

Politics of Punishment

SOLITARY CONFINEMENT OF PRISONERS AND DETAINEES IN ISRAELI PRISONS Status Report

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Executive Summary

With this report, Physicians for Human Rights – Israel (PHRI) seeks to set in motion a process that will help protect the rights of prisoners held in solitary confinement and eventually lead to a prohibition on the use of solitary confinement in Israeli prisons. This report presents the current trends in the use of solitary confinement in Israeli prisons, and offers operational ways to end this practice.

Solitary confinement is a form of incarceration that is seriously detrimental to prisoners' short and long-term mental and physical health and in some circumstances constitutes torture. It involves the distancing of a prisoner from the other inmates, for 23-24 hours a day, indefinitely at times, cutting him off from virtually any meaningful human contact and social interaction. It is a cruel practice that runs fundamentally counter to any attempt to rehabilitate and treat prisoners.

The first chapter in the report reviews major trends towards change in the prohibition of solitary confinement in international law, in particular the shift observed in recent years in international views on solitary confinement, and the intensifying call to limit—and stop—its use. The two most important changes have been: (1) the affirmation made by the UN Special Rapporteur on torture, in 2011, that solitary confinement exceeding 15 days constituted torture or cruel and degrading treatment or punishment; (2) the adoption of the amended version of the Standard Minimum Rules for the Treatment of Prisoners, otherwise known as the Mandela Rules, by the UN General Assembly, in December 2015. Unlike the old rules, the amended rules directly address the issue of solitary confinement, recognizing its negative impact on prisoners, and among other things prohibit prolonged or indefinite solitary confinement, where prolonged solitary confinement is defined as one that exceeds 15 days. In addition, they absolutely prohibit the solitary confinement of prisoners who suffer from physical or mental disabilities.

The second chapter in the report discusses the lack of transparency and control as regards the extent to which the IPS (Israeli Prison services) uses solitary confinement as well as the growing use of solitary confinement under the separation ordinance, as these are reflected in the quantitative data. The IPS does not at all collect data on the holding of prisoners in punitive solitary confinement. The only figures provided by the IPS relate to the solitary confinement of prisoners under the separation ordinance, and these indicate that some prisoners are held long term for years on end. Moreover, the data also point to the greater, intensified use of solitary confinement under the separation ordinance, as manifest in the twofold

increase in the number of placements in solitary confinement under the separation ordinance in the past two years, reinforcing suspicions that the IPS is using this type of solitary confinement sweepingly rather than as a measure of last resort.

The report's third chapter elaborates on the various trends in the use of solitary confinement against prisoners in Israel by the IPS and the security authorities.

Protected wards: The IPS established so-called "protected" wards, where it holds prisoners under conditions of solitary confinement similar to those prevailing in solitary-confinement wards and cells, without this being subject to any limitation or judicial review or any other form of review. Because these wards are not defined by the IPS as solitary-confinement wards or cells, they are neither included in the statistics on solitary confinement nor subject to any judicial or other form of review.

Solitary confinement of prisoners suffering from mental problems: This section dwells on solitary confinement as applied to the population of prisoners suffering from mental-health problems and on the failures of the mental-health apparatus, which only compound the harm caused to this population. Worse still, even though solitary confinement is very harmful to the mental health of this population, delaying and obstructing psychological treatment for its members, the IPS uses it as an easy, aggressive and offensive substitute for genuine, adequate treatment.

Punitive punishment: Prisoners are placed in punitive solitary confinement for committing disciplinary offenses listed in IPS ordinances. These offenses are given general, broad-based definitions so as to be able to encompass practically any human behavior, and might be used as a means of retribution against prisoners. In addition, when used as a punitive tool, solitary confinement is employed arbitrarily without any true control mechanism. It is one and the same entity that decides whether a disciplinary offense was committed, that imposes the punishment and carries it out.

Solitary confinement on grounds of protecting state security and solitary confinement of detainees during interrogations: solitary confinement as a tool of political oppression and control, used on prisoners accused of security offenses by the various security agencies both during detention and interrogation and against convicted prisoners under the pretense of protecting state security. Both situations predominantly involve political Palestinian prisoners defined as "security" prisoners.

Unlike other situations, the decision to hold prisoners in solitary confinement on grounds of "protecting state security" falls to the

intelligence agencies and the General Security Service. The decision to prolong solitary confinement is often made on the basis of confidential evidence, which prisoners cannot defend against.

Every year, hundreds of Palestinian detainees are put through the interrogation facilities. These interrogations are usually conducted with the prisoner held incommunicado in solitary confinement. Solitary confinement is chosen for the duration of interrogations precisely because of its devastating psychological effects on individuals, so that, coupled with other offensive methods of interrogation as an inherent part of the interrogation process, it not only deprives the detainee of basic protections but might lead to false confessions being obtained by force from detainees.

The fourth chapter analyses the involvement of health professionals in approving and sustaining the practice of solitary confinement and discusses their ethical obligations and the responsibility falling upon the health establishment to put a stop to the harm inflicted on imprisoned patients through solitary confinement: There are various nodes at which prisoners held in solitary confinement come across health professionals, whose cooperation with the security authorities allows the latter to use solitary confinement freely with the backing of the medical system and, frequently, its approval and blessing. Such cooperation contradicts the ethical and professional obligation of health professionals, which prohibits their participation in harmful practices against their patients, such as solitary confinement, and even binds them to take active steps to put an end to them. A significant number of prisoner medical files received at PHRI suggest that the practice where health professionals in prisons give solitary confinement a medical stamp of approval is commonplace.

In the last two chapters, the report traces the structural changes and the changes in values that must take place if the use of solitary confinement in Israeli prisons is to stop: We believe that the medical community in Israel, and first and foremost the Ministry of Health, should actively buckle down and engage in a fight against solitary confinement as a detention practice in Israel, or at least prohibit medical involvement in the solitary confinement of prisoners.

As both the State of Israel's health regulator and the entity directly in charge of the mental-health apparatus for prisoners, the Ministry of Health is doubly responsible for spearheading the fight against the solitary confinement of prisoners. The IPS's mental-health center (*Maban*) should operate independently in compliance with ethical and professional medical standards regardless of any considerations of and limitations on the IPS's

security apparatus; it should likewise take concrete steps to denounce the practice of placing prisoners in solitary confinement.

The Israeli Medical Association (IMA) and the Israel Psychiatric Association have, as their members, thousands of health professionals who are bound to these organizations' ethical code; this gives them the power to influence both the medical community and decision-makers in matters of medicine and health. It is also these organizations' responsibility to lead a struggle against solitary confinement and physicians' involvement therein. This holds particularly true of the IMA, which has positioned itself as a compass for medical ethics in Israel.

It is our opinion that it is the duty of the Ministry of Public Security and the IPS to maintain the health of those placed in their custody. The state cannot go on ignoring the devastating effects of solitary confinement on prisoners, which is why it must act to eradicate this harmful practice and desist from the use of solitary confinement as a pressure tool serving political and punitive purposes and as a tool for handling individuals with mental-health problems.

INTRODUCTION

Israeli legislation provides for the solitary confinement of prisoners and detainees (hereinafter: "**prisoners**") via three main procedures: solitary confinement for and during interrogation,¹ solitary confinement as a form of disciplinary punishment² (hereinafter: "**punitive solitary confinement**"), and solitary confinement under a procedure called separation³ (hereinafter: "**solitary confinement under the separation ordinance**"); solitary confinement under the separation ordinance is supposed to be a measure of last resort meant to achieve a number of goals: prison security, preventing serious disruption of discipline and normal prison routine, maintaining the well-being and safety of the prisoner or other prisoners, state "security", preventing violence or drug offenses.

Beside these legislated procedures, the Israel Prison Service (IPS) holds many prisoners under conditions of solitary confinement, in so-called protected wards, on no clear legal authority. As shall be specified in this report, detention in protected wards is essentially tantamount to detention in solitary confinement without, however, being subject to the provisions of the law governing detention in solitary confinement under the aforementioned procedures or to the accountability and safeguards built into the law in cases of solitary confinement.

