

# 5. Solitary confinement as a prison health issue

Sharon Shalev

## Key points

- Solitary confinement is used in prison systems across the world.
- Research demonstrates that solitary confinement has a negative impact on the health and well-being of those subjected to it, especially for a prolonged time.
- Those with pre-existing mental illness are particularly vulnerable to the effects of solitary confinement.
- Solitary confinement can affect rehabilitation efforts and former prisoners' chances of successful reintegration into society following their release.
- International human rights law requires that the use of solitary confinement must be kept to a minimum and reserved for the few cases where it is absolutely necessary, and that it should be used for as short a time as possible.

## Introduction

WHO defines health as a “state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity”, affirming that health, as defined, is a fundamental human right (1). Solitary confinement negatively affects all these aspects of health. It is an extreme form of confinement whose deleterious physical, mental and social health effects have long been observed and documented by practitioners and researchers alike. Yet solitary confinement is a common and universal feature of prison systems worldwide, used throughout the various stages of the criminal justice process and for a variety of reasons including punishment, containment and protection. This chapter offers a brief overview of the practice, with a particular focus on key issues relevant to prison health care staff.

## What is solitary confinement?

The term “solitary confinement” refers to the physical and social isolation of an individual in a single cell for 22.5 to 24 hours a day, with the remaining time typically spent exercising in a barren yard or cage (2–4).<sup>2</sup> Different jurisdictions may use other terms to describe what is essentially a regime of solitary confinement as defined above, including segregation, isolation, closed

confinement, 23/7 regime, cellular confinement and super-maximum security (supermax).<sup>3</sup>

The deprivation of human contact inherent in solitary confinement is usually accompanied by additional restrictions and controls applied to the prisoner. The exact nature of these will of course vary from one jurisdiction to another. But in most, isolated prisoners will have very limited, if any, access to educational, vocational and recreational activities, all conducted in isolation from others. The number and type of personal belongings allowed in prisoners' small, sometimes windowless cells are highly restricted and closely regulated. Their cells and few belongings are closely monitored and regularly searched. Inside their cells, prisoners are monitored either by closed circuit television or directly by guards. Family visits, where allowed at all, may be held through a glass barrier, preventing any physical contact between the prisoner and others. On the few occasions prisoners leave their cells, they are typically escorted by a minimum of two guards and restrained with handcuffs and in some cases placed in additional body restraints, such as leg-irons and body-belts. Prior to being returned to their cells, they will be body-searched and, in some jurisdictions, subject to a full body-cavity search.

In short, isolated prisoners would typically spend a minimum of 22.5 hours a day locked up alone in a small cell with few personal belongings and little to do. They are routinely subjected to body searches and the application of physical restraints, as well as limits on their communication with the outside world. This regime can last for months or years, and can be of an indeterminate duration.

## How does solitary confinement affect health and well-being?<sup>4</sup>

The physical conditions in solitary cells range from reasonably sized cells with windows and natural light, self-contained with a toilet and a shower screened-off from the rest of the cell to protect the prisoner's privacy, to small, windowless, filthy cells where prisoners have to use a bucket to relieve themselves. Similarly, in some

<sup>2</sup> The requirement to provide prisoners with a minimum of one hour of fresh air and exercise daily is enshrined in international law as well as in national laws in many jurisdictions.

<sup>3</sup> This should be distinguished from isolation (or seclusion) for medical purposes, which is not discussed here.

<sup>4</sup> This section is adapted from Chapter 2 of the *Sourcebook on solitary confinement* (3).

prisons, isolated prisoners may have access to books, television and a radio inside their cells, whereas in others prisoners may only be allowed a copy of a religious text, if any books at all. Finally, the degree and quality of human contact prisoners enjoy varies greatly, from no human contact other than with silent prison staff who deliver food and medication to the prisoner inside his cell, to regular contact with family, lawyers, religious personnel and so on.

Three main factors are inherent in all solitary confinement regimes: social isolation, reduced activity and environmental input, and loss of autonomy and control over almost all aspects of daily life. Each of these factors is potentially distressing. Together they create a potent and toxic mix, the effects of which were well summarized as early as 1861 by the Chief Medical Officer at the Fremantle Convict Establishment in Western Australia:

In a medical point of view I think there can be no question but that separate or solitary confinement acts injuriously, from first to last, on the health and constitution of anybody subjected to it ... the symptoms of its pernicious constitutional influence being consecutively pallor, depression, debility, infirmity of intellect, and bodily decay (5).

