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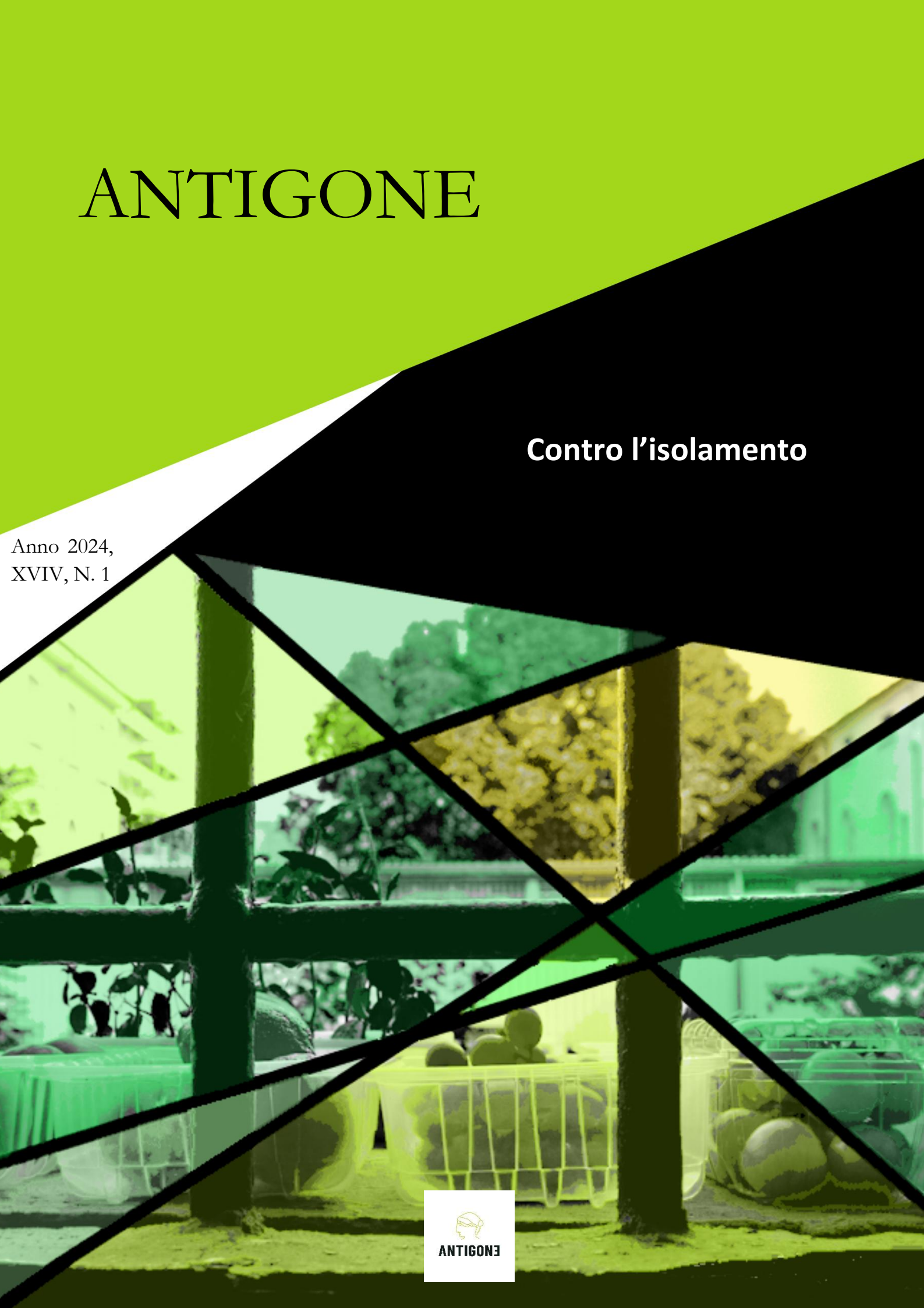