All the procedures above constitute solitary confinement, by means of which a prisoner is kept away from the rest of the prisoners in a cell alone or with another prisoner, 23-24 hours a day, for periods ranging from a single day to an indefinite stretch of time,⁴ cut off from virtually all significant human contact and social interaction. Beyond the health-related, mental and physical damage it causes in both the short and long terms⁵, solitary confinement represents a cruel practice that runs

¹ Regulation 5B of Israel's Prisons Regulations, 5738 - 1978.

² Section 58 of the Prisons Ordinance [New Version], 5732 - 1971, and IPS Commission Ordinance No. 04.14.00 "Detention in Isolation".

³ Section 19B of the Prisons Ordinance [New Version], 5732 - 1971, and IPS Commission Ordinance No. 04.03.00 "Holding Prisoners in Separation".

⁴ Punitive solitary confinement can last 14 days, provided it is no longer than seven days in a row; solitary confinement for interrogation can last 35 days, extendable by approval of the Attorney General; and solitary confinement under the isolation ordinance can last indefinitely. For more on this, see: PHRI, Al Mezan Center for Human Rights, and Adalah, [Solitary Confinement of Prisoners and Detainees in Israeli Prisons](#) (June 2011).

⁵ For more on the health-related damages of solitary confinement, see, e.g., Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J. L. & Pol'y 325 (2006); Peter Scharff Smith, *The effects of solitary confinement on prison inmates: A brief history and review of the literature*, 34 Crime and Justice 451 (2006); Ruchama Marton, "Mental Effects of Solitary Confinement", Lecture given at Tel Aviv University conference: Security Prisoners or Political Prisoners? (8 January 2006); Dr.

fundamentally counter to the attempt to rehabilitate prisoners, which is one of the objectives of the IPS.⁶

Physicians for Human Rights – Israel (PHRI) receives complaints, every day, from prisoners and detainees held in severe conditions of solitary confinement. These describe considerable suffering, deficient and insufficient medical treatment, inhumane conditions of detention, ongoing punishment and the deprivation of basic rights such as education, family visits, use of telephones, daily walks in the yard, etc.

The IPS's use of this cruel and inhumane practice remains unshaken, even after the media exposed cases of suicide committed by prisoners who had been held in solitary confinement and other cases where solitary confinement produced some dire consequences. Apart from some slight embarrassment for the IPS and policy-makers, no real change ensued, nor any substantial examination of solitary confinement as a practice used in prisons. The continued, unperturbed use of solitary confinement despite its devastating effects on prisoners is made possible, amongst others, by the immunity and legitimacy granted by the medical community, in particular the Ministry of Health and the community of institutional mental-health practitioners.

For years, PHRI has fought against solitary confinement and the participation of physicians in this practice. Physicians are duty bound to care for the health and well-being of prisoners, and this includes the obligation to warn against and actively oppose any act that is liable to be detrimental to the health of their patients, such as solitary confinement. PHRI's position is that all forms of solitary confinement in prisons should be stopped, and that the Ministry of Health, the Israeli Medical Association and the Israel Psychiatric Association must interface with the security authorities and the government in order to put an end to the use of solitary confinement in prisons and promote change in the relevant legislations.

PHRI previously issued two position papers, in 2008⁷ and 2011,⁸ which reviewed solitary confinement as a mechanism used to control and oppress Palestinian prisoners. These include legal and political analysis as well as an overview of the health-related damages of solitary

Zeev Wiener, *Psychiatric Opinion on the Mental Consequences of Prisoners' Solitary Confinement* (2005).

⁶ [IPS website](#), "The IPS views as a key objective the treatment and rehabilitation of the prisoner and preparing him for re-insertion into society after serving his sentence".(Hebrew)

⁷ Tal Assif and Sahar Francis, [The Sounds of Silence: Isolation and Solitary confinement of Palestinians in Israeli Detention](#), Physicians for Human Rights – Israel and Addameer Prisoner Support and Human Rights Association (2008).

⁸ Physicians for Human Rights – Israel, Al Mezan Center for Human Rights and Adalah, supra note 4.

confinement. The present report is intended as an update on trends in the use of solitary confinement in Israeli prisons. The report will provide data on the scale of the phenomenon, survey continuing and new trends—both local and international—while touching on the role of the medical community in shaping these trends.

CHAPTER 1

MAJOR TRENDS TOWARDS CHANGE IN PROHIBITION of SOLITARY CONFINEMENT IN INTERNATIONAL LAW

International and regional human rights law includes treaties and guidelines seeking to limit or prohibit the solitary confinement of prisoners. Thus, for example, in 1992 the UN Human Rights Committee (HRC) determined that prolonged solitary confinement of prisoners might constitute torture or cruel, inhuman or degrading treatment or punishment, thereby violating Article 7 of the International Covenant on Civil and Political Rights.⁹ In 1999, the Inter-American Court of Human Rights determined that solitary confinement under certain conditions represented cruel, inhuman or degrading treatment or punishment as defined in the American Convention on Human Rights.¹⁰

In December 2007, the International Psychological Trauma Symposium adopted the Istanbul Statement on the use of solitary confinement and its effect on prisoners. According to the Statement, this practice should be absolutely prohibited when it serves as a mechanism meant to subject prisoners to psychological pressure, when it is part of the punishment for death row and life-sentenced prisoners, or when it is used against people who suffer from mental illness or against minors under the age of 18.¹¹ The Statement further says that solitary confinement should be limited to exceptional cases only, as a last resort and for the shortest duration possible.

In 2009, the UN Committee against Torture criticized Israel's use of solitary confinement against Palestinian prisoners, whether as a means of encouraging confessions from minors, of punishing disciplinary offenses, or during interrogations conducted in small cells with no ventilation or sunlight, and stated that Israel had to amend its laws in order to ensure that solitary confinement would only be resorted to in exceptional cases and for short lengths of time.¹² These points of criticism were included among the issues that the Committee asked Israel to address before its

⁹ UN Human Rights Committee (HRC), *CCPR General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)*, 10 March 1992.

¹⁰ *Castillo Petruzzi et al. v. Peru*, Inter-American Court of Human Rights Series C No. 52 (May 30, 1999).

¹¹ [The Istanbul Statement on the Use and Effects of Solitary Confinement](#), Adopted on 9 December 2007 at the International Psychological Trauma Symposium, Istanbul.

¹² UN Committee against Torture (CAT), *Concluding observations of the Committee against Torture: Israel*, 23 June 2009, CAT/C/ISR/CO/4, para 18.

scheduled review in May 2016.¹³ Israel submitted its response on 16 February 2015.¹⁴

The recent years have seen a shift in international views on solitary confinement, most prominently bringing to the fore those calling for significantly limiting the use of solitary confinement or stopping it outright. In 2011, the UN Special Rapporteur on torture presented an interim report to the UN General Assembly which determined that the negative, acute and hidden physiological and psychological effects of prolonged solitary confinement amounted to severe mental pain or suffering as defined in Article 1 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and that, consequently, **solitary confinement exceeding 15 days constituted torture or cruel and degrading treatment**, depending on circumstances, prohibited by Article 7 of the Convention against Torture.¹⁵

This opinion of his was presented by the Rapporteur in 2013 to the Inter-American Commission on Human Rights, which adopted his position and stressed that “the OAS [Organization of American States] Member States must adopt strong, concrete measures to eliminate the use of prolonged or indefinite solitary confinement”, and that “this practice may never constitute a legitimate instrument in the hands of the State”. The Commission further stated that solitary confinement must never be used against minors or people with mental disabilities.¹⁶

In 2013, the Rapporteur submitted an opinion to Brazil’s Supreme Court regarding the constitutionality of a law allowing up to 360 days of solitary confinement extendable, without judicial review, to as far as a sixth of the prisoner’s prison term in the event of future offenses being committed. The opinion was submitted as part of a petition filed against the law by one of the human rights organizations in Brazil. The Rapporteur reiterated his aforementioned opinion, stating that the law contradicted the Convention against Torture and the American Convention on Human Rights.¹⁷

¹³ UN Committee against Torture (CAT), *List of Issues Prepared by the Committee prior to the Submission of the Fifth Periodic Report of Israel (CAT/C/ISR/5)*, adopted by the Committee at its forty-eighth session, 7 May–1 June 2012, CAT/C/ISR/Q/5.