The rich body of literature that has accumulated since that time on the effects on health of solitary confinement largely echoes these observations and includes anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia and psychosis among other symptoms resulting from solitary confinement. Levels of self-harm and suicide, which are already much higher among prisoners than in the general population (6), rise even further in segregation units (3,7).

The effects on health of solitary confinement include physiological signs and symptoms, such as:

- |   |   |
|---|---|
| • gastro-intestinal and genito-urinary problems | • heart palpitations                            |
| • diaphoresis                                   | • migraine headaches                            |
| • insomnia                                      | • back and other joint pains                    |
| • deterioration of eyesight                     | • poor appetite, weight loss, diarrhoea         |
| • lethargy, weakness, profound fatigue          | • tremulousness                                 |
| • feeling cold                                  | • aggravation of pre-existing medical problems. |

Psychological symptoms occur in the following areas and range from acute to chronic:

- anxiety, ranging from feelings of tension to full-blown panic attacks:

- persistent low level of stress;
- irritability or anxiety;
- fear of impending death;
- panic attacks;
- depression, varying from low mood to clinical depression:
  - emotional flatness/blunting;
  - emotional lability (mood swings);
  - hopelessness;
  - social withdrawal, loss of initiation of activity or ideas, apathy, lethargy;
  - major depression;
- anger, ranging from irritability to rage:
  - irritability and hostility;
  - poor impulse control;
  - outbursts of physical and verbal violence against others, self and objects;
  - unprovoked anger, sometimes manifesting as rage;
- cognitive disturbances, ranging from lack of concentration to confused states:
  - short attention span;
  - poor concentration;
  - poor memory;
  - confused thought processes, disorientation;
- perceptual distortions, ranging from hypersensitivity to hallucinations:
  - hypersensitivity to noises and smells;
  - distortions in time and space;
  - depersonalization, detachment from reality;
  - hallucinations affecting all five senses (for example, hallucinations of objects or people appearing in the cell, or hearing voices);
- paranoia and psychosis, ranging from obsessional thoughts to full-blown psychosis:
  - recurrent and persistent thoughts (ruminations) often of a violent and vengeful character (for example, directed against prison staff);
  - paranoid ideas, often persecutory;
  - psychotic episodes or states: psychotic depression, schizophrenia;
- self-harm and suicide.

How individuals will react to the experience of being isolated from the company of others depends on personal, environmental and institutional factors, including their individual histories, the conditions in which they are held, the regime provisions which they can access, the degree and form of human contact they can enjoy and the context of their confinement. Research has also shown that both the duration of solitary confinement and uncertainty as to the length of time the individual can expect to spend in solitary confinement promote a sense of helplessness and increase hostility and aggression (3). These are important determinants of the extent of adverse health effects experienced.

The adverse effects of solitary confinement will thus vary, depending on the pre-morbid adjustment of the individual and the context, length and conditions of confinement. The experience of previous trauma will render the person more vulnerable, as will the involuntary nature of his/her solitary confinement and confinement that persists over a sustained period of time. Initial acute reactions may be followed by chronic symptoms if the regime of solitary confinement persists.

There is, however, and regardless of these variables and with a few notable exceptions,<sup>5</sup> a general consensus among health practitioners and researchers that solitary confinement adversely affects health and well-being and prisoners' chances of successful reintegration into society.<sup>6</sup> Indeed, observations on the effects of solitary confinement are so consistent that Harvard psychiatrist Stuart Grassian, a long-time researcher of and commentator on solitary confinement, contends that the constellation of these effects forms a unique syndrome, which he terms the "isolation syndrome":

... while this syndrome is strikingly atypical for the functional psychiatric illnesses, it is quite characteristic of an acute organic brain syndrome: delirium, characterized by a decreased level of alertness, EEG abnormalities ... perceptual and cognitive disturbances, fearfulness, paranoia, and agitation; and random, impulsive and self-destructive behaviour ... (13).

### Particularly vulnerable groups

While the effects of solitary confinement vary from one individual to another and depend on the factors listed above, some individuals are particularly vulnerable to the negative effects of isolation, including those with pre-existing mental and learning disabilities, children and young people and detainees held on remand. These categories are briefly examined below.

#### **Prisoners with mental problems**

People who suffer mental problems are grossly overrepresented in prisons in general, and in segregation units in particular (7,14). Such individuals may be segregated for their own protection because they are victimized by other prisoners, or they may end up in isolation because they misunderstand the rules and regulations that govern prison life. They may also behave in ways that, in the context of high-security confinement, are interpreted as violations of rules rather

than a manifestation of their mental problems. Where prisoners' progression through the system depends on their behaviour and perceived adherence to prison rules, this can "turn a minor incident into a serious situation" (15) and lead to a vicious cycle which results in a prolonged stay in isolation, where these very conditions make them worse and less able to abide by the rules and regulations. Furthermore, placement in isolation, as noted earlier, also limits prisoners' access to privileges, programmes and work release assignments and affects their chance of early parole (15).

