Putting solitary confinement in the spotlight: new international initiatives to map, monitor and end its use.

Joint Piece in collaboration with OMCT, as part of the Global Torture Index data analysis series, Antigone and Dr. Sharon Shalev (Oxford university & SolitaryConfinement.Org).

INTRODUCTION

Solitary confinement is one of the most severe forms of deprivation of liberty that can be legally imposed on a person. Under the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), it is defined as the *confinement of an individual for 22 hours or more a day without meaningful human contact*[1]. The Mandela Rules provide procedural safeguards against the misuse of solitary confinement [2] and strictly prohibit indefinite and prolonged solitary confinement (used for more than 15 consecutive days) on the basis that they inflict serious psychological and physical harm. Solitary confinement, therefore, must be used only in exceptional circumstances, as a last resort, for the shortest time possible, and subject to independent review and oversight.[3]

International human rights standards call on States to ensure that such practices are never applied to individuals with mental or physical disabilities, women who are pregnant, breastfeeding or with a child in prison, and children, whose vulnerability makes isolation particularly damaging to them.[4] Upholding these standards is not only a matter of compliance with international law but a core responsibility to ensure humane and dignified detention conditions to all individuals under State custody. However, data and practices across the globe gives us a different view of reality.

THREE KEY RESEARCH INITIATIVES AND REPORTS ON SOLITARY CONFINEMENT

In June 2025, the World Organisation Against Torture (OMCT) launched the Global Torture Index, with the support of more than 80 national civil society organisations, which assesses the risk of being subjected to torture and other forms of ill-treatment in any given country on an annual basis. In 2025, 27 countries across five regions were included, with plans to scale up coverage in future years. Through seven thematic pillars, the Index focuses, among others, on **freedom from torture while deprived of liberty, and including safeguards and guarantees during detention**. The data collected allows us to identify several key findings regarding solitary confinement.

In January 2024, the Mapping Solitary Confinement project was launched online on the SolitaryConfinement.Org site, with key findings published jointly with the Association for the

[1] United Nations General Assembly, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, GA Res 70/175, UN Doc A/RES/70/175 (17 December 2015). Rule 44.
[2] Ibid. Rule 43.
[3] Ibid. Rule 45.
[4] Including the UN Rules for the Protection of Juveniles Deprived of their Liberty (resolution 45/113, annex); and the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) (resolution 65/229, annex).

Prevention of Torture. This is a collaborative project coordinated by Dr Sharon Shalev, involving an international network of academics, lawyers, civil society organisations, prison administrations and oversight bodies spanning six continents. The project aims to map the legal regulation, use, monitoring and oversight of solitary confinement practices in places of detention across the world, using a detailed standardised questionnaire. This project is ongoing, with new "country reports" being added on a regular basis. As of November 2025, it included reports from 65 jurisdictions in 49 countries.

In January 2022, Physicians for Human Rights Israel (PHRI) and Antigone convened an international group of experts with multidisciplinary skills to develop a set of guidelines to overcome solitary confinement at a global level. The result of this process is the International Guiding Statement on alternatives to solitary confinement (IGS)[5], published in May 2023. The IGS 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. On 11 December 2025, the IGS was launched worldwide during the online conference "Ending Solitary Confinement", with the aim of encouraging the positioning of the IGS within the framework of international soft law.

WHAT CAN WE LEARN FROM THE GLOBAL TORTURE INDEX?

The findings below are based on data collected across 27 countries between 2023 and 2024.

A common practice across all countries

A common practice highlighted by the Global Torture Index in 2025 is the worldwide use of solitary confinement. All 27 countries measured in 2025 used this method frequently and half of them use it inadequately, either exceeding the maximum 15 days or keeping prisoners in poorly lit or permanently lit cells for more than 22 hours a day. Almost half of the countries rarely or very rarely meet the standard of using solitary confinement as a *last resort*. The use of solitary confinement is only referred to the approval of the competent authority by 22% of the countries measured.

Solitary confinement is frequently used as a form of punishment

Solitary confinement is widely used as punishment. The Index reports that 44% of the countries analysed place those who file complaints of torture or other forms of cruel, inhuman, or degrading treatment or punishment (CIDTP) in solitary confinement. This practice has been documented in several countries including Colombia, Türkiye, Mexico or Libya.