¹⁴ UN Committee against Torture (CAT), *Consideration of reports submitted by States parties under article 19 of the convention pursuant to the optional reporting procedure, Fifth periodic reports of States parties due in 2013, Israel*, 16 February 2015, CAT/C/ISR/5.

¹⁵ UN GA, 66th, 05/08/2011, A/66/268, [Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment](#), p.21.

¹⁶ Inter-American Commission on Human Rights (IACHR), [Press Release April 3 2013](#).

¹⁷ Juan E. Méndez, [Amicus Curiae Brief to the Supreme Federal Court of Brazil on the Constitutionality of the Differentiated Disciplinary Regime](#).

In December 2015, the UN General Assembly adopted the amended version of the Standard Minimum Rules for the Treatment of Prisoners.¹⁸ These rules were initially adopted by the first UN Congress on Crime Prevention and Criminal Justice in 1955, and recently underwent a number of amendments by a number of committees and experts, in order to adapt them to needs and developments in the fields of human rights and criminal justice. The rules were called **"Mandela Rules"**, after Nelson Mandela, who was imprisoned for 27 years, some of them spent in solitary confinement. Unlike the old rules, the amended rules directly address solitary confinement, recognizing its negative impact on prisoners. Rule 43, amongst others, prohibits prolonged or indefinite solitary confinement. Rule 44 states that prolonged solitary confinement is one that exceeds 15 days. In addition, rule 45 prescribes that solitary confinement shall only be used in exceptional cases, as a last resort, for the shortest period possible, and this subject to independent review and only after authorization by a competent authority. The rule further states that solitary confinement should be prohibited in cases of prisoners with physical or mental disabilities when their condition would be exacerbated under conditions of solitary confinement. The rule states that the use of solitary confinement prohibited in other UN standards relating to prisoners who are minors,¹⁹ pregnant women, women with babies and nursing women²⁰ shall continue to apply.

¹⁸ UN GA, 70th, 17/12/2015, A/Res/70/175, [United Nations Standard Minimum Rules for the Treatment of Prisoners \(the Mandela Rules\)](#).

¹⁹ Rule 67, United Nation Rules for the Protection of Juveniles Deprived of their Liberty, Resolution No. 45/113 adopted by the UN General Assembly on 14 December 1990.

²⁰ Rule 22, [The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders](#), Resolution No. 65/299 adopted by the UN General Assembly on 21 December 2010.

CHAPTER 2

SOLITARY CONFINEMENT IN NUMBERS

The data below solely relate to the solitary confinement under the separation ordinance. The IPS has no data on prisoners held in punitive solitary confinement.²¹

1. Number of prisoners held in solitary confinement

According to data from July 2015, 117 prisoners were held in solitary confinement.²² Compare this to 131 prisoners held in solitary confinement in December 2006,²³ 150 in November 2010,²⁴ 121 in June 2012,²⁵ and 135 in October 2013.²⁶

Solitary v. dual confinement: In July 2015, 85 (73%) of all prisoners held in solitary confinement were held in solitary confinement, as compared to 32 (27%) held in dual confinement.

Criminal vs. political: 94 prisoners (80.3%) of all prisoners held in solitary confinement were defined as criminal prisoners, a category accounting for 68% of the general prisoner population,²⁷ as against 23 (19.7%) "security"-political Palestinian prisoners,²⁸ a category accounting for 32% of the total number of prisoners.

Women and minors: Two (2%) of all prisoners held in solitary confinement were women, who make up about 1% of the total prisoner population, while 7 (6%) are minors, accounting for 2% of the prisoner population.

²¹ From the IPS's response dated 2 July 2015, at the request of PHRI based on the Freedom of Information Law.

²² Ibid. Despite PHRI's request, no figures were provided on the total number of prisoners isolated in 2015.

²³ From the IPS's response dated 21 December 2006, at the request of PHRI based on the Freedom of Information Law.

²⁴ From the IPS's response dated 22 November 2010, at the request of PHRI based on the Freedom of Information Law.

²⁵ Data provided to the Public Defense, taken from the Public Defense report "Separated from their Rights", September 2012.

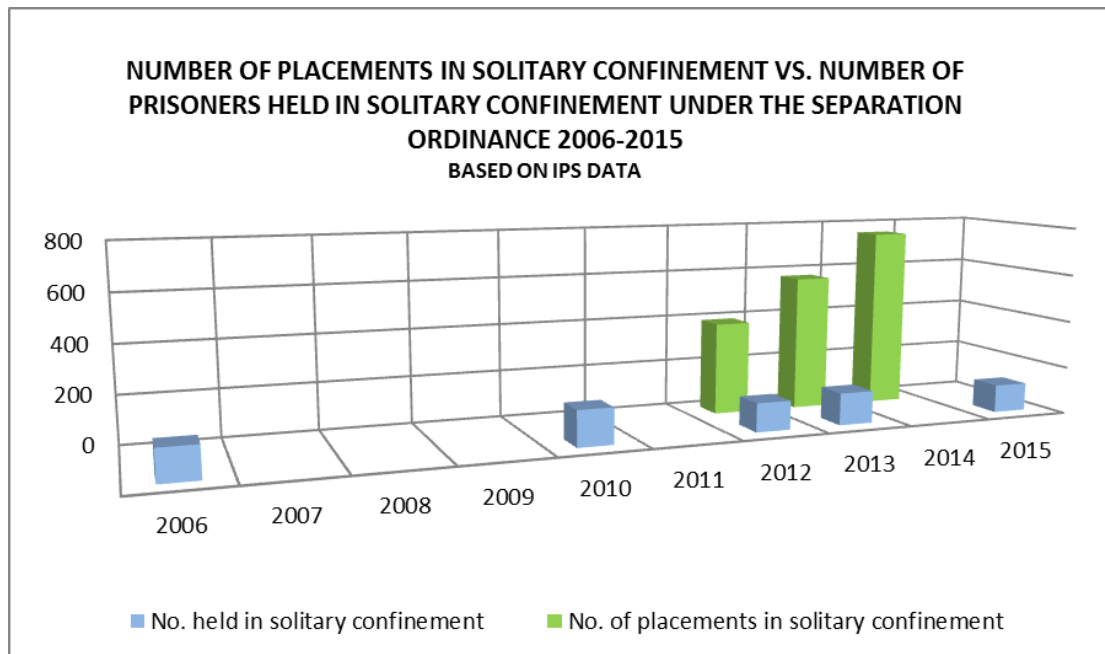
²⁶ From the IPS's response dated 31 October 2013, at the request of PHRI based on the Freedom of Information Law.

²⁷ IPS data dated 31 July 2015, as furnished to B'Tselem.

²⁸ According to section 1 of Commission Ordinance No. 04.05.00, "Rather than being the result of some provision of the law, the classification of prisoners as security prisoners is an internal IPS administrative decision meant, amongst others, to facilitate the normal management of incarceration facilities by holding them apart".

2. Placement in solitary confinement²⁹

Three hundred and ninety placements in solitary confinement were recorded in 2012, 570 in 2013 and 755 in 2014. The figures record the number of placements in solitary confinement, and thus the same prisoner might be counted more than once. As can be seen, the number of placements in solitary confinement doubled from 2012 to 2014.



3. IPS Grounds for Isolating Prisoners

According to IPS data, in July 2015:

9 prisoners were held in solitary confinement on grounds of protecting “state security”, most of them Palestinian political prisoners defined as “security” prisoners.