Experts largely agree that individuals with pre-existing mental illness are at a particularly high risk of worsening psychiatric problems as a result of their isolation (for example, Grassian (13); Haney (16); Kupers (17); Reid (18)). This is increasingly being recognized by the courts on both sides of the Atlantic. In a case involving the placement of a prisoner with known mental health problems in punitive isolation for 45 days and his subsequent suicide, for example, the European Court on Human Rights reiterated that:

... the vulnerability of mentally ill persons calls for special protection. This applies all the more where a prisoner suffering from severe disturbance is placed, as in [this] case, in solitary confinement or a punishment cell for a prolonged period, which will inevitably have an impact on his mental state, and where he has actually attempted to commit suicide shortly beforehand (19).

In a class action lawsuit involving the Security Housing Unit at Pelican Bay, California, federal judge Thelton Henderson observed that conditions there may well "hover on the edge of what is humanly tolerable for those with normal resilience, particularly when endured for extended periods of time" (20). But for some, the conditions of prolonged isolation at the Unit were not tolerable. These prisoners included, according to the court:

The already mentally ill, as well as persons with borderline personality disorders, brain damage or mental retardation, impulse-ridden personalities, or a history of prior psychiatric problems or chronic depression. For these inmates, placing them in the SHU is the mental equivalent of putting an asthmatic in a place with little air to breathe (18).

The particularly devastating effects that solitary confinement has on the mentally ill were more recently also recognized by the American Psychiatric Association,

<sup>5</sup> Most recently, these include O'Keefe et al. (8), who found that: "segregated offenders were elevated on multiple psychological and cognitive measures when compared to normative adult samples. However, elevations were present among the comparison groups too, suggesting that high degrees of psychological disturbances are not unique to the [administrative segregation] environment". The study also found that mentally ill prisoners were more aggravated by their experiences of isolation than prisoners who were not (diagnosed as) mentally ill, but this was true whether they were in segregation or the general population. The study and its methodology were the subject of much criticism, including by Cassela (9) and Grassian (10), among others (11).

<sup>6</sup> For full referencing and review of the literature, see Shalev (3) and Scharff Smith (12).

which stated that: “Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates” (21).

### **Children and young adults**

Children and young adults are still developing physically, mentally and socially. This makes them particularly vulnerable to the negative effects of solitary confinement which, as psychologist Craig Haney put it, is the equivalent of placing them in a deep-freeze. Furthermore, the prevalence of mental illness among young people in prison is even higher than among adult prisoners, with as many as 95% having at least one mental health problem and 80% having more than one (6). In this context, it is important to note that young people in prisons are 18 times more likely to commit suicide than their counterparts in the community (6). In 2012, a task force appointed by the United States Attorney General to report on children exposed to violence noted the following:

Nowhere is the damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement .... Juveniles experience symptoms of paranoia, anxiety, and depression even after very short periods of isolation. Confined youth who spend extended periods isolated are among the most likely to attempt or actually commit suicide. One national study found that among the suicides in juvenile facilities, half of the victims were in isolation at the time they took their own lives, and 62 percent of victims had a history of solitary confinement (22).

The practice of isolating young people, both in juvenile facilities and in adult prisons, either for their own protection or as punishment is nonetheless common. In Texas, for example, a 2012 survey found that “the majority of jails held juveniles in solitary confinement for 6 months to more than a year” (22).<sup>7</sup> An inquiry into the use of physical restraint and solitary confinement of children in England and Wales found that solitary confinement was widely used in institutions for young offenders: during an 18-month period, for example, 519 children were placed in solitary confinement in 6 such institutions (23).

Such practices and the particular vulnerability of young people have led international bodies as well as professional associations to call for a prohibition on the use of solitary confinement for juveniles. Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (24) specifically lists solitary confinement among a list of prohibited treatments:

All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned. The reduction of diet and the restriction or denial of contact with family members should be prohibited for any purpose.

The Istanbul Statement (2), the United Nations Special Rapporteur on Torture (4) and the Essex Expert Group (25), among others, all call for a complete ban on the use of solitary confinement with juveniles and young people. The American Academy of Child and Adolescent Psychiatry has stated that where solitary confinement is used, the young person should be evaluated by a mental health professional within 24 hours (26).

