



Guidance: Isolation in detention

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Contents

Introduction.....	1
General guidance for all detention settings.....	2
Guidance for monitoring isolation of children in custody.....	6
Guidance for monitoring isolation in cases of detention in health care settings.....	9
Guidance for monitoring isolation in prisons.....	11
Guidance for monitoring isolation in police and other short-term custody.....	13
Guidance for monitoring isolation in immigration detention.....	15

Introduction

The UK National Preventive Mechanism was established to fulfil the UK's obligations under the Optional Protocol to the UN Convention against Torture and has a remit to prevent ill-treatment in detention.¹ Known in different settings by a range of different names, including segregation, separation, seclusion, time out and removal from normal location, isolating practices are examined regularly by NPM members as part of their remit to prevent ill-treatment in detention.

This guidance was developed on the basis of the findings of the review of isolation and solitary confinement across detention settings conducted by NPM members in 2014-15,² and draws from international standards and best practice. NPM members found wide variations in the practices, procedures, safeguards against harm and experiences of detainees arising from isolation, even when it was applied in similar circumstances.

The guidance provides a framework that NPM members will apply when examining the issue and making recommendations, and aims to improve consistency of approach. It allows NPM members to identify and promote good and improved practice. We hope the document will also inform detention practice and policy.

Basic principles

Prisoners and other detainees are isolated from others for a number of reasons, including:

- as a disciplinary sanction arising from offences or disruption caused within the place of detention;
- as an administrative measure;
- for investigative purposes;
- as a preventive measure against future harm or risk;
- as a measure to protect an individual from others;
- as a result of a regime and/or physical environment that restricts contact with others.

As with any restrictions imposed on persons already deprived of their liberty, isolation practices must only be used when absolutely necessary, for the shortest time possible, and be proportionate to the legitimate objective for which they are imposed. Because of the harm that can be caused by isolation, specific and additional safeguards also need to be in place. These safeguards should become more exacting as the time in isolation increases. While isolation in some instances may be legitimate, the justification for such measures and their severity must be examined carefully by monitoring bodies. The risk is that, where out of sight, detainees' rights can be overlooked or undermined.

The NPM has adopted the following definition of isolation in order to examine practices they encounter in detention, regardless of how they are named. It was designed to capture both more formal practices and informal isolation arising from restrictive or limited regimes or practices not subject to specific procedures or oversight.

Isolation

The physical isolation of individuals who are confined to cells or rooms for disciplinary, protective, preventive or administrative reasons, or who by virtue of the physical environment or regime find themselves largely isolated from others. Restrictions on social contacts and available stimuli are seldom freely chosen and are greater than for the general detainee population.

1 <http://ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx> [accessed 17/01/17]

2 Published in the Sixth Annual Report of the United Kingdom's National Preventive Mechanism, <http://www.nationalpreventivemechanism.org.uk/wp-content/uploads/2015/12/NPM-Annual-Report-2014-15-web.pdf> [accessed 17/01/17] pp21-47.

The United Kingdom is a signatory to the majority of European and United Nations international human rights treaties and standards and has committed to upholding them in practice.³ The Human Rights Act (1998), the European Convention on Human Rights (ECHR)⁴ and specifically its articles relating to the right to be free from torture and cruel, inhuman or degrading treatment (Article 3), the right to liberty and security of person (Article 5), the right to a fair hearing (Article 6) and the right to privacy and respect for family life (Article 8) are part of the law, create remedies against authorities that violate these provisions and must guide policy and practices relating to isolation in detention.

Recent international standards on conditions in prisons define solitary confinement as 'the confinement of prisoners for 22 hours or more a day without meaningful human contact' and solitary confinement for a time period in excess of 15 consecutive days as 'prolonged solitary confinement'. Indefinite or prolonged solitary confinement should be prohibited, as should imposing solitary confinement on prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures.⁵

This document contains general guidance that should apply across all detention settings.⁶ It also provides additional guidance that should apply to specific types of detention: prisons, mental health detention, immigration detention, police and court custody, and children in detention.

This document should be used by all NPM inspectors, monitors and visitors to evaluate the isolation and solitary confinement practices that they encounter, whether formal or informal. It should also be used in settings such as police and court custody where short-term single cell occupancy is usually the norm and has a specific rationale.

General guidance for all detention settings

a. General – isolation practices across detention settings

Stays in isolation are proportionate, limited in use and short in duration.