33 prisoners were held in solitary confinement on grounds of protecting prison security.

20 prisoners were held in solitary confinement on grounds of maintaining discipline in prison, among them two women and two minors.

4. Solitary confinement Period

²⁹ From the IPS’s response dated 2 July 2015. This answer by the IPS came in response to a question regarding the number of prisoners held in solitary confinement, at some stage, in the years 2012, 2013, 2014.

Data provided by the IPS indicate that 63 prisoners, accounting for 54% of all prisoners held in solitary confinement, have been held in solitary confinement for six months or more, meaning that their solitary confinement was extended by a court of law. Hence, 46% of all prisoners held in solitary confinement were kept that way by virtue of an IPS administrative decision that has yet to undergo judicial review.

Solitary confinement period	Number of prisoners
One day to two months	28
Two to six months	26
Six months to one year	20
One year to three years	34
Three to five years	2
More than five years	7

CHAPTER 3

TRENDS AND CHANGES IN ISRAEL

1. Number of prisoners held in solitary confinement and the growing number of placements in solitary confinement

The number of prisoners held in solitary confinement under the separation ordinance in July 2015 was lower than it was in 2013, 2012, 2010 or 2006, a fact that does not, however, indicate a drop in the number of prisoners held in solitary confinement with each passing year. The number of prisoners held in solitary confinement furnished by the IPS holds true for a given point in time, and does not reflect the average or total number of prisoners held in solitary confinement that year. In the absence of such information, the figure provided by the IPS cannot reflect the extent to which solitary confinement under the separation ordinance is employed.

In addition, the number of placements in solitary confinement under the separation ordinance has risen sharply, doubling within two years. This sharp increase does not necessarily indicate a drop or increase in the total number of prisoners sent into solitary confinement from one year to the next, as individual prisoners might have multiple placements in solitary confinement recorded each year, but it definitely suggests greater use of solitary confinement under the separation ordinance, reinforcing suspicions that this is a measure applied by the IPS sweepingly rather than as a last resort.

Israel's response³⁰ to the list of questions posed by the UN Committee against Torture³¹ explicitly stated that the IPS was unable to provide information on the scope of use of solitary confinement against Palestinian prisoners, since this measure was used, according to them, for short periods of time, mostly two to three days.³²

It can be established with certitude, without even collecting data, that the answer above does not at all reflect a reality where Palestinian prisoners are held in solitary confinement for interrogation for as long as 35 days, even more by approval of the Attorney General, and in solitary

³⁰ UN Committee against Torture (CAT), *Consideration of reports submitted by States parties under article 19 of the convention pursuant to the optional reporting procedure, Fifth periodic reports of States parties due in 2013*, Israel, 16 February 2015, CAT/C/ISR/5.

³¹ UN Committee against Torture (CAT), *List of issues prepared by the Committee prior to the submission of the fifth periodic report of Israel (CAT/C/ISR/5), adopted by the Committee at its forty-eighth session, 7 May–1 June 2012*, CAT/C/ISR/Q/5.

³² UN Committee against Torture (CAT), *Consideration of reports submitted by States parties under article 19 of the convention pursuant to the optional reporting procedure, Fifth periodic reports of States parties due in 2013*, Israel, 16 February 2015, CAT/C/ISR/5. p. 9.

confinement under the separation ordinance for periods lasting years and possibly indefinitely; it clearly does not reflect the reality of all prisoners held in punitive solitary confinement for up to 14 days. This being said, it is impossible to gauge the scope of the phenomenon and the ways it is applied to political and criminal prisoners without the IPS starting to collect data, not just on the number of prisoners held in solitary confinement, but also about their identity (gender, nationality, age, type of prisoner and civil status), the grounds, periods, the alternatives considered, the number of times where decisions to use solitary confinement have been subjected to judicial review, and the outcomes of such review.

2. Protected Wards

Commission Ordinance No. 03.01.00—Rules on the Operation of Prisons for Criminal Prisoners—defines the protected ward as follows: “1. A ward whose purpose is to house prisoners who, due to their negative behavior or to their being at risk or posing a risk, are separated from the rest of the prisoners, and who do not take part in the various prison activities. 2. Life in the ward shall follow a normal routine, with the prisoners in this ward kept separate from the other prisoners in the other wards. 3. Prisoners in this ward are not defined as prisoners held in isolation”.³³

Despite the Ordinance’s clear assertion that life in the protected ward is to run normally and that prisoners are not defined as prisoners held in solitary confinement under the separation ordinance, PHRI is approached by prisoners who report that they are held in protected wards under conditions resembling solitary confinement, without assumably being defined by the IPS as being in solitary confinement. A review report published by the Public Defense for the years 2013-2014³⁴ pointed out the existence of protected wards in which conditions of imprisonment were similar to those prevailing in solitary confinement wards and cells; however, because the IPS does not define them as such, they are neither included in the statistics nor given to any judicial review. Thus, for example, the entire solitary confinement ward in Ayalon Prison was cancelled, only to be replaced by a protected ward that serves the same purpose in reality:³⁵ to hold prisoners 23-24 hours a day alone in small cells, with no significant possibility for human contact or interaction.

³³ Section 2(D) of Commission Ordinance 03.01.00 – Rules on the Operation of Prisons for Criminal Prisoners.

³⁴ Ministry of Justice, Public Defense, [Conditions of Detention and Incarceration in IPS Detention Facilities in 2013-2014](#) (July 2015).

³⁵ Ibid, p. 12.

Mahdi (pseudonym), is a criminal prisoner who had been brutally raped in prison, and even contracted HIV as a result. Declaring him a prisoner requiring protection, the IPS held him in a protected ward. In the first seven months there, he was allowed out on the daily stroll in the yard with other inmates, and was subsequently prevented from doing so.

Mahdi asked PHRI to act in order to allow him to spend time near other prisoners. He described immense suffering in solitary confinement, especially late at night; his stay alone was the cause of severe mental anguish, and made him relive daily the hard sexual assault that he had gone through.

"I tried to commit suicide three times, but I am condemned to a life of misery... The prison's management sees me as a weirdo, a caveman... Every day I see my attacker—I see him in my food plate, in the glass I drink from; I wake up in the morning and open the faucet to wash my face, but see his face instead... no one can feel what I feel".³⁶

Mahdi reported verbal and physical violence from guards and other prisoners, and said that the medical staff ignored his complaints and bruises. The response received in October 2015 from the Prisoners Complaints Officer to our question regarding his solitary confinement reads as follows: "As for the prisoner's stay in solitary confinement, an inquiry into the matter showed that the prisoner spent time in solitary confinement because he had cursed the ward's commander and threatened to harm himself; the prisoner spent his punishment period in solitary confinement under conditions of separation, and was returned to a protected ward on 12 August 2015". The response did not at all address Mahdi's detention in conditions of solitary confinement in the protected ward. Mahdi was held in the protected ward for approximately two years, after which he was transferred to a normal ward, without any explanation. Throughout his stay in the protected ward, Mahdi was never brought before a judge to have his detention in solitary confinement extended.

3. Isolation of Prisoners with Mental Disorders

Prisoners worldwide, and Israel is no exception, are known to be the most mentally-vulnerable population, and this for a variety of reasons related, among other things, to and negative effects that deprivation of freedom and conditions of incarceration have on people. According to the State Comptroller's report for 2015, "approximately 73% of criminal detainees

³⁶ Taken from a letter sent by Mahdi to PHRI in the beginning of 2014.

and prisoners imprisoned in 2009 were examined by psychiatrists, compared to 1%-2% of the general population who were examined and treated by psychiatrists in the community".³⁷

Mental state is no reason justifying solitary confinement, and solitary confinement is by no means a form of treatment. On the contrary, solitary confinement exacerbates existing mental conditions, and might even cause irreversible mental issues and damage. Still, the IPS continues to isolate prisoners who suffer from mental problems as a way of dealing with their mental condition or as punishment for behavior they cannot control.