### **Pre-trial detainees**

Detainees held on remand are another particularly vulnerable group, and research shows that their vulnerability is made worse in solitary confinement. In England and Wales, one study found that 54% of prison suicides took place among detainees held on remand, and that around half of these occurred within one month of being taken into custody (27). Another study, of detainees held on remand in Denmark, found that where detainees were isolated for four weeks, “the probability of being admitted to hospital for a psychiatric reason was about 20 times as high as for a person remanded in non-solitary confinement for the same period of time” (28,29). A more recent longitudinal study commissioned by the Swedish Prisons and Probation Service to examine the health effects of restricted detention among those held on remand (including solitary confinement) found that such detention poses a “significant risk of mental illness” (30) even when other factors (previous psychiatric contact, substance abuse, gender, parenting) are controlled for. One in four of those detained with restrictions suffered mental illness, compared to one in five of those held without restrictions. A qualitative study carried out in parallel to the main study found that three factors are particularly harmful to mental well-being and behaviour in prison: passivity, uncertainty and feelings of impotence. These factors, which are present to some degree in any form of confinement, are of course magnified in isolation.

In sum, the literature shows that solitary confinement is damaging across the board, with young people, detainees held on remand and people with learning difficulties and mental illness being particularly vulnerable to the damaging

<sup>7</sup> In the United States, a jail is a city or county prison.

effects of solitary confinement. The key negative health effects of solitary confinement are listed above.

### Long-term effects

While some of the adverse health effects of solitary confinement will subside on its termination, others may persist. The lasting effects of solitary confinement are perhaps most evident in social settings and with interpersonal relationships:

Although many of the acute symptoms suffered by inmates are likely to subside upon termination of solitary confinement, many – including some who did not become overtly psychiatrically ill during their confinement in solitary – will likely suffer permanent harm as a result of such confinement. This harm is most commonly manifested by a continued intolerance of social interaction, a handicap which often prevents the inmate from successfully readjusting to the broader social environment of general population in prison and ... often severely impairs the inmate's capacity to reintegrate into the broader society upon release from imprisonment (13).

The transition from life in solitary confinement to co-existence with others, whether in general prisons or in free society, can be sharp and unsettling. Some of the very survival skills adopted in reaction to the pains of isolation, such as withdrawal and going mute, render the individual dysfunctional upon release. Some become so dependent on the structure and routines of the prison for controlling their behaviour that they find it difficult to function without them. This problem of becoming institutionalized is experienced by many prisoners on their release, but it takes on a much more acute form when the transition is from years of social isolation (31). Unable to regain the necessary social skills to lead a functioning social life, some of those held in solitary confinement in prison may continue to live in relative social isolation after their release. In this sense, solitary confinement operates against one of the main purposes of the prison, which is to rehabilitate offenders and facilitate their reintegration into society.

### When and why is solitary confinement used in contemporary penal systems?

Each state has its own peculiarities but in most, solitary confinement is used throughout the different stages of the criminal process: pre-charge, pre-trial and following conviction. The principle of isolation is common to all these uses, but each entails slightly different arrangements and has a different rationale and different official goals.

Solitary confinement can be used:

- when a suspect is being questioned *before being charged*, to prevent collusion between suspects; it

is also an interrogation technique, particularly for people suspected of committing acts against state security;

- when a suspect *has been charged and is awaiting trial*; the purpose of isolating detainees held on remand is to prevent collusion and to prevent them from intimidating potential witnesses;
- *during the trial and immediately after it* in a penal institution while the newly arrived prisoner is being risk assessed.

Solitary confinement also has several roles or purposes *during imprisonment*. It can be used:

- as a short term-punishment for prisoners who break prison rules;
- to prevent escape;
- for the prisoners' own protection to prevent them from harming themselves or being harmed by others;
- as a prison management tool for the safe management of difficult and challenging prisoners, and for the management of prisoners belonging to certain groups (such as prison gang members);
- where capital punishment is still practised; death row prisoners are typically held in solitary confinement, and where the death penalty has been abolished it is often substituted with a sentence of life in conditions of solitary confinement, on the basis that prisoners sentenced to death have nothing to lose and may therefore commit serious crimes inside prison or indeed attempt to escape;
- increasingly, with immigration detainees (32,33);
- while awaiting transfer to another prison or to a hospital, disciplinary or classification hearing, or a bed; these are temporary measures, but in some cases the prisoner may be isolated for many weeks and sometimes months;
- *de facto*; staff shortages, convenience or as group punishment can mean that prisoners are confined to their cells for an entire day or for several days at a time in what is commonly known as lockdown.

As Hayes (14) notes, all these protocols could be considered hidden forms of isolation.

