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THE CRUELTY of INDIFFERENCE:
solitary confinement surfaces again.

Dr Judith van Heerden (11/6/99)

They call it HARD-EDGED SILENCE: encased in grey cement, with a stainless steel wall fixtures (bed, basin and loo), devoid of visual or sensory stimulation, in absolute silence and under constant (24 hour) video surveillance. Even the exercise yard is covered over to block out the sky. Should a blade of grass surface the guards pounce on it: neat and tidy is the watchword of law and order. They live in this solitude and silence not for 90 or 180 days, but day after day, month after month, year in and year out.
This is a personal account of conditions at Pellican Bay, Super-Maximum Security prison in California.

In fact 10% of America's 1.8 prisons are in long-term solitary confinement: that is 180,000 in isolation for anything from 2, 3, 5, 7, 10 to 15 or more years.

Why this? Why now? Didn't SA put the evil of Detention-Without-Trial, and in particular the 180-Days-in-Solitary behind it on 2 February 1990? No decent person wants anything to do with the shame, horror and inhumanity of isolation and torture. Even those among us too young to remember the bad old days of Apartheid, surely heard or read the reports of victims at the TRC hearings: about torture and death in detention, about disappearances. Heart-wrenching stories. Stories told because the past must never be repeated. Based on report to the Health Sector Hearings and drawing on the Prison Hearings the TRC in its recommendations sign posted the way forward. Of prime importance is the need for primary care services linked with equity and accountability. To avoid repeating errors of the past (omissions, commissions and neglect) this should go hand on glove with legislation, transparency, evaluation and monitoring. These noble goals support the human rights ideals of our constitution.

The truth of the matter is that our new transparent lawmaking procedure, the democratic consultative process, is sometimes side-stepped. The introduction of C-Max Units (Control Super-Maximum Security Units) is a prime example of this.

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The idea of isolating those prisoners "beyond rehabilitation" was first mooted in August 1995. The plan was to convert worked out mines in remote areas into maximum security prisons where hardened criminals could be held in isolation far way from family and contacts. This statement was ignored until the Commissioner of Prisons on national TV said that violent criminals, like animals, should be caged. It unleashed nation outrage .... the Department of Correctional Services fell silent .... for a year.

On 22 September 1997 the Minister of Correctional Services announced that Death Row (at Pretoria Central), no longer in use, had been refurbished to hold 95 prisoners in C-Max. No consultation preceded this introduction of a new form of solitary confinement. From experience the Department learnt that public opinion was a powerful deterrent. Best not to tell them. Four months ago we learnt that underground prisons remain an option (CTimes Feb '99).

What we can learn from the past, the current state of affairs, and what are our future challenges?

This talk covers:

1) Research findings: solitary confinement (and torture)
2) Developments in the Department of Correctional Services
   * Correctional Services Act (no 111 of 1998)
   * C-Max units (long term isolation)
   * Overcrowding and Prison Building
3) TRC Recommendations.

In the 70s and 80s political oppression and detention (without trial) intensified. Detainees resolutely demanded education, health care and human rights in prison Much of what they struggled for is enshrined in our Constitution.

My own interest in Prison Health stems from work in detainee support groups and hearing their stories of neglect and medical mistreatment. Calls for a single law to regulate prison conditions were repeatedly ignored. Laws governing medical care were skimpy, and

hidden among draconian security clauses. They were seldom challenged in court. The category under which the person was detained determined the type of treatment he should receive.

Media exposure was explicitly banned by law. No prison information was allowed to be shared, not even at a visit or in a letter (while detained or after release). This law was in force until June 1992.

I could best record detainees' experiences by detailed research. My aim was to determine whether health care (in prison) met legal standards.

Legal vulnerability, linked to security, dictated that interviewees be self-selected. They were drawn mainly from the informed and articulate political leaders committed to the fight for human rights. They were fully aware of the risks taken by giving information.

123 interviews were completed in 1991 (males/females, reflecting age patterns) covered the Eastern and Western Cape, urban and rural areas.