Often used against people belonging to specific groups

The Index reports striking examples where isolation methods are used to target specific groups. Only 11% of the countries analysed do not apply solitary confinement to prisoners with disabilities, and only 33% do not apply this practice to pregnant women, women with infants and breastfeeding mothers. In Ethiopia, solitary confinement lacks adequate safeguards and is routinely applied, affecting vulnerable groups such as pregnant women and mothers with infants.

[5] The IGS is accompanied by a Background Brief: Alternatives to Solitary confinement aimed at providing additional background in formation.

Out of the 27 countries analysed, 26% use solitary confinement on LGBTQIA+ individuals, and the same proportion applies to people belonging to ethnic and/or religious minorities. For instance, in Malaysia, transgender detainees are frequently placed in solitary confinement cells, ostensibly for their safety.

Migrants in Libya face severe human rights violations like beatings, sexual violence and prolonged solitary confinement in trafficking warehouses. Only 14% of the countries assessed in 2025 prohibit the use of solitary confinement in immigration centres.

In some countries it is common that individuals on death row are held in solitary confinement. For instance, in Malaysia, individuals on death row are typically held in solitary confinement for up to 23 hours a day. In Pakistan, given the death penalty applies to blasphemy convictions, accused individuals often remain on death row for extended periods while awaiting appeals, such as in the case of Anwar Kenneth, who has spent over 22 years in solitary confinement.

Used to silence political dissent

A high proportion, 55% of the countries analysed, commonly use solitary confinement for political prisoners while deprived of liberty. In the Russian Federation, political prisoners are subjected to unnecessary disciplinary measures and solitary confinement. The treatment of political prisoners in this country has significantly worsened, marked by the growing use of punitive solitary confinement (SHIZO) and cell-type confinement (PKT) for prolonged periods, effectively amounting to torture. In Belarus, solitary confinement, excessive use of restraints, and isolation from the outside world are common practices with political prisoners.

Children are frequently victims of isolation punishments

The Global Torture Index also documents the conditions of children in detention. The use of solitary confinement for children is strictly prohibited by international standards since it greatly affects the development of the child and cause dire psychological trauma.[6]However, the Index reports that 8 out of 27 countries measured frequently use solitary confinement for children detainees, including in Afghanistan, Honduras, the Philippines, Bahrain, Colombia and Mexico. In the Democratic Republic of the Congo, for instance, solitary confinement of prisoners, including women and minors, is widespread, often exceeding the legal maximum of 15 days.

Lack of available information

19 out of the 27 countries analysed, report an absence of accessible State data on the use of solitary confinement. This lack of transparency significantly impedes efforts to assess the scope of solitary confinement and determine whether its use amounts to torture or ill-treatment. Moreover, the informal use of this practice further exacerbates the challenges in accurately documenting isolation in detention facilities.

[6] Manfred Nowak, *The United Nations Study on Children Deprived of Liberty*, 2019, p. 257. Accessible at : https://eprints.bournemouth.ac.uk/38497/1/UN-GLOBAL-STUDY-ON-CHILDREN-DEPRIVED-OF-LIBERTY-%282019%29.pdf

WHAT CAN WE LEARN FROM THE MAPPING SOLITARY CONFINEMENT PROJECT?

Solitary confinement is used in all the 65 jurisdictions covered by the project. The similarity in what solitary confinement looks like across the world, both in terms of material conditions and regime, and the reasons why it is used; punishment, prisoner management, prevention, protection; is much more striking than differences between countries and typically involving a barren cell where the individual will spend 22-24 hours a day locked up. There are marked differences in how long solitary confinement can be imposed as punishment. Permitted durations ranged from, for example, 3 days in Ireland and Scotland, to 14 or 15 days in various countries including Albania, Columbia, Sri Lanka and Venezuela, increasing to 30 days in countries as diverse as Brazil, Croatia, France, Japan, Peru and Switzerland, and up to 3 months in Estonia and Ukraine. These periods could often be extended.

