

WHAT IS SOLITARY CONFINEMENT?

According to the Mandela Rules, solitary confinement is the confinement of detainees for 22 hours or more a day without meaningful human contact. Human contact in solitary confinement is often reduced to the minimum and is usually monotonous in nature (1). Other terms for solitary confinement include *segregation*, *isolation*, *lockdown*, and *the hole*.

According to the UN Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules), the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules), the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules) and the Special Rapporteur on Torture, solitary confinement should be prohibited for juveniles, pregnant women, women with infants, and for individuals with mental and/or physical disabilities when their conditions will be exacerbated by the confinement (1–4).

The Rules further prohibit indefinite and long-term isolation defined as exceeding 15 consecutive days and stipulate a daily visit by a health care personnel.

The above documents encourage efforts to limit or abolish solitary confinement.

IN PRACTICE

Solitary confinement is an established fixture in most prison systems. In most countries, the purpose is disciplinary, but may also be for protection or security reasons. The practice of solitary confinement varies significantly across countries and even individual detention facilities when it comes to what justifies solitary confinement and who can be subjected to it; time limitations on solitary confinement; and conditions of solitary confinement.

HEALTH IMPACT AND RISKS

Mental health symptoms are significantly more prevalent among prisoners subjected to solitary confinement compared to the general prison population (5–9). Health consequences vary depending on the conditions of confinement, including physical conditions such as exposure to light and sound stimuli, the pre-existing health status of the prisoner, and the duration of the solitary confinement.

Some of the most common psychological symptoms related to solitary confinement are: depression, anxiety, difficulty concentrating, substance abuse and dependence, cognitive disturbances, perceptual distortions, paranoia, psychosis and Post Traumatic Stress Disorder (PTSD) (5–12). Solitary confinement is an established risk factor for suicide and self-harm in prisons (13). In the USA, prisoners in solitary confinement are about seven times more likely to self-harm and three times more likely to commit suicide than other prisoners (14). The effects of solitary confinement increase the longer it lasts. A study in Italy found the suicide rate among detainees in short-term isolation went from being 239% higher than among other detainees to 439% among detainees in maximum security isolation (15).

Several problems pertaining to physical health have been found to be more prevalent in prisoners exposed to solitary confinement than in others. This includes insomnia, lethargy, headaches and pain in the back and neck (5,7,9).

Pre-existing medical issues can be exacerbated when exposed to isolation, especially among prisoners suffering mental health illness (16). Not enough is known about the long-term effects of solitary confinement, but studies have shown that some of the above symptoms last beyond the solitary confinement period and that fear of social interaction may hinder re-insertion in society (12).

CONCLUSION

United Nations and international guidelines prohibit the practice of solitary confinement for juveniles, pregnant women and those with infants, and individuals with mental and/or physical disability. Evidence shows that even when practiced on other individuals, solitary confinement has adverse effects on the physical and psychological status of detainees. Detention practitioners, legal and health professionals as well as policy makers should be aware of the effects of solitary confinement.

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