- Where detainees are confined alone for more than 22 hours a day with minimal or no meaningful contact with others, this constitutes solitary confinement. Where this lasts for more than 15 days, it will be considered prolonged solitary confinement and should cease at that point.
- There should be a specific rationale for placing any individual in isolation, with evidence that other options have been considered.
- Isolation should be used for the shortest possible period.
- Where detainees seek to engineer their own isolation, or 'self-segregate', efforts should be made to identify and address the problems that led to the situation.
- All efforts should be made to avoid detainees experiencing informal isolation as a result of restrictive regimes, staff shortages and/or the design of facilities.
- The design, provision and organisation of facilities and services in the wider detention estate should be aimed at preventing the need for isolation being used as a protective measure.

3 These include the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Covenant on Civil and Political Rights, the UN Convention on the Rights of the Child, the UN Convention on the Rights of Persons with Disabilities, The European Convention for the Protection of Human Rights and Fundamental Freedoms, and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

4 European Convention for Human Rights, http://www.echr.coe.int/Documents/Convention_ENG.pdf [accessed 17/01/17]

5 United Nations, *Standard Minimum Rules for the Treatment of Prisoners, (the Mandela Rules)*, Rule 43–44.

6 This guidance does not apply to isolation on medical grounds. There may be some aspects of the general guidance that are not applicable to short-term detention such as police custody.

b. Procedures

Clear and transparent procedures provide an appropriate safeguard against harm for all isolation practices.

- There should be clear, transparent procedures in place to guide the decision to isolate detainees, which should only happen in exceptional circumstances.
- Evidence should be provided to demonstrate that alternatives to isolation have been considered.
- Detainees at significant risk of suicide or self-harm should not be held in isolation other than in exceptional circumstances which are clearly documented, for the minimum time necessary, regularly and substantively reviewed and authorised by the most senior manager in the institution.
- Decisions to isolate should be authorised and recorded by a senior staff member and open to challenge by other staff and, where they exist, visiting bodies or advocates.
- Detainees should be informed of the purpose and reasons for their isolation in a format and language they can understand. Where the detainee is isolated for longer than 24 hours, the information should be provided in writing.
- The procedures should set out clearly that particularly vulnerable detainees or those who are mentally ill should not be isolated unless there are exceptional circumstances and all other options have been exhausted. In such cases, evidence must be provided to support this.
- Monitoring of those in isolation should be carried out in person at appropriate intervals. CCTV monitoring should not be automatically used in cases of isolation but should be justified on the basis of risk assessment. Where used, the reason for its use, the way it will be used and any specific privacy provisions (such as pixellating out the toilet area) should be explained to the detainee.
- Health care staff should assess the mental health and wellbeing of isolated detainees no later than two hours after placement in isolation.
- Procedures should ensure that children, detainees with physical disabilities, those who are mentally ill and pregnant women are never subject to solitary confinement.
- Procedures should ensure that episodes of isolation cannot be repeated or reclassified without initiating new procedures. Prior episodes must be considered in the decision to isolate.
- Transfer of detainees from an isolation facility in one establishment to an isolation facility in another should be exceptional and approved by the most senior manager in each establishment. In such cases, the detainee's stay in isolation will be considered as consecutive.
- Procedures must make clear the frequency of assessment care planning, record-keeping and review, as well as the pathway planned to cease or minimise periods of isolation.
- Procedures that apply to formal isolation in dedicated units, including debriefing, should be applied in instances where detainees are isolated in the main location of a detention facility.

c. Conditions and daily routine

Conditions are good quality and decent and daily routines are varied and mitigate the harmful mental health impact of isolation.

- Isolated detainees should be held in a safe and clean environment.
- Isolated detainees should be aware of the passage of time, either by seeing a clock or watch or by other means, which may include receiving meals at recognised times or having access to a radio. Detainees without access to a clock or watch should be told the time on request.

- Daily routines in isolation should be rich and varied to ensure the potential harmful impact of isolation is mitigated.
- On arrival, detainees should be provided with an explanation of the regime or routines that operate when in isolation in an appropriate format and language that they can understand. They should also be provided with information about their rights and entitlements.
- Isolated detainees should have equal access to a full range of basic activities, facilities or services, to include telephone, visits, books/reading materials, showers, fresh air and exercise, meals and chaplaincy.
- As far as possible and based on ongoing and individual risk assessment, isolated detainees should have access to further meaningful activities, which may include library, education, work and communal worship.
- As far as possible and based on risk assessment, isolated detainees should be able to access activities in association with others.
- Isolation facilities should be well-maintained and clean, with good ventilation and natural light.
- Individual cells/rooms should be appropriately furnished.
- Provision of articles such as kettles, TVs and radios should be based on dynamic and individual risk assessment and not denied as a matter of policy.
- Staff working in isolation facilities should be trained and selected for their ability to interact and play a positive role with detainees.
- Staff should encourage meaningful activity and good quality, face-to-face interactions.
- Staff managing isolation facilities should establish a positive rather than a punitive culture, aimed at helping the individual manage their behaviour.
- In the exceptional circumstances when unfurnished facilities are used this should be only for the shortest time possible (no more than a few minutes or hours) and for no longer than the detainee is violent or refractory. Due to the additional adverse impact such isolation can have, there should be additional authorisation by a senior manager with clear records of the underlying rationale.
- Detainees are required to wear special clothing only in exceptional circumstances where an individual risk assessment suggests there is a present risk. Detainees should never be naked.

d. Health care and well-being

Isolated detainees have equal access to health services and are monitored by health care professionals who do not take a role in non-health-related decisions around isolation.

