Introducing the International Guiding Statement on alternatives to solitary confinement

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Abstract
Based on the reflections of a multidisciplinary group of experts, Physicians for Human Rights Israel and Antigone worked on the *International Guiding Statement on Alternatives to Solitary Confinement*, proposing global guidelines for reducing and finally overcoming the use of solitary confinement in prisons.

Keywords: solitary confinement, prison, human rights, alternatives.

Despite the devastating effects of solitary confinement on the minds and bodies of incarcerated individuals, (Shalev 2008; Toch, 1992, Haney 2017; Lobel & Smith, 2019), in defiance of several international recommendations, solitary confinement continues to be extensively used in incarceration settings worldwide.

Actually, it could be argued that imprisonment (as a punishment, not as a custodial option) was even born in solitary confinement. The first recognised penitentiary system, known as the Philadelphia System, employed absolute solitary confinement in institutions like the Walnut Street Prison and the Eastern Penitentiary, since it was considered the most suitable technique for the purpose of achieving the moral reform of the inmate (Howard, 1777; De Beaumont & De Tocqueville, 1833; De La Rouchefoucauld-Liancourt, 1796). Although the functions attributed to this segregative practice have been changing - and multiplying, as will be seen below - the human rights violations produced by solitary confinement persist over time, demonstrating, thus, the unacceptability of the use of isolation in contemporary prison systems.

According to international standards, solitary confinement means "the isolation of prisoners for a minimum of 22 hours without appreciable human contact[1]", while prolonged solitary confinement refers to "isolation for a period of more than 15 consecutive days" (Mandela Rules, 2015, n° 44). Prolonged isolation is strictly prohibited by international standards, because of the effects that it is likely to produce on incarcerated people, according to the scientific literature[2]. However, prison

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1 On the meaning of "appreciable human contact" see Brioschi & Paterniti Martello, 2021.

2 The Report of the Special Rapporteur on Torture, Juan Méndez, published in 2011, states that the choice of 15 days stems from a review of the literature indicating that beyond this point "some of the harmful psychological effects of solitary confinement may become irreversible". See General Assembly, United Nations, *Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman and degrading treatment or punishment*, A/66/268, 5 August 2011, §§19, 26, 60, 79.

authorities commonly claim that, in response to certain individual cases, there are no alternatives, except to place that individual in solitary confinement, including people belonging to vulnerable populations[3]. Thereby, the lack of credible alternatives to solitary confinement reaffirms the latter as an indispensable tool for the orderly functioning of the prison institution.

For this reason, in January 2022, Physicians for Human Rights Israel (PHRI)[4] and Antigone[5] convened an international group of experts with multidisciplinary skills to develop a set of guidelines to overcome solitary confinement at a global level. Specifically, the experts involved were prison administrators, mental health professionals, correctional staff and academics, who have either implemented alternatives to solitary confinement or proposed alternatives to the practice. Rick Raemisch (former Executive Director of the Colorado Department of Corrections), Dr. Terry Kupers, (Professor Emeritus at The Wright Institute), David C. Fathi, (current Director of the American Civil Liberties Union National Project), Peter Scharff Smith (Professor of Sociology of Law at the University of Oslo) took part in the group, sharing their theoretical perspective and practical experience in the field of prisons and, in particular, about solitary confinement.

The result of this process is the *International Guiding Statement on Alternatives to Solitary confinement*[6], published in May 2023. The *International Guiding Statement* aims to bridge the gap between international law and medical positions on the harm caused by solitary confinement, by presenting a consensus on measures that can help reduce and ultimately abolish this practice. The *International Guiding Statement* is accompanied by a *Background Brief: Alternatives to Solitary confinement*[7] aimed at providing additional background information, in which the subscriptions of international experts collected so far also can be known. The document boasts the signature of the former Special Rapporteur on Torture, Professor Juan Méndez, and the former President of the CPT and Italian NPM, Professor Mauro Palma. The *International Guiding Statement* has been already presented to the Committee Against Torture, the UN Special Rapporteur on Torture, and the International Committee of the Red Cross. The dissemina-

3 The criminalisation of vulnerable populations is directly linked with the prison overcrowding phenomenon. In fact, mass incarceration has emerged as a system of racialised social control disproportionately affecting vulnerable populations, resulting in their disproportionate representation in prison worldwide. These communities are also over-represented in solitary confinement. About this point, Mears *et al.* (2021a) question the factors that appear to favour the use of long-term solitary confinement. Thus, there is the possibility that the functioning of the prison system may disadvantage certain groups or contribute to creating conditions that increase problematic behaviour among them. There is also the possibility that staff are more likely to interpret the behaviour of different groups in prison as more problematic. For these authors, the individuals most likely to be placed in solitary confinement are young, racialised men, with little or no schooling and, above all, with mental health problems.

4 For further information about the organisation, refer to https://phr.org/ (consulted on 02.10.23).

5 For further information about the organisation, refer to https://www.antigone.it/index.php (consulted on 02.10.23).

6 To consult the document refer to https://www.antigone.it/upload/5298_SolitaryStetement_paper_Eng_24.08.23.pdf (consulted on 02.10.23).