Whatever the reason for placing a detainee or prisoner in solitary confinement, its use in any one case must be proportionate and reasonable and the decision taken by the competent lawful authority. The prisoner must be informed, in writing, of the reasons for his/her placement in solitary confinement, its expected duration and the appeal process. A record of the decision must be kept on file, and it must be substantively reviewed at regular intervals by a body different to that which took the initial decision (3,25,34).

## How do international law and human rights bodies view solitary confinement?

The severity of solitary confinement and its potentially devastating effects on the health and well-being of those subjected to it are recognized under international law, where the practice occupies a special place. The United Nations has gone as far as calling for its abolition as punishment (35). Rule 60.5 of the European Prison Rules states: “Solitary confinement shall be imposed as a punishment only in exceptional cases and for a specified period of time, which shall be as short as possible” (36).

The courts and international monitoring bodies also pay particular attention to the practice and, in the light of its severity, have asserted that it is a practice which in some circumstances constitutes a form of torture, inhuman or degrading treatment (see, for example, the United Nations Special Rapporteur on Torture (4,37); the CPT (34); and European Court of Human Rights cases including *Ramirez Sanchez v. France* [2006] (38) and *Razvyazkin v. Russia* [2012] (39)).

As far back as 1978, the former European Commission of Human Rights stated the following:

Complete sensory isolation coupled with complete social isolation can no doubt ultimately destroy the personality; thus it constitutes a form of inhuman treatment which cannot be justified by the requirements of security, the prohibition on torture and inhuman treatment contained in Article 3 being absolute in character (40).

This position has since been affirmed and reaffirmed by the European Court in numerous cases: see, for example, *Ramirez Sanchez, v. France* [2006] (38), *Öcalan v. Turkey* [2005] (41) and *Babar Ahmad and Others v. the United Kingdom* (42). More recently, in a case involving the isolation for more than three years of a prisoner labelled as a persistent rule-breaker, the court reiterated that: “... solitary confinement without appropriate mental and physical stimulation is likely, in the long term, to have damaging effects, resulting in deterioration of mental faculties and social abilities” (39).

To fall under the scope of Article 3, the prisoner’s treatment must cause suffering which exceeds the unavoidable level inherent in detention (*Onoufriou v. Cyprus* [2010] (43)), depending on the court’s assessment of all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the state of health of the victim (*Kudła v. Poland* [2000] (44); *Peers v. Greece* [2001] (45)). The purpose of such treatment will be taken into account, in particular the question of whether it was intended to humiliate or

debase the victim, but the absence of any such purpose does not necessarily mean that Article 3 has not been violated (45).

While solitary confinement has always been viewed by international human rights law and bodies as an undesirable, if legitimate, prison practice, it is only in the last few years that a more concentrated and targeted campaign against its use especially for prolonged periods, has begun. In 2007, a group of international experts adopted the Istanbul Statement on the Use and Effects of Solitary Confinement, calling on states to limit the use of solitary confinement to very exceptional cases, for as short a time as possible, and only as a last resort (2). In 2008, the then United Nations Special Rapporteur on Torture, Manfred Nowak, endorsed these recommendations and added that: “Regardless of the specific circumstances of its use, effort is required to raise the level of social contacts for prisoners: prisoner-prison staff contact, allowing access to social activities with other prisoners, allowing more visits and providing access to mental health services” (35).

In August 2011, the then new United Nations Special Rapporteur on Torture, Juan Mendez, focused his periodic report to the United Nations General Assembly on the practice of solitary confinement, stating that it is a “harsh measure which may cause serious psychological and physiological adverse effects on individuals” and which can violate the international prohibition against torture and cruel, inhuman or degrading treatment (4). Importantly, the Special Rapporteur called for the absolute prohibition of prolonged solitary confinement, which he defined as a period in excess of 15 days. Soon thereafter, in November 2011, the CPT also focused its annual report on solitary confinement, stating that it is a practice which “can have an extremely damaging effect on the mental, somatic and social health of those concerned. This damaging effect can be immediate and increases the longer the measure lasts and the more indeterminate it is” (34). The CPT called on states to reduce the use of solitary confinement to an absolute minimum and ensure that its use in any given case meets what the CPT has termed the PLANN test: it must be proportionate, lawful, accountable, necessary and non-discriminatory (34).

## Conclusion

Solitary confinement is a prison practice whose harmful effects on health and well-being are well documented. The extent of psychological damage varies and will depend on individual factors (such as personal background and pre-existing health problems), environmental factors (physical conditions and provisions), regime (time out of cell, degree of human contact), context of the isolation (punishment,

own protection, voluntary/non-voluntary, political/criminal) and its duration. Notwithstanding variations in individual tolerance and environmental and contextual factors, there is remarkable consistency in research findings on the health effects of solitary confinement dating back to the 19th century. These have demonstrated negative health effects, in particular psychological but also physiological.