The detrimental effect of solitary confinement, as mentioned, on the mental health of prisoners is greater when the mental-health apparatus in charge of treating prisoners has many shortcomings and fails to meet the acute mental needs of prisoners. In a report on his behalf, the State Comptroller severely criticized the conduct of the IPS's mental-health apparatus and the huge discrepancy observed between prisoners' mental-health needs and the deficient, poor-quality services provided in reality: "For about 15 years now, the mental-health apparatus at the IPS has not been adapted to the increase in the prisoner population in general, and in the number of prisoners requiring psychiatric treatment in particular. Neither does the response actually provided satisfy the needs: This is due to the lack of consistency in treatment; to inefficiency brought about by the multiplicity of actors involved in treatment; to the absence of a body responsible for coordinating the management and training of all those involved; to the unavailability of psychiatrists; and to the absence of multi-professional work as a matter of routine. Even though the problems have been known for years to the IPS and the Ministry of Health, they have failed to come up with a practical, professional and qualitative solution to an essential problem affecting one of the weakest populations in terms of mental health, which does not always receive optimal service in the right amount".³⁸

PHRI has often taken up the matter with the Ministry of Health, in charge of the psychiatric service at the IPS's Mental Health Center (*Maban*), with *Maban's* management and with the chairman of the Israel Psychiatric Association, requesting their intervention to stop the practice of putting prisoners suffering from mental problems in solitary confinement. The response received from the Ministry of Health, in a nutshell, expressed

³⁷ State Comptroller, *Ministry of Public Security – Israel Prison Services – The Medical Apparatus for Treating Prisoners in the Israel Prison Services*, Annual Report 65C for 2014 and for the 2013 Financial-Year Accounts (2015), p. 389.

³⁸ Ibid.

their opinion that decisions pertaining to solitary confinement were strictly a matter of security, to be made by the IPS alone.³⁹

Against this background, psychiatrists working on behalf of *Maban* sometimes recommend “supervision as per IPS procedures”. Since the actual supervisory actions required and the time allotted for such supervision are never indicated, recommending supervision as per IPS procedures is akin to recommending solitary confinement. In addition, hospitalized prisoners held in solitary confinement at *Maban* due to deterioration in their mental condition are sometimes returned to their solitary confinement cell after being stabilized in the absence of any other instruction from *Maban*. In most cases, these patients relapse, requiring re-hospitalization.

This being said, since 2011, following pressure by PHRI and the Public Defense and their explicit demand that *Maban* address the implications of isolation and its damaging effects on prisoners, we are witnessing that some of the opinions submitted by *Maban* to court in proceedings to extend the solitary confinement of prisoners on the grounds that they pose a threat to themselves or others due to their mental state, have started including a review of the literature on the psychological harm brought about by this practice. Important as this change is, it is not accompanied by any change in conduct or in *Maban*’s recommendations, and is therefore suspected of being nothing more than a formality.

The opinions of the above type fail to clearly state that the prisoner in question is being held in solitary confinement, do not address the effect of solitary confinement on the prisoner in question beyond the general statement presented in the form of the literature review, and do not make any recommendation to remove the prisoner from solitary confinement or devise a program for his integration in a normal ward. It follows that the literature review is merely there by way of going through the motions and has no effect on the recommendations made with respect to the prisoners. This conduct by of the mental-health apparatus in charge of treating prisoners is mainly the product of the lack of a decisive stand against solitary confinement as an incarceration practice for prisoners suffering from mental illness.

³⁹ Tal Assif and Sahar Francis, *supra* note 7. See the response from Moshe Berger, Director of the Psychiatric Service at the IPS’s Mental Health Center, dated 13 December 2007, and the response from Mr. Yair Amikam, Deputy Director-General for International Relations at the Ministry of Health. Also see the response received from the Ministry of Health and IMA in Chapter 3.7 in the present report that deals with the involvement of medical practitioners in solitary confinement, which expresses the same notion.

Mu'tassem (pseudonym), was detained in 2006, suffered from mental problems prior to his arrest. In 2007, at the height of a psychotic episode, Mu'tassem attacked a prison guard, and was kept alone in solitary confinement from that moment on. In early 2010, after the Public Defense intervened while representing him in court during the periodic hearings on extending his detention in solitary confinement, the court ordered his removal therefrom. It was also determined, following psychiatric evaluation, that the assault on the guard took place during a psychotic episode, and that Mu'tassem should be given treatment in jail.

Following the court's decision, Mu'tassem was moved to a cell in the protected ward together with two other prisoners. After several months, due to problems arising between Mu'tassem and his cellmates, he was put back in solitary confinement. His attorney's attempts to appeal his isolation came to naught, especially given the opinions submitted by Maban emphasizing the potential danger he poses, and the importance of solitary confinement "in curbing the danger", and this contrary to the rules of medical ethics. In 2011, a volunteer psychiatrist on behalf of PHRI visited Mu'tassem in prison, and referred to his solitary confinement in his opinion: "As concerns the conditions of detention in separation, it seems that the need for them stems from a difficulty dealing with behavior resulting from his illness wherein this illness is not treated optimally and the conditions, in fact, serve as a sort of punishment for the illness, absurdly exacerbating his state, since the absence of stimuli from his surroundings and contact with others can contribute to the constant paranoid psychotic state he is in".

The opinion was submitted to court when debating an extension of his solitary confinement, but the court accepted the IPS's request to extend it. Mu'tassem is still held in solitary confinement, continues to be taken for psychiatric hospitalization at Maban every now and then and is then returned to solitary confinement pending the next deterioration in his condition and re-hospitalization.

Aiman (pseudonym) was arrested in 2007 and moved to solitary confinement three years later due to his behavior. He was diagnosed with mental problems. The first request to have Aiman's solitary confinement extended, after six months, was accepted on the strength of an opinion by Maban indicating that he was "impulsive and aggressive, and unfit for integration in a normal ward or even in dual separation".

The second request for an extension of his solitary confinement was accepted with both parties' consent after the IPS promised to find some

other solution for Aiman during that period, which it failed to do. It even submitted a third extension request, which the court approved. Aiman appealed the decision through his attorney, backed by a psychiatric opinion by a PHRI volunteer who had evaluated him. According to her opinion, "[Aiman] suffers from personality disorder, a low frustration threshold and difficulty with delayed gratification. These personality components make his rehabilitation a complex process. His placement in solitary confinement perpetuates his problematic complexity, causes cumulative mental damage and sentences him to a life that is inhuman. [Aiman] has rehabilitative potential; he responds well to respectful treatment like the one he was given at Shita prison from the guards and the warden. He is aware of the potential chance and hope inherent in a gradual process of being moved to the wards". The psychiatrist on behalf of PHRI recommended a gradual program for his removal from solitary confinement. In August 2011, the IPS started implementing a program for Aiman's gradual removal from solitary confinement. He is currently in a normal ward.

In most cases involving psychiatric problems in prisoners who are held in solitary confinement, the IPS lays the blame on the Ministry of Health and *Maban*. While the Ministry of Health and *Maban* do carry responsibility for treating prisoners who suffer from mental-health problems, it is also the IPS's responsibility to see to it that prisoners are held in conditions that do not negatively affect their health or dignity, and if it is incapable of providing such conditions, it is its duty to declare that it is not the right structure for imprisoning individuals with mental-health issues.

4. Solitary confinement on grounds of protecting state security

Unlike other situations, placing prisoners in solitary confinement on grounds of "protecting state security" is a decision that falls to intelligence organs and the General Security Services (GSS). The difficulty in these cases is that unlike detention in solitary confinement for other reasons, the decision to extend solitary confinement is often based on confidential evidence that a prisoner cannot, naturally, defend against. Also, the chances of a court of law rejecting requests to prolong solitary confinement on these grounds are slim. In the past year, two rulings were rendered in which the court intervened and rejected the State's request to prolong the solitary confinement of two "security" Palestinian prisoners,⁴⁰ but these rulings are rather the exception.