7 To consult the document refer to https://www.antigone.it/upload/5298_SolitaryBrief_paper_Eng_24.08.23.pdf (consulted on 02.10.23).

tion of these documents and the collection of signatures aims to ensure that its provisions will be used as a reference by international institutions and, thus, become part of soft law.

Surely, the paradigmatic case with respect to the use of solitary confinement is represented by the U.S. *Supermaxes* (Pizzarro & Stenius, 2004; Mears & Reisig, 2006). The phenomenon of *Supermaxes* have proliferated throughout the U.S. national scene (Austin & Irwin, 2001; Shalev, 2009), being today the most used resource to manage "the worst of the worst" (Riveland, 1999). In fact, across the United States, federal and state adult prisons and local and federal jails reported on a given day in 2019 locking approximately 122840 people in solitary confinement (Solitary Watch & the Unlock the Box Campaign, 2023, p. 8), although the number of people subjected to isolation across the country is far greater (*ivi,* p. 11).

According to the CLA and the Liman Center, a snapshot in 2019 found that between 55000 and 62500 people had been in prolonged solitary confinement for at least 15 continuous days. Similarly, a snapshot in 2021 showed that between 41000 and 48000 people had been in prolonged solitary confinement for at least 15 continuous days. Nearly a quarter of those individuals had been in solitary confinement for years, including nearly 4% who had been in solitary confinement for more than a decade (*ivi,* p. 12).

In the face of this dramatic landscape, however, it must be remembered what the Special Rapporteur on Torture reiterated; namely, that prolonged solitary confinement can amount to inhuman or degrading treatment and, in some cases, to torture[8]. In 2007, the UN General Assembly adopted the *Istanbul Statement on the Use and Effects of Solitary Confinement*, banning the practice for various groups, including those who have mental disabilities[9]. The prohibition was reinforced by the *World Medical Association Statement on Solitary Confinement* (2019) and the *Consensus Statement from Santa Cruz Summit on Solitary Confinement and Health* (2020).

As for the prevalence of solitary confinement in Europe, there is a lack of complete data, which prevents a true understanding of the extent of the phenomenon. In this regard, the *International Guiding Statement* recommends and encourages the collection of data - made available to the public - on the number of people held in solitary confinement, reasons for confinement, duration, indication whether individuals belong to a vulnerable population, and earlier steps to prevent placement[10].

Regarding the formal explanations for the use of solitary confinement, prison authorities cite various justifications, including responding to violence, disciplinary sanctions, security concerns, preventing self-harm, and responding to the requests of individuals. Isolation is thus configured as a hybrid phenomenon, to which the institution resorts to deal with the most problematic situations (Stroppa, 2022), to maintain order in the prison system (Mears *et al.*, 2021b).

Recently, it has been observed that prison administrations are increasingly resorting to solitary confinement to manage individuals with psychiatric problems and even mental disabilities. In fact, the use of solitary confinement is linked to unavailable or low-quality

8 United Nations General Assembly, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment,* A/63/175, 28 July 2008, §§ 77-83.

9 Adopted on 9 December 2007 at the International Psychological Trauma Symposium, Istanbul, https://www.solitaryconfinement.org/istanbul (consulted on 03.10.23).

10 See Section A.

psychiatric and psychological treatment and a lack of rehabilitation and education programming. Insufficient health services contribute to the deterioration of mental health problems, while a lack of programming leads to idleness, the inability to release tensions, and feelings of despair regarding post-release prospects. These consequences lead to more rule-breaking and violence (Kupers, 2015), and therefore to an increased use of solitary confinement[11]. Hence, solitary confinement units are moving away from the rehabilitative ideal towards a warehousing approach that does not rest on any pretence of self-transformation (Rhodes, 2004, p. 16). Solitary confinement is becoming one of the main modalities of management in the prison universe.

The *Background Brief* explains in detail the effects of solitary confinement on the incarcerated population. The psychological impacts of solitary confinement range from a state of confusion and inability to concentrate to disturbing hallucinations and paranoia, depression and anxiety, post-traumatic stress disorder, increased suicidal ideation, self-harm, and suicide (Shalev, 2008, p. 20; Haney, 2003, p. 134; Kaba *et al.*, 2014). Physcological symptoms include cardiovascular and gastrointestinal complications, migraines, deteriorating eyesight, fatigue, and muscle pain (Smith, 2006, p. 477, Strong *et al.*, 2021). The effects of solitary confinement depend on individual and environmental factors and may begin to appear after several days. They can continue to impact individuals long after they are released from solitary confinement and may remain chronic for many years (Kupers, 2016, 2017)[12].