- Health care professionals should closely monitor the health condition of isolated individuals and raise any concerns that they have with the manager responsible for the decision to isolate. These concerns must be recorded and taken into account.
- Health care staff who are familiar with the detainee and his/her medical history should be routinely involved in reviews.
- Isolated detainees should have daily confidential access to and meaningful interaction with a health care professional. Where isolation is for a prolonged period they should have confidential access to a health care professional with mental health expertise.
- Isolated detainees should be aware of how to access health care.

- A confidential record of the detainee's state of health should be kept while in isolation, in which all signs or specific triggers for the detainee's deterioration should be set out. If isolation clearly leads to deterioration, alternatives should be sought.
- Staff working in designated isolation facilities should have specific training on identifying mental health issues arising from isolation.

e. Oversight and safeguards

Robust oversight measures and safeguards are in place against the harmful or discriminatory application and impact of isolation practices.

- There should be multidisciplinary management of isolation that ensures sufficient attention to mental health and other needs of detainees.
- Peer support or advocacy schemes (for example, Listeners) should be available to all isolated detainees.
- Isolated detainees should be able to access the usual complaints processes, and their complaints must be responded to efficiently.
- Detaining authorities must monitor the use of isolation to identify when and where it is used and for how long.
- Monitoring of isolation should also identify trends, including the proportion of detainees with different protected characteristics and detainees who are repeatedly isolated, and action should be taken to address any problems identified.
- Staff working in isolation units should participate in regular guided reflective practice sessions with an appropriately trained facilitator to contribute to good-quality interactions with detainees and learning.
- Where NPM members have a specific independent oversight role in reviews of isolation, they should be provided with the information they need to be able to play a meaningful role in the review, and should apply the principles set out in this guidance to their scrutiny of cases and practices.

f. Reintegration and prevention

There is a focus from the outset on preventing isolation throughout the detention establishment and emphasis on reintegrating the detainee throughout any isolation episode.

- There should be a focus on returning detainees to their normal location/regime from the beginning of any isolation episode.
- Detainees should be made aware of what they need to do to return to their normal location/regime in a language and format they understand.
- All detainees should be encouraged to debrief with staff and be provided with extra care and support after a period of isolation with a view to preventing future episodes, preferably with a member of staff independent of the isolation decision/episode.
- Where appropriate, this may involve the preparation of advance statements for future situations where restrictive interventions may be necessary.
- After a period of prolonged isolation, detainees should be involved in decisions about reintegration and a phased return should be arranged.
- Detaining authorities should aspire to prevent or eliminate the use of isolation by focusing on the root causes of incidents that lead to its use, with a specific focus on repeated episodes and self-isolation.

Guidance for monitoring isolation of children in custody

Specific attention is required when dealing with children in detention who are especially vulnerable to potential harm or ill-treatment by virtue of their age. The use of segregation and isolation in child detention facilities should be inspected regularly.⁷ There are particular considerations that must be taken into account in monitoring children including:

- Children have a range of specific rights that continue to apply when they are in detention – including those enshrined in the United Nations Convention on the Rights of the Child⁸ and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules).⁹
- All detainees under the age of 18 years are considered children for monitoring purposes, even if they are held in adult settings.
- The best interests of the child must be a primary consideration in all decisions concerning them; this must include considerations of well-being, health and safety.
- The legislative framework governing detention and the use of isolation is frequently different to that pertaining to adults.
- Children, because of their stage of development, past history and particular vulnerabilities, may experience isolation and the time spent in isolation differently from adults.
- Given that many children in detention may have been victims of abuse and other adverse experiences, the potential for re-traumatisation through isolation must be considered.
- Isolation of children can occur in both educational and residential parts of the setting.
- As a consequence of the above, the potential damage to children of isolation is greater than that to adults.

