300>
- Rodley, N., & Pollard, M. (2009). The treatment of prisoners under international law. Oxford University Press on Demand. DOI:10.1093/acprof:osobl/9780199693566.001.0001
- Scharff-Smith, P. (2008) Solitary confinement: An introduction to the Istanbul Statement on the Use and Effects of Solitary Confinement February 2008 *Torture Journal* 18(1):56-62
- Shalev, S. (2021) First, Do No Harm: segregation, restraint, and pepper spray use in women's prisons in New Zealand. New Zealand Human Rights Commission, Wellington.
- Shalev, S. (2015) Solitary confinement as a prison health issue. In: Enggist S, Moller L, Galea G, et al. (eds) Prisons and Health: A World Health Organisation Guide to the Essentials in Prison Health (2nd ed.). Copenhagen: WHO, pp. 27-35.
- Shalev, S. (2009) Supermax: controlling risk through solitary confinement. Willan: Abingdon.
- Shalev, S. (2011) Solitary Confinement and Supermax Prisons: A Human Rights and Ethical Analysis, *Journal of Forensic Psychology Practice*, 11:2-3, 151-183, DOI: 10.1080/15228932.2011.537582
- Shalev, S., Lloyd, M., (2011) Though this be method, yet there is madness in't: Commentary on One Year Longitudinal Study of the Psychological Effects of Administrative Segregation. *Corrections & Mental Health*
- Snacken, S. (2010). Resisting punitiveness in Europe? *Theoretical Criminology*, 14(3), 273-292. <https://doi.org/10.1177/1362480610370165>
- Smith, C. S. (2007). *Bad men: Guantanamo Bay and the secret prisons*. Weidenfeld & Nicholson.
- Sprott, J. B., Doob, A.N., & Ifene, A. (2021). *Do Independent External Decision Makers Ensure that "An Inmate's Confinement in a Structured Intervention Unit Is to End as Soon as Possible"?* Fourth report on Correctional Service Canada's (CSC) "Structured Intervention Units" (SIUs). Online: <https://www.crimsl.utoronto.ca/news/reports-canada%E2%80%99s-structured-intervention-units>
- Sykes GM and Matza D (1957) Techniques of neutralization: A theory of delinquency. *American Sociological Review* 22(6): 664-670.

- DOI: <https://doi.org/10.2307/2089195>
- Wildeman, C., & Andersen, L. H. (2020). Solitary confinement placement and post-release mortality risk among formerly incarcerated individuals: a population-based study. *The Lancet Public Health*, 5(2), 107-113. DOI:[https://doi.org/10.1016/S2468-2667\(19\)30271-3](https://doi.org/10.1016/S2468-2667(19)30271-3)
- Wright, T. (2019). Canada's new solitary confinement bill makes it easier to put inmates in isolation, senator says. *The Canadian Press*, 5 May 2019. Online: <https://globalnews.ca/news/5241955/canada-solitary-confinement-bill-inmates-isolation/>
- United Nations Basic Principles for the Treatment of Prisoners, adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990
- United Nations General Assembly GA/SHC/4014, 18 October 2011
- United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) (resolution 65/229, annex)
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty (resolution 45/113, annex), 1990
- United Nations Committee on the Rights of the Child (CRC) General comment No. 10 (2007) Article 37 of the CRC (Children's Rights in Juvenile Justice, 25 April 2007, CRC/C/GC/10, available at: <https://www.refworld.org/docid/4670fca12.html> [accessed 25 November 2021])
- Victorian Ombudsman, OPCAT in Victoria, A thematic investigation of practices related to solitary confinement of children and young people (Final Report, 2019).
- Washington Post Editorial, Rethinking solitary confinement. Editorial Board, October 19, 2014. Online: https://www.washingtonpost.com/opinions/rethinking-solitary-confinement/2014/10/19/1c38cb6c-5579-11e4-892e-602188e70e9c_story.html

Cases cited

United States

- Ashker v. Governor of California, No. 4:09-cv-05796-CW (N.D. California, 2012)
- C.B., et al. v. Walnut Grove Correctional Authority, et al., Case No. 3:10-cv-663 (S.D. Miss. Feb. 3, 2012).
- Madrid v. Gomez, 889 F. Supp. 1146, 1261 (N.D. Cal., 1995).
- Ruiz v. Johnson, 37 F. Supp. 2d 855, 908 (S.D. Tex. 1999)

European Court on Human Rights

- Ramirez Sanchez v. France. [GC], 2006, § 120