It is important to point out that the experts' view in reasoning on *the International Guiding Statement* does not look at the phenomenon of solitary confinement as something isolated, but rather as the consequence of broader shortcomings that afflict the prison system (as it can be seen in the *Appendix*). In this vein, the increasing presence of psychiatric individuals inside prisons is only one of the causes that may help to explain the placement of people in solitary confinement. Indeed, in order to fully understand the underlying reasons for the application of solitary confinement, it is necessary to analyse the systemic problems that plague prisons. The solitary confinement pipeline includes both conditions within prisons - such as overcrowding, lack of adequate mental health care, a punitive approach to prison management - and broader structural issues, such as mass incarceration, criminalisation of vulnerable populations, as well as insufficient mental health care in the community and the use of prisons as places of detention for individuals with mental health problems, as has been pointed out earlier. Nevertheless, according to the *International Guiding Statement*, until these structural changes are addressed, short-term measures must be implemented to ensure that individuals currently held in solitary confinement can be taken out. As stakeholders increasingly implement the recommendations of the *International Guiding Statement*, more tools and alternatives to solitary confinement will be available for use.

The recommendations in the *International Guiding Statement* are divided into 4 sections

11 As King *et al.* (2008 p. 144) argue, the prison model that relies on solitary confinement as the primary mean of prison governance - combined with the culture of both staff and individuals in incarceration - fosters a self-fulfilling prophecy: that of violence.

12 Regarding the medico-legal documentation of the effects produced by solitary confinement, see Brasholt et al., 2023.

and the *Appendix*. The following is a summary of each one:

- Section A – Documentation, oversight and accountability measures:
  Understanding the way in which and the extent to which solitary confinement is carried out, as well as the individuals most likely to be targeted, is a necessary step in reducing and ultimately abolishing this practice. In this vein, the *International Guiding Statement* suggests implementing urgent legislative action to ban solitary confinement in incarceration settings for all individuals, as well as a specific regulation and judicial review[13] of all forms of solitary confinement until its abolition, and a comprehensive incident report of any use of force.
  In addition, in order to document the phenomenon as comprehensively as possible, it is recommended to get comprehensive, anonymised and individual records which include whether the individual belongs to a vulnerable population, the official reason for placement in solitary confinement, steps taken to avoid using the measure and a schedule for removal from confinement[14].

- Section B – Preventing placements in solitary confinement, alternative measures:
  In any situation where individuals experience a mental health crisis and acts of self-harm, the *International Guiding Statement* recommends an immediate assessment by mental health professionals[15], an individualised care plan, and that de-escalation measures be put in place by prison staff. The establishment of an independent body of mental health professionals, which will be authorised to recommend a person's release from prison, is also a recommendation emphasised in the *International Guiding Statement*. In addition, the latter discourages the imposition of solitary confinement even in cases where it is requested by the incarcerated person himself/herself, submitting a different arrangement, having carried out a process to understand the underlying reasons behind that request. Furthermore, in the *International Guiding Statement* it is stated that regularly reviewed, evidence-based risks and needs assessments may contribute to the prevention of the imposition of solitary confinement, especially for purported security reasons.

- Section C – Individualised care plans:
  The *International Guiding Statement* recommends that individuals be offered a tailor-made care plan, developed in collaboration with health professionals (with their families' support), that addresses their unique circumstances in a transparent, responsive, and compassionate way, in accordance with full compliance with the principle of normalisation[16]. The first objective is to re-

13 Despite often taking part in prolonging solitary confinement measures, judges rarely conduct on-site visits to verify the accuracy of data given by prison authorities. As such, the *International Guiding Statement* recommends the institutionalisation and regularisation of on-site visits by judges involved in solitary confinement cases.

14 This last indication is included in the individualised care plan.

15 According to the *International Guiding Statement*, health professionals should be prohibited from participating in any part of the decision-making process resulting in solitary confinement, as well as they should recommend removal from solitary confinement in all cases.

16 In this regard, current incarceration settings are characterised by a one-size-first-all approach that negatively impacts the health of individuals in

integrate the individual into less restrictive conditions of confinement, but the ultimate and most important goal is to prepare them for life post confinement.

- Section D – Measures to ensure staff competency and well-being:
  The approach and decisions taken by staff are key factors in determining whether individuals are placed in solitary confinement. Lack of appropriate training and tools too often result in the use of punitive approaches and the misinterpretation of individual behaviour, such as characterising self-harm as 'attention seeking'. To minimise triggers, reduce dangerous incidents, de-escalate situations, and avoid the use of restrictive practices (including solitary confinement), it is crucial to offer prison staff training, guidance, and professional support, including secondary trauma care. In this sense, the *International Guiding Statement* includes recommendations on what should be included in training for prison staff, how it should be evaluated, and who should deliver that training and supervision.

- Appendix – Steps for stopping the solitary confinement pipeline:
  The *International Guiding Statement* operates within a complex context, and the *Appendix* proposes the broader societal changes needed to end solitary confinement. Therefore, this section provides the comprehensive and holistic view that is a necessary accompaniment to the short-term and medium-term measures. The holistic view is declined as follows:

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

In conclusion, although there is a long way to go before the use of solitary confinement will end, the recommendations contained in the *International Guiding Statement* are a valuable, fundamental, and pragmatic tool to centralise the issue of prison isolation in the debate on the rights of incarcerated individuals,and to achieve its end.

incarceration. People placed in solitary confinement often struggle with the homogenous order of prison systems, demonstrating a connection between solitary confinement and failure to develop individualised care programs.

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