Reflecting these differences and specificities, the following guidance has been developed to apply specifically to children in detention. This must be read alongside the general guidance provided.

a. General – isolation practices across detention settings

- Children must never be isolated as a punishment.
- Children must never be isolated as a standard or default response to particular episodes or practices (for example, restraint). Decisions to isolate must always be made on a case-by-case basis depending on the individual circumstances of the child.
- Isolation must not automatically lead to any other form of sanction, for example reduced privileges.
- Children must only be isolated as a last resort and if it represents the safest form of intervention in the circumstances. Evidence must be provided to demonstrate that alternatives to isolation have been considered.
- Every child in detention must have a care plan. This care plan must be reviewed and, where necessary, amended in light of any episode of isolation.
- Children at risk of self-harm must not be isolated other than in exceptional circumstances where assessment indicates that isolation would reduce that risk.

7 United Nations Committee on the Rights of the Child, *Concluding observations on the fifth period report of the United Kingdom of Great Britain and Northern Ireland*, paragraph 79 (f). 12 July 2016.

8 <http://ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx> [accessed 17/01/17]

9 https://www.unodc.org/pdf/criminal_justice/United_Nations_Rules_for_the_Protection_of_Juveniles_Deprived_of_their_Liberty.pdf [accessed 17/01/17]

- Staff in settings detaining children must have an understanding of children’s rights and the impact of isolation on children, and must be skilled in the use of forms of behaviour management that reduce the need for isolation.
- In determining what length of isolation is proportionate to the circumstances, the totality of the child’s experience must be taken into account rather than simply the chronological duration of the episode. For example, a number of episodes of isolation in close proximity (whatever the context or setting) may be as distressing as a single, longer, episode. It must be noted that some children may become extremely vulnerable after a very short time in isolation.
- Isolation need not always be a negative experience for children and can be used for short periods as a form of positive ‘time out’, or as part of a care plan with a clear path to reintegration. Isolation in these circumstances will often involve the child taking part in constructive activities away from others rather than being isolated in their cell/room.
- There must be clear evidence that alternatives to isolation are available and used – such as enabling children in conflict to mediate and allowing children to mix with others when they can safely do so.

b. Procedures

- When children are isolated they must be monitored/observed at 10-minute intervals as a minimum. Such observations must be recorded and reviewed.
- Any period of isolation longer than 30 minutes must be authorised by a senior manager.
- Every episode of isolation involving children must have a specific or clear rationale that is recorded. There must be a clear process for returning the child to normal regime.
- All incidents of self-isolation must be identified and recorded.
- Given the differential experience of children of the passage of time, staff must assess the well-being of isolated children no later than one hour after placement in isolation.
- Whenever children are isolated or self-isolate for more than one hour, relevant professionals and families must be notified.
- Processes must be in place to ensure that any extended period of isolation is reviewed daily by senior management to ascertain that it is still required and consistent with the best interests of the child being a primary consideration. Reviews must occur more frequently where the individual’s needs or risks are particularly acute.
- Where the same child is subject to two or more episodes of isolation totalling more than four hours in a week, a review must be undertaken to consider what action and support can be put in place to reduce the risk of future episodes occurring.
- Children must not be kept in isolation (i.e. largely isolated from their peers) for more than 22 hours in one day unless there are exceptional circumstances, which must be evidenced and all other options exhausted, and only where it is in their best interests, consistent with their care plan and where there is a clear pathway for a return to the normal regime. The daily management reviews must confirm that these criteria are satisfied. Solitary confinement – where meaningful contact with others is reduced to a minimum for that period – must never occur and should be prohibited in all circumstances.¹⁰

¹⁰United Nations Committee on the Rights of the Child, *Concluding observations on the fifth period report of the United Kingdom of Great Britain and Northern Ireland*, paragraph 79 (f). 12 July 2016.

c. Conditions and daily routines

- Conditions for children in isolation must mirror those for children in the normal regime. In particular they must have at least as much access to education, exercise, showers, telephone calls and access to the open air as children who are not in isolation. Children's right to high-quality education applies equally to those in isolation.
- Arrangements must be in place to provide emotional support to children in isolation through meaningful and extensive contact with staff with whom they have a relationship.
- Children in isolation must have at least the same rights to contact with their family as those that are on the standard regime. Where there are concerns about the wellbeing of the child, enhanced contact must be facilitated.
- Children in isolation must never be required to wear special clothing as a consequence of being in isolation, although belts and other items may be removed if they are reasonably considered to pose a risk to the child's wellbeing.
- Particular care must be taken over the removal of any furniture and, in particular, any personal effects of children isolated in the cells/rooms as these may hold additional significance to the child. Such items must not be removed unless there is clear evidence that the child will otherwise be at risk of self-harm.

d. Health care

- Any concerns for the health of a child in isolation must be recorded and mechanisms for addressing those concerns, including access to health care professionals, must be reflected in the care plan and put into place.
- Where children are isolated because of mental health issues, there must be ongoing interventions and treatment from Child and Adolescent Mental Health Services (CAMHS) as part of the agreed care plan.

e. Oversight and safeguards

- All agencies working with children have a statutory duty of safeguarding and this extends to children in isolation. Policy and practice must clearly reflect that duty.
- Regulatory bodies and other agencies with safeguarding responsibilities for children in detention must ensure that they review data on isolation and reasons for its use and intervene where they consider its use is excessive or unjustified.
- Children in isolation must continue to have access to independent advocacy and the right to seek support from any person with whom they have a trusting relationship.

f. Reintegration and prevention

- A reintegration plan must be in place for every child in isolation. This plan must contain meaningful targets that the child understands.
- Restorative processes that aim to resolve differences between children or between children and staff must be in place to prevent isolation of children and to facilitate an early return to normal regime.