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N. 1/2024 CONTRO L'ISOLAMENTO

a cura di Rachele Stroppa

INDICE

THE INTERNATIONAL GUIDING STATEMENT ON ALTERNATIVES TO SOLITARY CONFINEMENT*

*Susanna Marietti**

Abstract

While international standards recognize the devastating impact of solitary confinement and restrict its use, solitary confinement continues to be extensively used in incarceration settings worldwide, including for vulnerable population. This is primarily due to a lack of alternatives. The "International Guiding Statement on alternatives to solitary confinement" aims to bridge this gap. It provides universal guidelines to reduce and eventually overcome solitary confinement, holistically tackling the challenges of incarceration systems while offering concrete interim steps for removing individuals from confinement and phasing out the practice. Its formulation brought together an international group of prison administrators, corrections staff, prison reform, solitary confinement, and mental health experts led by Physicians for Human Rights Israel and Antigone. The Statement, which embraces a comprehensive conception of the causes leading to the overuse of solitary confinement, is here explored in all its sessions.

Keywords: *solitary confinement, International Guiding Statement, Antigone, Physicians for Human Rights Israel, human rights*

* This is the presentation speech of the International Guiding Statement that I gave at the Multilateral Meeting on *Solitary confinement in prison and its alternatives: a human rights perspective* organized by the CPDL (Co-operation Police and Deprivation of Liberty) Division of the Council of Europe and attended by the prison administrations of the Member States. The Meeting was held at the Palais of the Council of Europe (Strasbourg) on 24-25 September 2024.

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I am truly honored to have the opportunity to present today to such a relevant audience the *International Guiding Statement on alternatives to solitary confinement*. I want to deeply thank the organizers of this meeting and all of you for being here. The International Guiding Statement, which proposes global guidelines for reducing and finally overcoming the use of solitary confinement in prison, is the result of the work of Antigone, the organization I direct, and Physicians for Human Rights Israel, a non-governmental organization founded in 1988 with the goal of promoting the rights to health, and is based on the reflections of a multidisciplinary group of experts at the international level. The Statement is accompanied by the Background Brief, which provides additional context and background.

The need to think about global guidelines for limiting and eventually overcoming the use of prison solitary confinement stemmed, I would say, from Antigone's daily work. Antigone is an Italian Ngo born in 1991 and committed to the promotion of human rights and individual guarantees in the criminal justice system. We are strongly engaged in prison monitoring. Since 1998, the members of Antigone's Prison Observatory – today around 80 – are authorized by the Ministry of Justice to visit all Italian prison facilities. We make about 100 visits a year to juvenile and adult prison facilities and publish periodic reports that are the result of our direct observation. We are also allowed to enter the prison with video cameras to witness the conditions of detention through images as well.

Solitary confinement is one of the central aspects of our monitoring activities. More and more in recent years we have learned to pay attention to the places in the prison where formal or *de facto* solitary confinement is practiced. Indeed, these are the places most at risk of abuse and violation of human rights. We realized how the issue of solitary confinement lies at the handle of an ideal fan. It is central, in an almost geometric sense, to offering a reading of the current prison systems. It requires that many aspects of prison life be addressed:

- torture, as solitary confinement setting is often where torture takes place, but also as solitary confinement itself can amount to torture if used with the intent to obtain confessions or intimidate;
- use of force;
- disciplinary system: how and to what extent is the disciplinary system used to govern the prison? This raises questions about what model of prison we have in mind;
- pre-trial detention;
- mental health;
- health in general (as the pandemic has powerfully shown);
- self-harm;
- suicides (we have direct experience: in Italy, in the first half of 2024, we had 48 suicides in Italian prisons. Unfortunately, they have become many more today. Only 15 out of 48 occurred in ordinary wings of the prison. In all other cases it was a disciplinary solitary confinement wing, psychiatric solitary

confinement wing, solitary confinement wing as a form of protection, or a first reception wing, which should be the most open and caring but in Italy are often the ones where prisoners live in *de facto* isolation. In the USA, about half of all prison suicides takes place among the about 5% of prisoners held in solitary);
- vulnerable categories: how do we want to handle them?
- difficult situations: they often arise suddenly in prison and do not always relate to precise categories that can be classified in advance. Thus, again: how to handle them? And here comes the following issue;
- staff training;
- fundamental rights: they should never be compressed by prison life, in any of its forms, but solitary impacts on many of them.