Results illustrated that health care in SA prisons was NOT satisfactory. Little has changed. The discussion today is limited to the findings on Solitary Confinement (and torture).

Isolation

The United Nations and other human rights organisations have condemned prolonged solitary confinement of more than 30 days as unlawful. The reason is that torture always takes place in secret. Apart from secret mishandling, mental health experts view solitary confinement and its associated social and sensory deprivation as an exquisite form of psychological torture. This study confirmed the close links between isolation and torture. During interviews "torture" was understood to be violent forms of assault causing severe pain and anguish; the third degree. It was always associated with electric shocks and the much feared 'helicopter" method. Apart from causing intense physical suffering, torture created in victims feelings of extreme helplessness and terror.

Experienced, older detainees (30+) spoke about depression and "solitary" as psychological torture. Younger respondents described loneliness, crying, fears, uncertainty and difficulty sleeping. The incidence of physical and psychological findings provide a profile of the prisoners' symptoms. Chance is that few were due to physical illness, That many were psychosomatic. It tallies with the high ranking of imprisonment as a stressful life event (no 4, out of 100, on the social adjustment rating scale). These "soft" symptoms were generally labelled "malingering" - a word well known to the most illiterate among detainees. In addition, the power to decide which prisoner deserved to see the doctor was in the hands of prison warders; warders with minimal primary care and no mental health training; they are the gate-keepers to medical services in prison.

83 (67%) respondents spent time in isolation, either as Sec 29 Detainees (in isolation for the purpose of interrogation) or as emergency detianees alone under very similar circumstances (incommunicado/interrogated).

Of them (83).
90% (74) said that isolation effected them mentally or physically.
2 out of 3 (64%) saw a doctor, and
just over half of them complained to the DS about the effects of isolation.

Of the 30 who complained about isolation,

12 were ignored and

10 got the impression that it was a security not a medical matter.

. . . . . from comments like: "These are the rules", "There is nothing I can do about it", "This is none of my business", "You Have only yourself to blame". In solitary confinement the doctor was the only contact detainees had with persons other than (state) officers. Doctors had an important medical and ethical duty to protect and provide care for (ill/distressed) detainees in isolation.

Doctors **intervened** (to improve the situation) in 6 cases, only:

- 2 were referred for psychiatric help
- 2 were transferred from police cells to prison hospitals for better supervision of physical, not psychiatric care
- 1 was transferred from a single police cell to a communal prison cell (with company)
- 1 was given psychotrophics for his "nerves" and to sleep [his assessment of "help"]

The quality of psychiatric care was cause for concern. For a psychiatrist to admit that *"symptoms are related to detention"* and then to advise the patient *"to come back if things get worse"* does not do the caring professions justice. Severely depressed detainees had initial appointments of 15-30 minutes and follow-ups of 5-10 minutes.

Generally, ignorance and indifference were the main reasons for medical neglect. Doctors also failed to use their right to prescribe treatment (treatment perceived as drugs only):

- ample sleep and rest for the exhausted
- better food
- enough clean water
- company for the lonely
- reading matter
- proper exercise
- extra clothes and blankets

All crucial factors in the management of solitary confinement; in upholding human rights.

Today our CONSTITUTION guarantees that prisoners be treated with dignity and respect (12, 35) and protects them from abuse and torture. How are these principles being implemented?

Prison Law

A new Correctional Services Act (no111 of 1998) was passed last year. It was drafted as a fresh start rather than a series of amendments. It provides a progressive, constitutional policy framework (thanks to Prof DVZS) within which regulation are to be developed. It includes:

* The right of safe custody and dignity (of a prisoner) is linked to responsibilities such as planning a career, work and education. Abuse of power is curtailed,
* It makes provision for an independent Inspecting Judge (on the British model; HMIP), who reports directly to the Minister/ President. An independent (lay) "prison visitor" will be appointed to every prison.

In truth, once (Parliamentary) Law Advisors started to fill in the details - the small print taken directly from the old Prison Act (1959) - the tone of the document changed.