Guidance for monitoring isolation in cases of detention in health care settings

In contrast to other places of detention, such as prisons, the legitimate scope of isolation in health care settings is narrow: it can only be legitimately used to contain dangerous behaviour, and is not legitimate as a form of sanction or punishment. Isolation practices are emergency management procedures, to be used as a last resort and after all other reasonable steps to control the behaviour have been taken.

When isolation is used, a person is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit open to the patient, but any isolation from other patients/residents must be recognised as such and afforded the required safeguards of review.

In health care contexts, the most common term for the forcible denial of the company of other individuals by constraint within a closed environment is 'seclusion'. Other terms may be used in health care settings, for example 'time out' or 'removal'.

In order for the NPM-wide definition of isolation to address the specificities of detention in health settings, the UK NPM has adopted the following specific definition:

Isolation in health settings refers to the supervised confinement and isolation of a patient or resident, away from other patients or residents, in an area from which the patient or resident is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

If a patient or resident is confined in this way and even if they have agreed to or requested such confinement, they need to be considered formally isolated. Neither the use of any local or alternative terms (such as 'therapeutic isolation') nor the specific conditions of the immediate environment mean the requirements below need not apply.

It is also not relevant for the purpose of this definition of isolation or the requirements set out below that staff members of the detaining institution are in contact with the isolated person (indeed, they need to remain in contact). Nor is it relevant whether the place of isolation is an enclosed room (rather than, for example, a part of a larger space), or whether the door to such a space is closed or open, locked or unlocked.

Specifically in relation to detention in health settings, the Subcommittee on the Prevention of Torture (SPT) states that solitary confinement must never be used on persons who are detained in health care settings.¹¹ The SPT further states that 'solitary confinement... segregates persons with serious or acute illness and leaves them without constant attention and access to medical services. It should be differentiated from medical isolation. Medical isolation requires daily monitoring in the presence of trained medical staff and must not deprive the person of contact with others provided that proper precautions are taken.'¹²

Depriving any person with mental disorder of human contact for any significant amount of time is never an acceptable practice. Most of the instances of isolation that the UK NPM has identified are likely to fall within the SPT's term 'medical isolation' insofar as the isolated individual is likely to be deprived of free contact with other detainees even if subject to constant monitoring by and in contact with professional staff members. The guidance provided by the NPM set out below includes safeguards aimed to ensure medical isolation is

¹¹ *Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent*, adopted at the 27th session of the SPT (16-20 November 2015), para 10.

¹² *ibid* fn.10 above.

appropriately used, proportionate, and does not cause harm, as well as ensuring that it never constitutes solitary confinement.

Where seclusion extends over a longer period of time, it is sometimes referred to as 'long-term segregation' within mental health facilities.¹³ Such arrangements must be subject to strict safeguards and not result in an absence of meaningful human contact, and must be subject to careful scrutiny by both detaining authorities themselves and NPM monitoring bodies.

Reflecting these differences and specificities, the following points have been developed for monitoring isolation in health care settings and must be read alongside the general guidance provided.

a. General – isolation practices across health care detention settings

- Because of the harm that can be caused by isolation, specific safeguards should be in place. These safeguards should become more rigorous as the time in isolation increases.
- Isolation should only be used to contain severely disturbed behaviour which is likely to cause harm to others. It should never be used where it may exacerbate the risk that the patient may take his/her own life.
- Isolation should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, isolation should be used only when the professionals involved are satisfied that the need to protect other individuals outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed.
- Isolation should not be used as a punishment or a threat, or because of a shortage of staff.
- Isolation should not form part of a treatment programme.
- Where there is a sustained risk of harm posed by the patient or resident to others, which is a constant feature of their presentation, and services resort to long-term isolation, this should be subject to independent scrutiny by NPM bodies and must not be allowed to deprive the segregated person of meaningful human contact for any significant length of time.

b. Procedures

Clear and transparent procedures provide an appropriate safeguard against harm for all isolation practices.