⁴⁰ [Prisoner Appeal 42099-03-15 State of Israel v. N. Murad \(prisoner\)](#), and [Prisoner Appeal \(Naz\) 42930-04-15 State of Israel v. Mohammed Al-Bal \(prisoner\)](#).

This policy leaves considerable power in the hands of the security authorities, and also enables solitary confinement contrary to the law and its purpose. It is usually the accepted rule that the longer the period of solitary confinement, the greater the burden on the competent authority to establish a vital need for continued detention, but experience shows that this is not the case when it comes to Palestinian prisoners. Thus, for example, in 2012, some 18 Palestinian prisoners were taken out of solitary confinement after being placed there by order of the GSS, some of them by authorization of the court, as part of the achievements of the hunger strike that year. The IPS argued that the agreement with the Palestinian prisoners only released from solitary confinement those prisoners held therein by order of the GSS, and not those placed therein by order of the IPS on grounds of maintaining order and security in the prisons.⁴¹ This move reinforces the claim that placing these prisoners in solitary confinement was arbitrary and that the real reason behind it was punishment and vengeance.

Nimer (pseudonym) has been imprisoned since 2003. In March 2013, he was interrogated again by the GSS in Kishon prison. Two months after his interrogation, he was moved to solitary confinement. During the interrogation, he was threatened by the interrogators that if he did not confess, he would spend his life in solitary confinement.

On 20 November 2014, nineteen months into solitary confinement, Nimer began a hunger strike in protest of his solitary confinement and his being deprived of family visits. The conditions in solitary confinement "are hard and not meant for humans... What I ask is to be let out of solitary confinement into a normal prison, and there is no reason for solitary confinement apart from the threats made by the interrogators at Kishon who threatened me with it if I did not confess to what they wanted me to".⁴²

Nimer ended his strike on 19 December 2014, after reaching an agreement that allowed him to talk to his mother over the phone and allowed her to visit him. Nine months since the end of the strike, Nimer talked to his mother four times over the phone and received one visit from her.

The conduct of the security bodies, including their consent to some of his demands following the hunger strike, reinforces the assumption that placement in solitary confinement with its harsh conditions is done as an

⁴¹ Amany Dayif and Hadas Ziv, *The Hunger Strikes of Palestinian Prisoners in Israeli Prisons: Between Political and Moral Challenges and Medical Ethical Challenges in Treating Hunger Strikers*, Physicians for Human Rights – Israel (January 2013), p. 13.

⁴² Things he said during a visit paid to him by an attorney on behalf of PHRI on 23 October 2014.

act of revenge and punishment, and not in order to protect state security as claimed.

5. Punitive solitary confinement

Punitive solitary confinement is imposed on (both “security” and criminal) prisoners following disciplinary offenses, which are defined in Commission Ordinance No. 04.13.00—Prisoners Disciplinary Rules. Said ordinance lists various disciplinary offenses for four populations: prisoners, non-administrative detainees, administrative detainees, and unlawful combatants. The list of disciplinary offenses for the prisoner population is more detailed, but each of the groups has a clause defining a general disciplinary offense that can accommodate practically any human behavior that is not to the liking of the powers that be at the prison. Thus, for example, the list of disciplinary offenses for prisoners includes 41 offenses, where offense number 41 is general and broad-based: “Any act, behavior, irregularity or neglect in violation of propriety or discipline, even if not specified in the previous paragraphs”.⁴³ A similar clause applies to the other groups, along the lines of “An act in breach of discipline and propriety in the place of detention”. These generalized, broad-based definitions leave much room for interpretation, and might even serve as vehicles for revenge against prisoners. Reports received by PHRI from several prisoners suggest that some of them are punished with solitary confinement for behaviors that is within their rights as prisoners: filing petitions, repeated complaints to the clinic, filing a complaint against a prison guard to PHRI or some other outside bodies such as the Prisoners Complaints Officer, or an argument with a guard.⁴⁴

In its response to the UN Committee against Torture, Israel noted that the IPS Commission Ordinance on Prisoners Disciplinary Rules, which was updated in September 2011, included a table defining the maximum punishment for each offense, and that according to this table, some offenses do not carry a punishment of solitary confinement, while others carry a solitary confinement punishment limited to seven days. Of the 41 offenses defined for prisoners, only five are not punishable by solitary confinement, and only 14 are punishable by solitary confinement limited to seven days or less. This leaves 22 offenses that are punishable by solitary confinement exceeding seven days.

Mu'in (pseudonym), a criminal prisoner suffering from kidney problems, was let out for examinations in hospital following a deterioration in his

⁴³ Commission Ordinance 04.13.00, Section D(2)(41).

⁴⁴ See also Public Defense Report, supra note 34, p. 15.

health condition. During his hospitalization, he was chained to the hospital bed by the same hand that was connected to the infusion.

Mu'in complained to the prison guards and the medical team about the pains caused by the tightness of the handcuffs, but they refused to untie him or slightly loosen the pressure. The doctor in charge asked the guards to remove the cuffs, as they hindered his treatment, but they turned down his request as well. The doctor appealed to the prison warden, but to no avail. Due to the excruciating pain and the arrested flow of fluids, Mu'in asked to have the infusion removed and be returned to jail. The doctors told him and the guards that if he did not receive the treatment, his condition might worsen and he might lose his kidneys. One day after being hospitalized, Mu'in was discharged from hospital.

On his return to prison, he was punished with 14 days of solitary confinement on the grounds that he refused treatment. In the first three days, he was tied to bed by his hands and feet, with two handcuffs placed on the hand that was connected to the infusion. He was only untied during meal times, and had to discharge his body wastes in bed. After three days, and after visiting the prison clinic, he was relieved of his handcuffs, but continued to be held in solitary confinement all the way up to the 14th day.

6. Solitary confinement of detainees during interrogations

A lead interrogator may order the solitary confinement of a detainee and his separation from other detainees if—and as long as—this is required for the purposes of the interrogation.⁴⁵ In addition to this, section 5(B) of Commission Ordinance 04.03.00—Holding Prisoners in Separation—states that "A prisoner can be held in separation at the prison's initiative in light of information or an event in which the prisoner was involved or at the initiative of the Israeli police with respect to individuals held in pre-charge detention for interrogation purposes".

Every year, hundreds of Palestinian detainees are put through the interrogation facilities. According to a temporary order,⁴⁶ a judge may order the arrest of a person suspected of "security" offenses for a detention period of up to 35 days, or longer given the Attorney General's approval. These interrogations are usually conducted with the prisoner

⁴⁵ Regulation 5B of Israel's Prisons Regulations, 5738 - 1978.

⁴⁶ Criminal Procedure Law (Detainee Suspected of Security Offense)(Temporary Order), 5770 – 2006, extended to 31 December 2016 by Amendment No. 4. On the extension to the Temporary Order, see: Rima Ayoub, [*The Criminal Procedure Law and the Absent 'Security Suspect': More Time to Interrogate and Torture*](#), Adalah e-Newsletter, Volume 105, June 2013.

held incommunicado in solitary confinement throughout the entire interrogation period or a major part thereof, denied any external contact, including with his family and attorney.

Solitary confinement is a preferred course of action during interrogations precisely because of its devastating psychological effects on individuals, coupled with other offensive methods of interrogation, as an inherent part of the interrogation process. The interrogation process is meant to seclude detainees from their environment and from any other familiar anchor or support, with a view to enhance the uncertainty, helplessness and impact of the other torture and mistreatment methods used in interrogations. Thus, incommunicado solitary confinement under inhumane conditions, where a detainee is prevented from meeting his attorney, along with the use of torture methods such as continuous interrogation for many long hours and sleep deprivation, leaves detainees at the mercy of the interrogators and breaks their spirit.