The best way to avoid such damage to health and well-being is not to isolate prisoners. Where this is absolutely necessary, it should only be done as a last resort and for as short a time as possible. The decision to place a prisoner in solitary confinement must always be made by a competent body, transparently and in accordance with due process requirements, and be subject to regular, independent and substantive review. The prisoner must be kept in decent physical conditions and have regular access to fresh air and exercise. Educational, recreational and vocational programmes must be provided to prisoners, ideally in association with others, and prisoners should be allowed to keep books, magazines, hobbies and craft materials in their cells. They must be afforded regular, meaningful human contact, ideally also with people from outside the prison, but prison staff should also be encouraged to communicate informally with prisoners who are held in solitary confinement. Finally, isolated prisoners should be allowed, and encouraged, to maintain contact with their friends and family, through open (contact) visits, letters and telephone communications. Crucially, prisoners must always be treated with respect for their inherent dignity as human beings.

## References

1. *Declaration of Alma-Ata*. Copenhagen, WHO Regional Office for Europe, 1978 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0009/113877/E93944.pdf](http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf), accessed 10 November 2013).
2. *The Istanbul Statement on the Use and Effects of Solitary Confinement*. Adopted on 9 December 2007 at the International Psychological Trauma Symposium, Istanbul (<http://www.solitaryconfinement.org/istanbul>, accessed 10 November 2013).
3. Shalev S. *A sourcebook on solitary confinement*. London, Mannheim Centre for Criminology, London School of Economics, 2008 (<http://www.solitaryconfinement.org/sourcebook>, accessed 10 November 2013).
4. United Nations Special Rapporteur on Torture. *Interim report to the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment*. New York, NY, United Nations, August 2011 (DOC A/66/268).
5. Attfeldt GC. Surgeon at the Convict Establishment Fremantle. Letter to AE Kennedy, Governor of Western Australia, 30 April 186. In: House of Commons Parliamentary Papers Online [website] (<http://parli.papers.chadwyck.com/marketing/guide.jsp>, accessed 22 April 2014).
6. Prisons and health: data and statistics [web site]. Copenhagen, WHO Regional Office for Europe, 2013 (<http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/prisons-and-health/facts-and-figures>, accessed 13 January 2013).
7. Fazel S et al. Prison suicides in 12 countries: an ecological study of 861 suicides during 2003–2007. *Social Psychiatry Psychiatric Epidemiology*, 2011, 46:191–195.
8. O'Keefe ML et al. *One year longitudinal study of the psychological effects of administrative segregation*. Colorado Springs, CO, Colorado Department of Corrections, 2010.
9. Casella J. ACLU and experts slam findings of Colorado DOC report on solitary confinement. *Solitary Watch*, 4 December 2010 (<http://solitarywatch.com/2010/12/04/aclu-and-experts-slam-findings-of-colorado-doc-report-on-solitary-confinement/>, accessed 10 November 2013).
10. Grassian S. Fatal flaws in the Colorado solitary confinement study. *Solitary Watch*, 15 November 2010 (<http://solitarywatch.com/2010/11/15/fatal-flaws-in-the-colorado-solitary-confinement-study/>, accessed 10 November 2013).
11. Responses to One Year Longitudinal Study. *Corrections & Mental Health Review*, June 2011 (<http://community.nic.gov/blogs/mentalhealth/archive/2011/06/21/one-year-longitudinal-study-of-the-psychological-effects-of-administrative-segregation-introduction.aspx>, accessed 10 November 2013).
12. Scharff Smith P. The effects of solitary confinement on prison inmates. A brief history and review of the literature. *Crime and Justice*, 2006, 34:441–528.
13. Grassian S. Psychiatric effects of solitary confinement. *Journal of Law and Policy*, 2006, 22:325–383 (<http://law.wustl.edu/Journal/22/p325Grassian.pdf>, accessed 11 February 2014).
14. Hayes LM. *Juvenile suicide in confinement: a national survey*. Washington, DC, US Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 2004 (<http://www.ncjrs.gov/pdffiles1/ojdp/grants/206354.pdf>, accessed 13 January 2013).
15. Hills H, Siegfried C, Ickowitz A. *Effective prison mental health services: guidelines to expand and improve treatment*. Washington, DC, US Department of Justice, National Institute of Corrections, May 2004.
16. Haney C. Mental health issues in long-term solitary and 'supermax' confinement. *Crime & Delinquency*, 2003, 49(1):124–156.
17. Kupers T. *Prison madness: the mental health crisis behind bars and what we must do about it*. San Francisco, CA, Jossey-Bass, 1999.