- All health care detention establishments should have a seclusion or isolation reduction policy.
- Information must be given to those subject to isolation about their rights.
- The decision to use isolation in mental health services should be made in the first instance by a doctor, the nurse in charge of the ward or a senior nurse manager. Where the decision is taken by someone other than a doctor, arrangements must be made for a doctor to attend immediately.
- The focus of all intervention by professionals following the instigation of isolation should be towards ending the intervention as quickly and safely as possible, to place the least restriction possible on the individual concerned. Care plans should be explicit in achieving this aim for every episode of isolation.

¹³For example, the English *Mental Health Act Code of Practice* 2015 states that 'long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis.' *Mental Health Act Code of Practice* for England (2015), para 26.150

- Procedures that apply to formal isolation in dedicated areas, in any health or social care setting, should be applied in instances where individuals are isolated in the main location of a detention facility.
- The detaining body must make efforts to help individuals retain contact with family, friends and carers/advocates, with proper consideration given to the views of these individuals.
- Multidisciplinary review should include an advocate in cases where a person concerned has one.

c. Conditions and daily routine

Conditions are good quality and decent and daily routines are varied and mitigate the harmful mental health impact of isolation.

All of the points in the general guidance apply to the conditions and daily routine of isolated individuals in health settings. The dignity of detainees must be respected at all times and no detainee should be unclothed in isolation.

d. Health and well-being

Isolated individuals have equal access to health services and are monitored by health care professionals.

- Isolated individuals should have daily access to a health care professional and regular access to a health care professional with mental health expertise.
- A record of the individual's state of health should be kept while in isolation. This should include all potential signs or known triggers for the individual's deterioration so that these can be acted upon.

e. Oversight and safeguards

Robust oversight measures and safeguards are in place against the harmful or discriminatory application and impact of isolation practices.

All of the points set out in the general guidance above apply equally to the conditions and daily routine of isolated individuals in health settings.

f. Reintegration and prevention

There must be a focus from the outset on preventing isolation throughout the detention establishment and emphasis on reintegrating the detainee throughout any isolation episode.

- Care and support should be in place for any individual coming out of seclusion.
- Where appropriate, this may involve the preparation of advance statements for future situations where restrictive interventions may be necessary. This may involve anticipating situations where they would/would not find seclusion acceptable.

Guidance for monitoring isolation in prisons

The points covered below will be considered by NPM members when monitoring isolation specifically in prisons, in addition to the main guidance document.

A number of elements of the guidance below relate to informal isolation in prison custody. In this context, informal isolation is considered to be any situation falling into the description of isolation set out in the main guidance which is not governed by Prison Rules relating to disciplinary sanctions, protective or preventive measures.

a. General – isolation practices across detention settings

In relation to informal isolation:

- All efforts should be made to avoid individuals experiencing informal isolation as a result of restrictive regimes, overcrowding, staff shortages and/or the design of facilities.
- There should be clear procedures in place to identify and record isolated individuals not covered by formal isolation arrangements.
- There should be an appropriate record of the initial reason or rationale for the decision to isolate or the trigger for isolation.

b. Procedures

In relation to formal isolation:

- All points in section b. of the general guidance for all detention settings relating to mental health must be considered to apply widely to mental health and well-being.
- There must be a clear, rigorous risk assessment carried out by competent individuals (including health care professionals where appropriate) to support decision-making around isolation.

In relation to informal isolation:

- Where a decision is taken which has the effect of restricting the regime for a prisoner, the impact of this should be reviewed to consider whether it amounts to isolation.
- Where a prisoner is subjected to a restricted regime, whether by choice or for other reasons, there should be an agreed date for review, a plan for reintegration, and a clear record and review of the decision and/or reasons relating to the isolation, with a view to avoiding recurrence.

c. Conditions and daily routine

In relation to both formal and informal isolation:

- Isolated detainees should have appropriate access to a full range of varied, purposeful and meaningful activities, facilities or services, to include meals, at least one hour in the open air and exercise, showers, telephone, visits, books/reading materials and chaplaincy.
- Where access to meaningful activities including library, education, work and communal worship is restricted, a reasonable justification must be provided in writing to the detainee in a format and language they can understand.

d. Oversight and safeguards

In relation to formal and informal isolation:

- Isolated individuals and officers involved should be debriefed after incidents of isolation.
- Effective handover processes should be in place between shifts and across custody settings to ensure continuity of care, welfare and progression of those in isolation.

e. Reintegration and prevention

In relation to formal and informal isolation:

- Detainees should be involved in decisions about reintegration, and their involvement supported by an advocate or peer supporter if required.
- After a period of prolonged isolation a phased return should be arranged.
- Peer support schemes should be available to all detainees reintegrating following isolation.

- Isolated detainees should have opportunities to reflect during and debrief after periods of isolation.
- Detainees' access to legal advice should not be inhibited by their isolation.