Weakening the practice of solitary confinement means unhinging the most extreme and dangerous forms of incarceration. Dangerous for the violation of human dignity itself, as is tragically evident in every solitary confinement cell.

In the past it was believed that isolation could lead to rehabilitation, that through solitary confinement one could deconstruct the minds of prisoners and then rebuild them through work and religion. We now know for sure that solitary confinement certainly deconstructs people's minds, devastating them, but it is far from reconstructing them. Since the second half of the Twentieth Century, studies have been demonstrating beyond any doubt the many effects of isolation, both from a physical and physiological point of view.

Among them:
- states of confusion;
- hallucinations;
- paranoia;
- depression;
- memory and concentration problems;
- anxiety;
- post-traumatic stress disorder;
- self-destructive intents;
- rage;
- cardiovascular issues;
- lowered vision;
- stomach and intestinal complications.

Such effects may appear after a few days and continue long after the person has left the state of isolation. Solitary confinement increases the risk of premature death.

If we now look at penitentiary life, solitary has detrimental effects and undermines the very purpose of prison sentencing. First of all, it increases aggression: there is evidence that solitary confinement does not reduce but rather increases prison violence. Secondly, it of course increases the risk of torture. And finally, it increases recidivism: prisoners isolated for a long time unlearn social life, making it more difficult to reintegrate into the community.

We need to find different tools, unless we are prepared never to release people from solitary again. Because we will release people more dangerous than when they went in.

The harmful effects of solitary confinement are internationally recognized. Even as far back as 1990, the United Nations has called for overcoming isolation as a punitive measure. Principle 7 of the United Nations

Basic Principles for the Treatment of Prisoners (adopted by the General Assembly in December 1990) states: «Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged».

Despite awareness of its harmful effects, solitary confinement is still widely used in prison systems around the world, including for vulnerable populations. Far from being a measure of last resort, it is too often employed as a strategy of control or even as an ordinary means of running the prison, faced with a prison population increasingly selected on the basis of social characteristics of marginality. Today solitary confinement is the response of prison systems to a wide variety of situations, where the categories identified in research often mix. The excessive use of solitary is a legal problem but also a cultural one. There are too often grey areas where informal rules apply. There are *de facto* isolations that escape all categorization. There are provisions contrary to national and international norms. Too often a shared culture among prison staff members is lacking.

International human rights law does not prohibit solitary confinement in general. What is prohibited is prolonged solitary confinement, and there are specific prohibitions for certain categories of detainees. While stating that it should be used as a last resort, international law, monitoring bodies, international authorities, and experts have generally always interpreted such a measure as being unavoidable in some particular circumstances for maintaining safety and security in prison. As if there were no alternatives. Those alternatives that the International Guiding Statement aims to provide.

International standards agree – and increasingly so in recent years – that isolation should be avoided as much as possible, and in some cases and in some forms should be avoided altogether. These are the most relevant sources in this regard:

- Istanbul Statement on the Use and Effect of Solitary Confinement (2007);
- Interim report of the UN Special Rapporteur on torture (2008);
- Interim report of the UN Special Rapporteur on torture (2011);
- C.P.T. 21st General Report (2011);
- UN Mandela Rules (2015);
- European Prison Rules (2020, with revised rules on solitary confinement and separation);
- Consensus Statement from the Santa Cruz Summit on Solitary Confinement and Health (2020).

They tell us what must not be done. But they do not tell us what must be done. The lack of alternatives to solitary confinement ends up reaffirming that it is an indispensable tool.

This is why in January 2022 Antigone and Physicians for Human Rights Israel convened an international group of experts with the aim of reflecting collectively on alternatives to prison solitary confinement. The panel discussion took place remotely and was followed by an intensive dialogue that occurred by email and lasted over a year.