18. Reid WH. Offenders with special needs. *Journal of Psychiatric Practice*, 2000, 6(5):280–283.
19. *Renolde v France (application No. 5608/05)*. Strasbourg, European Court of Human Rights, 2008 ([http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-88972#{"itemid":\["001-88972"\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-88972#{)), accessed 13 November 2013).
20. The Civil Rights Litigation Clearing House. Madrid v Gomez [web site]. Ann Arbor, MI, University of Michigan, 1995 (<http://www.clearinghouse.net/detail.php?id=588>, accessed 13 November 2013).
21. *Position statement on the segregation of prisoners with mental illness*. Dallas, TX, American Psychiatric Association, 2012 ([http://www.dhcs.ca.gov/services/MH/Documents/2013\\_04\\_AC\\_06c\\_APA\\_ps2012\\_Priz\\_Seg.pdf](http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_Priz_Seg.pdf), accessed 10 November 2013).
22. *Report of the Attorney General's National Task Force on Children Exposed to Violence*. Washington, DC, US Department of Justice, December 2012 (<http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf>, accessed 10 November 2013).
23. Lord Carlile of Berriew QC. *An independent inquiry into the use of physical restraint, solitary confinement, and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes*. London, The Howard League for Penal Reform, 2006.
24. *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*. New York, NY, United Nations, 1990 (A/RES/45/113) (<http://www.un.org/documents/ga/res/45/a45r113.htm>, accessed 10 November 2013).
25. University of Essex and Penal Reform International. *Summary of an Expert Meeting at the University of Essex on the Standard Minimum Rules for the Treatment of Prisoners Review*. Vienna, United Nations Office on Drugs and Crime, 2012 (UNODC/CCPCJ/EG.6/2012/NGO/1) ([http://www.unodc.org/documents/justice-and-prison-reform/EGM-Uploads/NGO-1\\_PRI-ESSEXUNI.pdf](http://www.unodc.org/documents/justice-and-prison-reform/EGM-Uploads/NGO-1_PRI-ESSEXUNI.pdf), accessed 10 November 2013).
26. *Solitary Confinement of Juvenile Offenders*. Washington, DC, American Academy of Child & Adolescent Psychiatry, 2012 ([http://www.aacap.org/cs/root/policy\\_statements/solitary\\_confinement\\_of\\_juvenile\\_offenders](http://www.aacap.org/cs/root/policy_statements/solitary_confinement_of_juvenile_offenders), accessed 10 November 2013).
27. Liebling A. Prison suicide and its prevention. In: Jewkes Y, ed. *Handbook on prisons*. Cullompton, Willan, 2007.
28. Sestfot DM et al. Impact of solitary confinement on hospitalisation among Danish prisoners in custody. *International Journal of Law and Psychiatry*, 1998, 21(1):99–108.
29. Andersen HS et al. A longitudinal study of prisoners on remand: repeated measures of psychopathology in the initial phase of solitary versus non-solitary confinement. *International Journal of Law and Psychiatry*, 2003, 26:165–177.
30. Holmgren B, Frisell T, Runeson B. *Psykisk hälsa hos häktade med restriktioner [Mental health of detainees with restrictions]*. Norrköping, Swedish Prison and Probation Service, 2011.
31. Shalev S. *Supermax: controlling risk through solitary confinement*. Cullompton, Willan Publishing, 2009.
32. *Invisible in isolation: the use of segregation and solitary confinement in immigration detention*. Chicago, IL, Heartland Alliance National Immigrant Justice Center and Physicians for Human Rights, 2012 ([https://s3.amazonaws.com/PHR\\_Reports/Invisible-in-Isolation-Sep2012-detention.pdf](https://s3.amazonaws.com/PHR_Reports/Invisible-in-Isolation-Sep2012-detention.pdf), accessed 10 November 2013).
33. *Immigration detention: penal regime or step towards deportation? About respecting human rights in immigration detention*. The Hague, National Ombudsman of the Netherlands, 2012 (Report No. 2012/105) ([http://www.nationaleombudsman.nl/sites/default/files/report\\_2012105\\_immigration\\_detention.pdf](http://www.nationaleombudsman.nl/sites/default/files/report_2012105_immigration_detention.pdf), accessed 10 November 2013).
34. *21st general report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)*. Strasbourg, Council of Europe, 2011 (CPT/Inf (2011) 28) (<http://www.cpt.coe.int/en/annual/rep-21.pdf>, accessed 10 November 2013).
35. *Basic principles for the treatment of prisoners*. New York, NY, United Nations, 1990 (A/RES/45/111) (<http://www.un.org/documents/ga/res/45/a45r111.htm>, accessed 10 November 2013).
36. *Recommendation No. R (2006) 2 of the Committee of Ministers to member states on the European Prison Rules*. Strasbourg, Council of Europe, 2006 (<https://wcd.coe.int/ViewDoc.jsp?id=955747>, accessed 7 November 2013).
37. *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*. New York, NY, United Nations, 2008 (A/63/175) (<http://unispal.un.org/UNISPAL.NSF/0/707AC2611E22CE6B852574BB004F4C95>, accessed 10 November 2013).
38. *Case of Ramirez Sanchez v. France (Application no. 59450/00)*. Strasbourg, European Court of Human Rights, 4 July 2006 (<https://www.google.com/#q=Ramirez+Sanchez%2C+v.+France+%5BGC%5D%2C+no.+59450%2F00%2C+ECHR+2006-IX>, accessed 10 November 2013).
39. *Razvyazkin v. Russia (Application no. 13579/09)*. Strasbourg, European Court of Human Rights, 3 October 2012 ([http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-111837#{"itemid":\["001-111837"\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-111837#{)), accessed 10 November 2013).
40. *Ensslin, Baader, Raspe v. the Federal Republic of Germany (Application nos. 7572/76, 7586/76, 7587/76)*. Strasbourg, European Court of Human Rights, 8 July 1978 (<http://hudoc.echr.coe.int/sites/eng/pages/search>