Guidance for monitoring isolation in police and other short-term custody

Police custody

Monitoring isolation in police custody requires a tailored approach because, unlike other forms of detention, there is generally a presumption of isolation in police custody, rather than isolation being the exception to the norm. This general presumption results from the need to hold detainees on their own to avoid any investigation being compromised and because the majority of the police custody estate is designed for single cell occupancy.

While detention in police custody tends to be of relatively short duration its effects can be exacerbated by high levels of stress, anxiety and its unspecified duration. Cells are not designed for long periods of occupancy and the physical environment is often worse in comparison to other types of detention, with no natural light and no, or austere and small, exercise yards.

There are some exceptions to the short duration of detention in police custody. For example, those detained under the Terrorism Act 2000 can be held for up to 14 days, as can those held in legalised police cells in Scotland.¹⁴

In addition to basic principles applicable to isolation in all forms of detention, there are key considerations for police custody, as set out below, which can ensure detainees do not come to harm as a result of isolation. Effective risk assessments are essential to identifying vulnerabilities and any additional actions that may be required to encourage diversion from police custody or mitigate the impact of isolation.

Alternatives to custody

Efforts must be made to avoid holding detainees in isolation by diverting people from police custody in the first place. This is particularly relevant for vulnerable detainees, including children and young people and those who are mentally ill, for whom arrest and detention should be avoided wherever possible. Data on the volume and duration of detentions, broken down by age and other protected characteristics, should be gathered and analysed to assess the success of diversion schemes.

Release or transfer at the earliest opportunity

Most importantly, the negative impact of isolation should be mitigated by holding detainees for the shortest time possible and moving to release or transfer at the earliest opportunity.

- Investigative and other processes (such as fitness to detain or interview assessments) should be expedited. Delays in contacting or in attendance by, for example, interpreters, appropriate adults or health care professionals should be minimised. Delays should also be monitored and remedial action taken as required.
- Reviews of detention should be held regularly, with a view to releasing or transferring detainees at the earliest opportunity. The views of detainees should be sought as part of the review process.
- For vulnerable detainees including children, investigative, detention and release processes should be expedited to minimise the length of time spent in custody.

¹⁴In Scotland, legalised police cells (which are in police stations far from prisons) can hold prisoners for up to 30 days.

- Regard should be had to wider criminal justice system issues which may help to minimise the length of detention, thereby mitigating the impact of detention, for example weekend courts, flexible court cut-off times and ready availability of secure accommodation places for children.

Mitigation of impact of isolation

Monitoring should focus on what steps are taken by detaining authorities to mitigate the impact of isolation on detainees. The provision of basic entitlements that arise from the fact of detention can go some way to mitigating the impact of isolation. Monitoring should also focus on the specific efforts made to mitigate the impact of isolation on vulnerable detainees.

The effects of isolation can be mitigated by conditions and a daily routine which allow for:

- All basic rights and entitlements, such as access to a solicitor or a health care professional, to be provided.
- Access to reading materials, exercise, fresh air and showers. Consideration should be given to providing visits or telephone calls for children and other particularly vulnerable detainees. The availability of such items and activities should be made known to detainees, and detainees should be encouraged to access them.
- Meaningful regular interaction with staff using professional interpretation or communication aids as required.
- In the exceptional instances in which clothing has to be removed (for evidence gathering or based on an individualised risk assessment), this should be for the shortest time possible and frequent reviews should take place with a view to returning clothing at the earliest opportunity.
- Children and young people to be accompanied by a parent or appropriate adult throughout their stay in custody and all agencies responsible for their welfare informed of their arrest.
- Wherever possible, children to be supervised outside of cells and kept apart from adult detainees.
- Access to smoking facilities or if this is not possible prompt access to nicotine replacement therapy to reduce nicotine withdrawal.
- New custody facilities to be built in such a way that there is natural light in each cell, more sensory stimulation and exercise yards.

Conditions and the daily routine should be enhanced where the detention is of longer duration than the norm (for example, for those detained under terror legislation or those held in legalised police cells). Consideration should be given to, for example, longer periods of exercise and the provision of additional activities and radios, as well as visits from independent custody visitors. Consideration should also be given to allowing detainees some degree of control over their environment, activities and daily routine

In the exceptional instances in which detainees are held temporarily incommunicado (where notification of solicitors or family members has been lawfully delayed), particular attention should be paid to what steps have been taken to mitigate the impact of isolation, and to ensure that any delay is of the shortest time necessary.

Court custody

Isolation may be less of an issue in court custody due to its short duration (and multiple cell occupancy in some courts). However, it may still be significant for some detainees, particularly where the isolation is exacerbated by long journeys to and from the court in cellular vehicles and when detainees from prison are attending long trials which may mean they are excluded from contact with others on return to prison every evening.