The group of expert was composed of:
- Alan Mitchell: medical doctor, President of C.P.T.;
- Brian S. Fischer: former Commissioner of the New York State Department of Correctional Services;
- David C. Fathi: Director of the American Civil Liberties Union National Prison Project;
- David Jones: psychotherapist with extensive experience in prison setting;
- Grazia Zuffa: psychologist working in the field of drug use and prison policies;
- Hilgunn Olsen: Professor at the University College of Norwegian Correctional Service (Krus);
- Keramet Reiter: Professor in the Department of Criminology Law Society, University of California;
- Kim Pate: lawyer, former member of the Senate of Canada;
- Martin F. Horn: former Executive Director of the New York State Sentencing Commission;
- Peter Scharff Smith: Professor in the Sociology of Law at the University in Oslo
- Rick Raemisch: former Executive Director of the Colorado Department of Corrections;
- Sharon Shalev: Research Associate at the Centre for Criminology of the University of Oxford, founder of SolitaryConfinement.org;
- Terry A. Kupers: psychiatrist, Professor Emeritus at The Wright Institute and Distinguished Life Fellow of the American Psychiatric Association.

We had the honor of having with us Alan Mitchell, the President of the C.P.T. We had the honor of having with us Sharon Shalev, whose pioneering work provided for the first time to the world a full picture of the use and consequences of solitary confinement, as well as a comprehensive theoretical framework of what it implies for the human rights system. As you can see from the list of experts who participated in the discussion, multidisciplinarity was central to our work. All these people have many more titles than the short description you can read. And they all have long experience in the field of prison and in particular of solitary confinement. They are not just theorists who affirm from their desks that solitary can be dispensed with. Rick Raemisch, for instance, was the head of the Colorado prisons and succeeded in eliminating solitary confinement. He was appointed when his predecessor was murdered by a man with mental health issues who had spent seven years in solitary and was released directly into the community, something that many countries do. When he banned solitary confinement even in the prison facility dedicated to people with serious mental illness, someone said that he was going to get someone killed. But after some time they had to change their minds: incidences had dropped by over 80%.

Not all of them signed the final document (Rick Raemisch did), because of their institutional role or other considerations (the list of signatories can be accessed at the end of the International Guiding Statement). Other important signatures were added, including those of Juan Mendez, former UN

Special Rapporteur on torture who in 2011 presented the report on solitary confinement setting the 15-day limit, and Mauro Palma, former President of the C.P.T. as well as of the Council for Penological Co-operation of the Council of Europe. He is also the founder of Antigone.

Before today, the International Guiding Statement received much interest from both civil society organizations around the world to whom we presented it and international authorities, who encouraged us to continue our work. In particular, the most relevant presentations were made in Geneva between March and May 2023, when we had two closed briefing with the UN Committee Against Torture and the UN Subcommittee for the Prevention of Torture and personal presentations to the Un Working Group on Arbitrary Detention, the UN Special Rapporteur on the Rights of Persons with Disabilities, the UN Special Rapporteur on Torture, the Assistant of the UN Special Rapporteur on Health, the Secretariat of the UN Human Rights Committee, the ICRC (International Committee of the Red Cross), the A.P.T. (Association for the Prevention of Torture), the O.M.C.T. (World Organization Against Torture).

Two premises before going into the actual content of the International Guiding Statement. The first: this document does not situate itself in the hyperuranium. The working group addressed the real situation in current prison systems. The suggested measures start from a given fact: solitary confinement is still used. When it is abolished one day, in the hope that this will happen, some of the recommendations will no longer be needed. But nowadays there is no contradiction in regulating something about solitary in a document that wants to abolish solitary. The recommendations are intended to indicate a stepwise path. No one has a magic wand. Consider also that the Statement is designed on a global scale and requires a broad formulation that takes into account regional diversity.