- aspx?i=001-73445#{“itemid”:[“001-73445”]}, accessed 10 November 2013).
41. *Öcalan v. Turkey* (Application no. 46221/99). Strasbourg, European Court of Human Rights, 12 May 2005 ([http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-69022#{“itemid”:\[“001-69022”\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-69022#{“itemid”:[“001-69022”]})), accessed 10 November 2013).
  42. *Babar Ahmad and Others v. the United Kingdom* (Application nos. 24027/07, 11949/08, 36742/08, 66911/09 and 67354/09). Strasbourg, European Court of Human Rights, 24 September 2012 ([http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-110267#{“itemid”:\[“001-110267”\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-110267#{“itemid”:[“001-110267”]})), accessed 10 November 2013).
  43. *Onoufriou v. Cyprus* (Application no. 24407/04). Strasbourg, European Court of Human Rights, 7 April 2010 ([http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CC4QFjAB&url=http%3A%2F%2Fwww.law.gov.cy%2FLaw%2FLawoffice.nsf%2F0%2FA25CA98D198CFF44C225742D0022109E%2F%24file%2FOnoufriou%2520v%2520Cyprus.Judgment.07.01.10.doc&ei=Ua9\\_UryZJqiY4gSv-YCgBA&usg=AFQjCNGh01QV2vqmC6OIH5110rVFbuL91g](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CC4QFjAB&url=http%3A%2F%2Fwww.law.gov.cy%2FLaw%2FLawoffice.nsf%2F0%2FA25CA98D198CFF44C225742D0022109E%2F%24file%2FOnoufriou%2520v%2520Cyprus.Judgment.07.01.10.doc&ei=Ua9_UryZJqiY4gSv-YCgBA&usg=AFQjCNGh01QV2vqmC6OIH5110rVFbuL91g)), accessed 10 November 2013).
  44. *Kudła v. Poland* (Application no. 30210/96). Strasbourg, European Court of Human Rights, 26 October 2000 ([http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-58920#{“itemid”:\[“001-58920”\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-58920#{“itemid”:[“001-58920”]})), accessed 10 November 2013).
  45. *Peers v. Greece* (Application no. 28524/95). Strasbourg, European Court of Human Rights, 19 April 2001 ([http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59413#{“itemid”:\[“001-59413”\]}](http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-59413#{“itemid”:[“001-59413”]})), accessed 10 November 2013).

### Further reading

*Growing up locked down. Youth in solitary confinement in jails and prisons across the United States.* New York, NY, American Civil Liberties Union and Human Rights Watch, 2012.

Coyle A. *A human rights approach to prison management.* London, International Centre for Prison Studies, 2009.

European Committee for the Prevention of Torture (CPT) country reports. Strasbourg, Council of Ministers, 2013 (<http://www.cpt.coe.int/en/states.htm>, accessed 10 November 2013).

Haney C. Mental health issues in long-term solitary and ‘supermax’ confinement. *Crime & Delinquency*, 2003, 49(1):124–156.

*Break them down. Systematic use of psychological torture by US forces.* Boston, MA, Physicians for Human Rights, 2005.