In a study conducted by the Public Committee against Torture in Israel and the Palestinian Prisoner's Club,⁴⁷ solitary confinement and the deprivation of the right to consult a lawyer were described as a key element in the pressure brought to bear on detainees by their interrogators: many have testified that the fear, confusion, and uncertainty they were in obscured their judgment and influenced their confession. The study found that, in all cases examined but one, a person was not released from incommunicado detention or permitted to meet a lawyer before signing a confession.⁴⁸

⁴⁷ The Public Committee against Torture in Israel and the Palestinian Prisoner's Club, [*When the Exception Becomes the Rule: Incommunicado Detention of Palestinian Detainees*](#) (October 2010).

⁴⁸ *Id.*, p. 43.

CHAPTER 4

INVOLVEMENT OF HEALTH PROFESSIONALS IN SOLITARY CONFINEMENT

The involvement of health professionals in the solitary confinement of prisoners constitutes a violation of the rules of medical ethics and a violation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Yet, in the IPS and *Maban*, the involvement of health professionals in the solitary confinement of prisoners is a matter of routine.⁴⁹

Under the rules of medical ethics, health professionals cannot approve, support or take part in detention practices that are harmful to their patients.⁵⁰ The fundamental values of medical ethics place physicians under the obligation to prevent harm from coming to their patients; this obligation means that “a patient’s safety and health are a foremost value in medicine, and that physicians will always act to keep patients free from harm, whether deliberate or resulting from an act or an omission”.⁵¹ The rules of ethics demand that “the physician act to cure the patient, relieve his suffering, protect him from diseases and minimize their damage, and all this while providing professional and up-to-date medical care with compassion and respect for the patient’s dignity and rights”.⁵²

According to the WMA Declaration of Tokyo (1975),⁵³ adopted by the Israeli Medical Association,⁵⁴ a physician will not take part in, assist in, or directly or indirectly allow torture or cruel, inhuman or degrading treatment or punishment. The declaration obligates physicians to report to the relevant authorities any violation of the Geneva Conventions, including the Fourth Geneva Convention, which prohibits torture.⁵⁵ The Declaration of Tokyo was revised in 2005 and 2006, and the Israeli Medical Association approved the updates. In 2007, it even published a position paper on the prohibition on the participation of physicians in interrogations and torture, stating, amongst others, that “a physician who

⁴⁹ For more on the issue of physicians’ involvement in solitary confinement, see references in *supra* note 7 and 8.

⁵⁰ Israeli Medical Association – Ethics Board, [Medical Ethics: Rules and Position Papers](#) (2014).

⁵¹ *Id.*, Chapter 2.

⁵² *Id.*, Chapter 3, section 3.

⁵³ WMA Declaration of Tokyo, [Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment](#).

⁵⁴ [Israeli Medical Association website](#).

⁵⁵ *Loc cit.*, section 3.

had witnessed an interrogation or torture conducted in contravention of international conventions shall report this to the competent authority".⁵⁶

The UN General Assembly and the World Health Organization likewise adopted a series of rules defining, among others, the duty of physicians towards patients, also applicable in cases of physicians treating prisoners. One example is the Principles of Medical Ethics⁵⁷ from 1982, which forbid, among other things, any professional relationship between physicians and prisoners serving any purpose other than "to evaluate, protect or improve their physical and mental health".⁵⁸

Based on all of the above, one might say that health professionals cannot in any way approve or support the solitary confinement of patients, whether they are prisoners or not, as this is unequivocally harmful to their mental and physical health. Moreover, beside their duty to provide proper care and avoid directly or indirectly endorsing a patient's solitary confinement, **physicians are duty bound to act in order to stop his solitary confinement.**

A significant number of prisoner medical files received at PHRI suggest that the practice where health professionals in prisons give solitary confinement a medical stamp of approval is commonplace. This is done both directly, when health professionals explicitly say that a prisoner is "fit for solitary confinement" or that "there is nothing to prevent solitary confinement in his case", and indirectly, when they visit a prisoner held in solitary confinement or know about his solitary confinement but do nothing to stop it.

In May 2015, we approached Prof. Chaim Hershko, the Public Complaints Commissioner at the Ministry of Health, and Dr. Leonid Eidelman, President of the Israeli Medical Association, and presented them with a long list of cases where health professionals were actively or passively involved in giving solitary confinement a stamp of approval.⁵⁹ In our letter, we demanded that an investigation be undertaken into the involvement of these health professionals in the solitary confinement of prisoners, that action be taken against those medical teams involved in medical endorsement of prisoner solitary confinement, and that steps be

⁵⁶ Israeli Medical Association, [Prohibition on the Participation of Physicians in Interrogations and Torture](#) (December 2007).

⁵⁷ General Assembly resolution 37/194, *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (18 December 1982) available from undocs [A/RES/37/194](#).

⁵⁸ Loc cit., Principle 3.

⁵⁹ Letter dated 25 May 2015, on the subject of solitary confinement receiving a medical seal of approval.

taken to issue and implement instructions prohibiting the involvement of health professionals in legitimizing solitary confinement of prisoners, either by directly sanctioning solitary confinement or by failing to stop it. A copy of our letter was also sent to Ministry of Health's Director General. To date, however, no reply was received from any of the addressees. Further still, the individual complaints we submitted to the Ministry of Health on behalf of prisoners held in solitary confinement, concerning both their health condition and medical treatment and their very detention in solitary confinement, met with responses ranging from ignoring the issue to shaking off any responsibility for it. Thus, for example, in its response of February 2015, the Ministry of Health said: "From the medical perspective, we see no justification for your complaint. The other matters brought up in your complaint letter lie outside our authority within the framework of the Ministry of Health".⁶⁰ This approach is similar to that of the medical apparatus in the IPS, which does not consider solitary confinement to be related to prisoners' health. Our appeals to the IPS Chief Medical Officer to request the removal of prisoners from solitary confinement due to the health damage involved were not addressed, on the grounds that these were not medical matters.

Our letter of May 2015 was not answered by the Israeli Medical Association (IMA), but in reply to a letter concerning a prisoner kept in solitary confinement, Dr. Eidelman reiterated the IMA's stance as enshrined in a position paper of its own, which recognized that "separation or prolonged solitary confinement might have negative effects on the physical and mental health of the prisoner. This is why the position paper determines, among other things, that a physician shall not medically sanction separation or solitary confinement, and that if the physician were to identify some concrete risk to the prisoner's health as a result of solitary confinement, he should exercise his professional authority to end it immediately". As concerns the physicians who had approved the prisoner's solitary confinement, Dr. Eidelman wrote that "our records, show that they are not IMA members, which makes it hard for us to locate them and request their response in this matter, but once we find them, we shall do so".⁶¹ Our follow-up query on the search for these physicians remains unanswered.

Notwithstanding the IMA's position on solitary confinement and the recognition that it constitutes a harmful practice, their ethical code only requires physicians to act to end solitary confinement, as mentioned in Dr.

⁶⁰ Response from Prof. Chaim Hershko, the Public Complaints Commissioner for medical professions at the Ministry of Health, dated 31 May 2015, communicated to us on 14 June 2015.

⁶¹ Reply received from Dr. Leonid Eidelman in response to our request that they intervene in order to end the solitary confinement of a prisoner and consider the issue of physicians sanctioning solitary confinement and lending it legitimacy, dated 12 January 2015.

Eidelman's reply above, "if the physician were to identify some concrete risk to the prisoner's health as a result of solitary confinement". This approach fundamentally contradicts the ethical obligations falling to physicians as specified above, under which it is their duty to act in order to prevent damages to their patients and not just stop it after it occurred.

CHAPTER 5

SUMMARY AND CONCLUSIONS

Solitary confinement is a form of incarceration that causes prisoners grave mental and physical harm and in some circumstances constitutes torture or cruel, degrading or inhuman treatment or punishment. The currently prevailing trend in international human-rights law is to ban the use of this practice. In Israel, however, the opposite trend is observed, with the use of solitary confinement growing and intensifying, as evidenced by a twofold increase in the number of placements in solitary confinement in the last two years and the creation of the protected wards, which serve as a means to hold prisoners in solitary confinement without judicial review.