In all jurisdictions, the periods are often much longer and open ended for its use as an administrative prison management tool. People belonging to certain categories, for example those sentenced to death, those receiving life sentences, and high-ranking members of organised crime groups, were regularly held in solitary confinement, sometimes in very harsh conditions for long periods of time. In South Africa, for example, prisoners classified as maximum-security could be housed in one of two "supermaximum centres", where they would be locked up in their small cells for 23 hours with minimum allowable amenities and no TVs for a minimum of 30 months. In Turkey, the death penalty was abolished in 2002 and replaced with "aggravated life sentences" which entail being locked up for 23 hours a day, with one hour spent in the open air, for 36 years for non-political prisoners, or until their natural death for political prisoners. The isolation of people by virtue of their sentence goes directly against Mandela Rule 45.1, which prohibits such practices.

People from vulnerable groups continue to be isolated in a large number of jurisdictions, including people with mental illness and people who self-harmed or attempted suicide. In New Zealand, for example, people at risk of self-harm could be placed in "At Risk" units in conditions akin to solitary confinement for an unlimited duration. In Sri Lanka, it was reported that people with severe psychiatric disorders were routinely placed in solitary confinement. There were also pockets of good practice in this area: in Columbia, Ukraine, and the Federal system in Argentina, people with mental illness were specifically excluded from solitary confinement, and in the Yukon (Canada) people who were suicidal or chronically self-harming were excluded from solitary confinement. Worryingly, the vast majority of jurisdictions surveyed reported that medical staff played some role in decision-making on isolation placements, contrary to medical ethics and Mandela Rule 46 which calls on health-care staff not to have any role in the imposition of solitary confinement. Lastly, few jurisdictions were able to provide data on the extent of the use of solitary confinement – either because this data was not collected centrally, or it was collected but not made public. This makes any assessment of the extent of the use of solitary confinement globally difficult to make, but it is clear that, in most jurisdictions, it cannot be said that solitary confinement is used as an exceptional, last resort measure, for the shortest time necessary, as mandated by the Mandela Rules and other international good practice principles.

WHAT CAN WE LEARN FROM THE INTERNATIONAL GUIDING STATEMENT ON ALTERNATIVES TO SOLITARY CONFINEMENT (IGS)?

The recommendations contained in the IGS aim to be a pragmatic tool for bringing the issue of prison solitary confinement to the forefront of the debate on the rights of incarcerated persons and for proposing viable alternatives to this harmful prison practice. The IGS does not look at the phenomenon of solitary confinement as something isolated, but rather as the consequence of broader shortcomings that afflict prison systems as a whole. The solitary confinement pipeline stems from harmful prison conditions—such as overcrowding, inadequate mental-health care, and punitive management—and broader structural factors like mass incarceration, criminalisation of vulnerable populations, and the lack of community mental-health support. Nevertheless, according to the IGS, 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. The recommendations in the IGS are divided into the following sections:

• **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, in order to document the phenomenon as comprehensively as possible, it is recommended to collect exhaustive, anonymised 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.

• **Preventing placements in solitary confinement, alternative measures**:
In any situation where individuals experience a mental health crisis and acts of self-harm, the IGS recommends an immediate assessment by mental health professionals, 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 emphasised in the IGS. The IGS discourages the imposition of solitary confinement even where it is requested by the incarcerated person themselves, proposing instead a process to understand the underlying reasons behind that request.

• **Individualised care plans**:
The IGS 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 full compliance with the principle of normalisation.

• **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), according to the IGS it is crucial to offer prison staff training, guidance, and professional support, including secondary trauma care.

• **Appendix – Steps for stopping the solitary confinement pipeline**:
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. The holistic view is declined as follows: Reduce the prison population; prevent undue and disproportionate criminalisation of vulnerable populations; implement health and welfare safeguards; mainstream the normalisation principle; ensure the right to health for all.

KEY MESSAGES

Solitary confinement is extremely damaging to health and wellbeing, and it negatively affects a person's chances of successful reintegration. In some cases, it can amount to inhuman or degrading treatment or punishment, and even torture. Yet, it is a practice which is deeply embedded in prison systems worldwide. It is still used as the default option in certain situations and perceived by prison administrators as a necessary part of the fabric of the prison. Challenging that misconception is not easy, but there are examples of good practice and alternatives which can be amplified. Demonstrating that solitary confinement is still widespread internationally, recalling its harmful effects and proposing viable alternatives is necessary and an important step towards humanising, reducing and ultimately eliminating its use in places of deprivation of liberty worldwide.