Second premise: the working group took a comprehensive approach to the topic. We started from the assumption that solitary confinement is not a stand-alone phenomenon. The excessive use of solitary confinement depends on broader structural problems and is a consequence of wider systemic failures both of prison systems and community services. The Appendix of the International Guiding Statement, as well as the Background Brief, indicate these structural problems in what we have called the solitary confinement pipeline:

1. overuse of incarceration: overcrowding increases friction among people living in prisons, available prison resources inadequately address these frictions, leading prison authorities to resort to punitive measures. The overuse of incarceration is also due to the penal system's preservation of socio-economic inequalities, that leads to the following point;
2. undue and disproportionate criminalization of underprivileged groups: social disparities in the community results in the overrepresentation worldwide of vulnerable population and underprivileged groups in incarceration settings, including individuals with mental disabilities. And the prison

system's failure to meet their needs results in over-representation in solitary confinement: there is evidence that underprivileged groups are placed more frequently in solitary and for longer durations;
3. shortage of community welfare and health safeguards: too often, prison ends up being the last bastion of welfare. Prisons should not be used as holding facilities for individuals with psychosocial disabilities, who are frequently placed in solitary;
4. failures in the principle of normalization: prison systems should reflect the conditions of life outside the prison walls, all rights other than freedom of movement must be protected while in prison, which is often not the case and has an impact on the use of solitary;
5. failures in the right to health in prison: the adverse health outcomes of prisons and low health care standards harm the mental and physical well-being of individuals in incarceration and can result in their placement in solitary.

The solitary confinement pipeline marks a starting point in awareness of what leads to overuse of prison isolation. This of course does not mean that we must first eradicate the problems of mass incarceration before tackling solitary confinement. But it does mean that, in implementing alternatives to solitary confinement right now, we must maintain this holistic awareness. It is something like a regulatory horizon that must remain with us. More and more in the new millennium, the global prison population has become a population composed of socially marginal categories characterized by economic, educational, cultural, and health-related poverty. This is at the root of the overuse of solitary confinement. Only by looking at the global picture we can hope to achieve lasting results in our reforms.

And now we come to the actual content of the document. The International Guiding Statement is divided into four sections, complemented by a Preamble and an Appendix (that we have just seen).

Section A is devoted to «Documentation, oversight, and accountability measures». It proposes a framework of documentation, monitoring and supervision that must be: robust, coordinated and proactive. The starting point for countering the use of solitary confinement is to know it. Robust, in that Section A requires the recording in individual files of a very precise set of information ranging from the person's social and medical condition, official reasons for his or her placement in solitary confinement, all measures taken to avoid such placement, comprehensive incident reports, and more. These measures are aimed at both prevention and deterrence. Prevention of future placements in solitary: having an accurate picture of the attempts already made and what has worked better or worse is crucial to this. Deterrence in the use of solitary confinement: a very controlled and highly supervised practice is more likely not to be used lightly. Section A also requires a set of data on the use of solitary that must be made available to the public on an ongoing basis. This is data that will be useful both at the peripheral level, to understand if there are individual

facilities where things are not working, and at the centralized level. Transparency and social control is always the best form of human rights protection. And, of course, it is essential to always inform the individuals concerned of their rights and available remedies.

Oversight must be coordinated. Section A gives a role to national and international monitoring bodies, prison authorities, health authorities (who are bound to the same ethical codes as elsewhere; in section B there is a paragraph devoted to avoiding dual loyalty), judges, and civil society. As we all know, there are very different standards of work among monitoring bodies. There is not the same level of awareness among NPMs about which places in the prison are most at risk in terms of human rights compliance. There is not the same level of awareness about how to cross-reference information found on records. The same is true for judges, who do not everywhere assume a clear mandate as guardians of legality in prison. These documentation and oversight measures are intended to bring those standards upward.

Accountability measures must be proactive in that they must use the acquired knowledge in order to plan appropriate preventive actions.

Section B is in some ways the heart of the document. It is intended to provide concrete alternatives that can prevent placement in solitary confinement under different circumstances. But it is a heart that would be meaningless without the other sections around it. The document is interrelated, and each part needs the others. It is because of Sections A, C, D and the Appendix that the alternatives to solitary confinement become viable. By building on an awareness of the structural reasons for the overuse of solitary, providing targeted and effective documentation and supervision measures, as well as individualized care plans and adequate staff training, as we will see in the next sections, we can handle each of the situations for which solitary confinement is used today by reacting in an alternative way. Solitary confinement may be unnecessary.