The use of solitary confinement by the State of Israel is one of the most flagrant manifestations of its control and oppression ethos towards both political and criminal prisoners, the ethos on which its security apparatuses (in this case, the IPS and GSS) are founded, the one it implements while shirking any responsibility for the effects of this practice on the prisoner population. There are three significant uses of solitary confinement that reflect this notion.

The first is the use of solitary confinement as a substitute for proper psychological treatment and as a means for punishing prisoners who suffer from mental problems for their illnesses. Individuals who suffer from mental issues belong to one of the most weakened groups within the prisoner population. Although international human-rights law strictly prohibits the use of solitary confinement when it comes to mentally-ill prisoners, in Israel not only does this prohibition not exist, but the trend is to use solitary confinement in order to distance prisoners with mental problems from the rest of the prisoner population as an easy way of dealing with their health issues and as an aggressive and offensive substitute for genuine, proper treatment. Given the acute needs of prisoners and severe deficiencies in the mental-health apparatus supposed to serve them, one would expect to see the Ministry of Health, as the body in charge of this apparatus, investing resources to meet the needs and rectifying the deficiencies instead of adopting a measure that not only punishes prisoners for something they are not to blame for, but also deteriorates their condition and harms their health, irreversibly at times.

Secondly, solitary confinement is also manifest as an oppressive and domineering tool as used by the various security bodies during interrogations or on grounds of protecting state security. Prisoners in both these situational categories are predominantly Palestinian political "security" prisoners. Solitary confinement is much harder on the latter due

to the fact that they are denied phone calls and limited in family visits, which exacerbates the conditions of their solitary confinement. In addition, requests to extend their solitary confinement are mostly based on confidential information—which the victims of solitary confinement have no way to see and argue against—and usually accepted by the court.

Thirdly, solitary confinement is used as a punitive tool. Although this practice runs counter to the principles of international human-rights law, it is resorted to arbitrarily, with no real accountability. One and the same entity decides whether a disciplinary offense was committed, imposes the punishment and carries it out. Punitive solitary confinement is meted out to prisoners based on a table of offenses that can cover virtually any behavior that is not to the liking of IPS personnel, leaving considerable room for the maltreatment of prisoners.

Within each of the above uses of solitary confinement, there are various nodes at which prisoners held in solitary confinement come across medical practitioners, whose cooperation, both active and passive, allows the security authorities to use solitary confinement freely with the backing of the medical system and frequently its approval and legitimization. Such cooperation contradicts the ethical and professional obligation of health professionals, which prohibits their participation in harmful practices against their patients, such as solitary confinement, and even binds them to take active steps to put an end to them.

CHAPTER 6

RECOMMENDATIONS

1. **The Medical Community**

We believe that the medical community in Israel, and first and foremost the Ministry of Health, the Mental Health Center for prisoners (*Maban*), the Israeli Medical Association and the Israel Psychiatric Association, should actively buckle down and engage in a fight against solitary confinement as a detention practice in Israel, or at least prohibit physicians' involvement in it.

Ministry of Health

As both the State of Israel's health regulator and the entity directly in charge of the mental-health apparatus for prisoners, the Ministry of Health is doubly responsible for spearheading the fight against the solitary confinement of prisoners. Here are a number of steps that can help it move forward in meeting this responsibility:

1. To invest the resources needed to fix the acute shortcomings in the mental-health apparatus for prisoners.
2. To set up an investigation committee made up of experts together with representatives of the relevant authorities and human-rights organizations as well as independent physicians, in order to examine the performance of the mental-health system made available to prisoners, look at prisoners' mental-health needs and suggest a plan for a mental-health apparatus that would meet those needs.
3. To denounce and ban the use of solitary confinement.
4. To instruct health professionals regarding their prohibited active or passive involvement in the solitary confinement of their patients and their duty to uphold the pertinent rules of medical ethics.
5. To investigate complaints made against health professionals for taking part in solitary confinement, and take action in order to bring justice to bear on health professionals whose participation in this practice has been proven.

Maban

Maban should operate independently in compliance with ethical and professional medical standards regardless of any considerations of

and limitations on the IPS's security apparatus; it should likewise take concrete steps to denounce the practice of placing prisoners in solitary confinement. Following are a few recommendations in this matter:

1. To instruct physicians treating prisoners on behalf of *Maban* that every time they examine a patient held in solitary confinement, they should record in writing the following parameters: the fact that he is held in solitary confinement, the effects of solitary confinement on his mental health, and the manifestations of these effects. In addition, they should be instructed to recommend the patient's removal from solitary confinement while constructing an operative plan for psychological and social treatment conducive to removing the patient from the destructive vicious circle produced by solitary confinement.
2. In the opinions it submits to the courts, *Maban* should recommend removing each patient from solitary confinement and propose an operative plan for psychological and social treatment to the court in order to allow the prisoner's gradual rehabilitation from the effects of solitary confinement and make it possible to prepare him for integration in regular wards.
3. To avoid recommendations from psychiatrists that prisoners be kept under "supervision" without any time limit and conditions, which translate into indefinite solitary confinement for patients.
4. To see to it that patients released from *Maban* to the IPS come out with treatment recommendations and a specific recommendation not to be held in solitary confinement.

The Israeli Medical Association

The Israeli Medical Association and the Israel Psychiatric Association have, as their members, thousands of medical practitioners who are bound to these organizations' ethical code, which is the source of these organizations' power to influence both the medical community and decision-makers in matters of medicine and health. It is also their responsibility to lead the struggle against solitary confinement and physicians' involvement therein, especially the IMA, which has positioned itself as a compass for medical ethics in Israel.. Here are a few recommended steps to take in fighting solitary confinement:

1. To modify the IMA's ethical code on solitary confinement so as to cancel the stipulation establishing "tangible risk to a

prisoner's health as a result of solitary confinement" as a condition that gives cause for a physician to intervene and for stopping solitary confinement, instructing physicians instead to act in order to put a stop to solitary confinement under all circumstances.

2. To issue clear instructions to all health professionals, including IPS and *Maban* health professionals, clarifying the ethical prohibition on taking part in solitary confinement, regardless of whether damage was caused to the prisoner's health.
3. To investigate complaints made against health professionals for being involved in solitary confinement and take action in order to bring justice bear on medical practitioners proven to have taken part in this practice.
4. To interface with the IPS and the Ministry of Health in order to put an end to the solitary confinement of prisoners.
5. To propose that IPS health professionals be given seminars on the effects of solitary confinement on prisoners and the rules of medical ethics.

2. Incarceration and Interrogation Authorities

It is our opinion that it is the duty of the Ministry of Public Security and the IPS to maintain the health of those placed in their custody. The state cannot go on ignoring the devastating effects of solitary confinement on prisoners, which is why it must act to eradicate this harmful practice and desist from the use of solitary confinement as a pressure tool serving political and punitive purposes and as a tool for handling individuals with mental-health problems. The following actions are recommended as a way forward towards eliminating solitary confinement:

1. To find proper alternatives for dealing with disciplinary problems that are humane and respectful of human dignity.
2. To interface with the Ministry of Health in order to reinforce and strengthen the mental-health apparatus for prisoners.
3. To reinforce the social work apparatus.
4. To shut down the protected wards, which function as solitary confinement wards.
5. To collect data every year on the extent to which all types of solitary confinement are used—punitive solitary confinement,

solitary confinement under the separation ordinance and solitary confinement for interrogation. This data should be correlated with prisoner identity (gender, nationality, age characteristics, type of prisoner, and civil status) and should also include the grounds for solitary confinement, its duration, the alternatives considered, the number of cases of solitary confinement that had undergone judicial review and the outcome of such review.

6. To set up an independent experts committee—composed of medical practitioners, social workers and representatives from human rights organizations, the IPS, the Ministry of Health, the IMA and *Maban*—whose goal will be to elaborate a plan for the gradual abolishment of solitary confinement as a practice used in prisons, with precedence given to prisoners who suffer from mental-health issues and to minors.
7. To act to change the legislation so as to ban all forms of solitary confinement.