The effects of isolation can be mitigated by conditions and a daily routine which allow for:

- All basic rights and entitlements, such as access to a solicitor or a health care professional, to be provided.
- Access to reading materials. Consideration should be given to providing visits or telephone calls for children and other particularly vulnerable detainees.
- Meaningful interaction with staff using professional interpretation or communication aids as required.
- Wherever possible, children to be supervised outside of cells and kept apart from adult detainees.
- Access to smoking facilities, or if this is not possible, prompt access to nicotine replacement therapy to reduce nicotine withdrawals.

UK Border Force

Detainees held in Border Force cells are primarily people who are suspected of secreting or swallowing drugs and who may be held for an extended period of several days until the drugs have passed through their system.

The effects of isolation can be mitigated by conditions and a daily routine which allow for:

- All basic rights and entitlements, such as access to a solicitor or a health care professional, to be provided.
- Access to reading materials, exercise, fresh air and showers. Consideration should be given to providing visits or telephone calls for children and other particularly vulnerable detainees.
- Meaningful regular interaction with staff using professional interpretation or communication aids as required.
- In the exceptional instances in which clothing has to be removed (for evidence gathering, or based on an individualised risk assessment), this should be for the shortest time possible and frequent reviews should take place with a view to returning clothing at the earliest opportunity. The person's privacy should be respected as far as possible.
- Children and young people to be accompanied by a parent or appropriate adult throughout their stay in custody and all agencies responsible for their welfare informed of their arrest.
- Wherever possible, children to be supervised outside of cells and kept apart from adult detainees.
- Access to smoking facilities, or if this is not possible, prompt access to nicotine replacement therapy to reduce nicotine withdrawals.

Guidance for monitoring isolation in immigration detention

While the general guidance for monitoring isolation across all detention settings is for the most part equally applicable to immigration detainees, there are particular considerations that must be taken into account in monitoring immigration detainees in isolation:

- Detainee custody officers and managers have no power to punish detainees.
- Some detainees do not speak English and access to good-quality interpretation and translated documents is necessary to mitigate the negative effects of isolation.
- Detainees may face imminent removal and have an ongoing need for contact with legal representatives.

a. General

- Isolation should never be used as a punishment. It should be used for the shortest possible time and end as soon as the detainee has ceased to behave in a way that is harmful to themselves or others. There should be no restrictions on access to means of communication, including mobile phones, unless there is a clear and evidenced risk.
- The reasons for isolation should be fully documented and demonstrate proportionality, and all periods of isolation should be subject to rigorous management oversight.
- Detainees should not be routinely isolated prior to removal from the UK.
- Where a detainee does not speak English, staff should use interpretation to communicate. If the subject matter is confidential or requires accuracy, professional interpretation should be used.
- Where possible, female detention custody officers should attend and supervise isolated women.

b. Procedures

- Where detainees cannot read English, written reasons for isolation should be provided in the detainee's language. Where this is not possible, reasons for their isolation should be explained using an interpreter. The detainee's understanding of these reasons should be checked.

c. Conditions and daily routine

- Isolated detainees should be able to retain their mobile phones unless a written individualised risk assessment indicates otherwise.
- Isolated detainees should be able to access the internet, web-based email accounts, Skype and social media unless a written individualised risk assessment indicates otherwise.
- Isolated detainees should be able to receive visits from friends and family, subject to a risk assessment.
- Isolated detainees should be able to access a wide range of library materials in their own language, including books, newspapers, magazines and DVDs.

d. Health care and well-being

- Isolated detainees who do not speak English should be able to consult with health care staff using professional interpreters.
- Isolated detainees should not be inhibited from accessing the protections of rule 35 of the Detention Centre Rules. Medical practitioners should be able to access isolated detainees to conduct rule 35 assessments.

e. Oversight and safeguards

- Complaints forms should be available to isolated detainees in a range of different languages. Replies should be written in the language of the original complaint.
- Isolated detainees should be able to maintain contact with their legal representatives through unfettered access to phones, fax machines and email.
- Isolated detainees should be able to meet with their legal representatives face-to-face in a private setting.

- Isolated detainees should be able to access the Legal Aid Agency-funded duty advice surgeries available in English immigration removal centres. In Scotland, isolated detainees should be able to receive legal advice from solicitors.
- Detainees in isolation should be able to access support from third-sector organisations that regularly visit the centre they are held in. For example, Bail for Immigration Detainees, Detention Action and Hibiscus Initiatives.

f. Reintegration and prevention

- The prospect of imminent removal from the UK should not on its own prevent isolated detainees from returning to normal location.
- Isolated detainees should be able to receive support from their fellow nationals on return to normal location.