Solitary confinement imposed for judicial reasons during pre-trial detention is not necessary. In order to protect an ongoing investigation, it is only required that the person be allocated in an ordinary prison wing taking care to the choice of other people in the wing and certainly away from co-defendants.

The imposition of solitary confinement for supposed security reasons can be prevented through an early identification of the appropriate non-segregated allocation, identification that must be based on comprehensive and independent knowledge, that is, risk and needs assessment supervised by an independent body. Of course, what we saw in Section A is highly relevant here.

Solitary confinement upon the request of the persons concerned can be reduced and ultimately prevented first of all ensuring the person requesting solitary undergoes an assessment by mental health personnel and prison staff to examine the reasons for making the request. On this basis, and together with the individual, health personnel and prison staff can identify an alternative allocation and

daily program to address the individual's concerns.

The imposition of solitary confinement as a punishment must be prohibited. It is always possible to identify non segregating responses to disciplinary infractions. And of course it must be prohibited as part of a sentence, as stated by Mandela Rules and beyond. As the C.P.T. puts it, "offenders are sent to prison as a punishment, not to receive punishment".

The largest part of Section B is devoted to the form of solitary confinement that is most difficult to eradicate and the one that increasingly characterizes today's prisons around the world. With the rise of what we can call social detention, that is, the increasing criminalization of behavior peculiar to the most marginal sections of society, solitary confinement is more and more used as a means of prison management, an administrative tool for managing specific groups of prisoners for purposes of good order or prevention. Among these groups is obviously that of people who are considered to have psychiatric problems, an increasing number in prison. Also growing because of the widespread tendency to medicalize problems that have a social basis. Section B looks at the management of these categories, first of all, with an approach to the general well-being of the person as a measure to reduce friction, violence, self-harm; secondly, through de-escalation and prevention of mischaracterization, and thus with a strong commitment to staff training, as we shall see in Section D; thirdly, through individualized care plans, as we shall see in Section C (as we said, sections are interconnected).

Section C is devoted to individualized care plans. Too often current incarceration settings are characterized by a one-size-fits-all approach that negatively impacts the health and the well-being of people in prison. In particular, people who are placed in solitary confinement often struggle the most with this uniformity. There is a connection between solitary confinement and failure to develop individualized care plans.

Section D, the last section of the document before the Appendix that we have already been through, is devoted to the measures to ensure staff competency and well-being. Too often prison staff lack professional support and training. This leads to increased stress. And it does not allow de-escalation practices to be used to their full potential. Staff are often not trained to decode the behaviour of people in incarceration settings. For instance, they can tend to look uniformly at self-harm as manipulative or attention-seeking. This will lead to increased hostility and to the adoption of a punitive approach. Staff need to be trained at every level on the impact of trauma on individuals in incarceration settings, the specific needs of vulnerable populations, preventive intervention and de-escalation mechanisms, including conflict resolution and peer support, and of course the damaging effects of solitary confinement. Such a training must be multidisciplinary and independent, including both independent mental health professionals not employed by the prison and independent assessment of the training curriculum. And of course there

is a need for support for prison staff, who play a difficult and delicate role. In general, prison staff are not socially valued as much as they deserve. The Guidelines on recruitment and training of prison and probation staff adopted by the European Committee on Crime Problems of the Council of Europe in 2019 start from such an awareness but do not have a specific look at isolation. They were initially conceived during the Council of Europe Conference of Directors of Prison and Probation Services of 2017, and it would really be a great opportunity if more focused proposals in this direction came out of a context like today.

Thus, in conclusion: prison authorities all around the world continue to rely on solitary confinement despite the widespread consensus on its harm, mainly due to the lack of alternatives to address the challenges of contemporary prison settings. The International Guiding Statement – which we make available to prison authorities, governments, legislators, health authorities – develops recommendations to prevent its use. We are well aware that it has no magical powers. Like all international human rights instruments, it points to a direction to follow. What do we hope for its future? We hope that the International Guiding Statement can become part of international soft-law and referred to by international bodies. Antigone and Physicians for Human Rights Israel are two civil society organizations. We believe it is valuable to look at the work of civil society not only as a watchdog or a critical voice but also with an active and proactive role in many areas including legislation.