The Health Section consists of only 4 clauses, when in fact health matters are dispersed throughout the Bill. Human rights organisations submitted several recommendations, mainly around health to the Portfolio Committee. The issues they grappled with include:

1) "**Medical treatment**" is defined in a narrow curative sense (It omits promotive, preventive, rehabilitative and environmental health). The more explicit phrase . . . . *to provide an environment and service that will promote physical, mental and social well-being* (in line with WHO definition) was rejected.

2) from the bad old days we know that a **"visit"** by a doctor, judge or magistrate was often a passing "Hi!" . Nevertheless the suggestion that the well-being of prisoners be. . . "*monitor, record and if necessary report physical and mental health*" . . .was discarded outright.

3) "**Solitary confinement** . . . .(it says) must be discontinued if (the doctor thinks) it poses a danger . . . to health" (25)(4). Nothing is said about . . . . *careful screening for physical and mental fitness **before** confinement.*

4) This decision has serious implications in respect of penalties imposed for **disciplinary infringements**. The emotional stress of imprisonment is completely ignored. We know that distress, anxiety and mental disturbance can present with carelessness, disobedience,

foul language, indecent behaviour, noise and shouting, causing disturbance, insubordination, defacing property/environment, and self-harm (23). All of them are regarded as infringements. Especially self-harm may indicate early psychosis or suicidal intent. They need help, not punishment. Penalties vary from 7 to 30 days in solitary confinement. I fear that for "disruptives" it may become a matter of "two strike and you're out"; to long-term isolation in C-Max.

A HRW survey (1997) found that over 60% of those in punitive isolation were mentally disturbed (50% suffered from serious mental disorders); 5 times more than in the society generally. It regards routine screening and a meticulous assessments essential before banishment to (long-term) isolation in Super-Max. Proper examination is vital to separate out the physically and mentally unfit:

those mental disturbed
drug addicts
metabolic (diabetes) or
metastatic (brain tumour) disorders,

It's a pity the Act demonstrates a lack of learning from the past; that the ***dual loyalties of custodial versus health care are not addressed***. The history of solitary confinement (and torture) is peppered with examples of ethical dilemmas where health came off second best.

The C-Max Prison What then is C-Max, this maximum security prisons based on the American Super-Max model, all about?

Admission Criteria

The aim is to remove dangerous and disruptive prisoners from the general prison population; to create a safer prison environment for both prisoners and staff. It targets prison murders and violence, escapes, disruptive conduct and . . . sensational crime! That is the theory, the reality is more sinister. There is no legal procedure to "test the evidence". Transfers will be an internal arrangement and the decision of the prison officer.

Medical Concerns are:

- In screening for fitness for prolonged isolation: What criteria will doctors use to avoid this ethical dilemma?
- What criteria exist for **mental health** screening and examination
- Regular physical and mental health monitoring and reporting
  by whom? warders have no mental health training
  to whom?
- how will unruly prisoners be dealt with (punished/curtailed)

In addition:

* the lack of transparency
* no independent monitoring.

C-Max is a **closed facility** - no monitoring by national or international human rights organisations (like AI, Red Cross, HRW) is ***not*** permitted. Few are privy to what goes on inside.

The Human Rights Commissioners - among the handful officials (like judges), who have access - report that:

* Inmates occasionally see a psychologist (1 psychologist serves prisons of 1800-3000)
* If staff report "negative incidents" the periods of isolation is extended.

Apparently there are no gang-lords among our C-max prisoners. The acid test will be when astute, wealthy gang-lords employ the smartest lawyers to bring a class action suit (constitutional clause 38) to defend their constitutional rights to humane, dignified treatment. Such action could cost the government millions

* (firstly in) building and refurbishing costs.
* (and then in) damages.

Over crowding and Prison Building.

Statistics: The SA prison population is 148,000 and prisons 140% overcrowded. Prisons in big cities are often 200-300% overcrowded. One third of the prison population (50,000) are unsentenced. Half of them remain in jail because they cannot afford to pay R50 bail.

Members of parliament tell the story of an unemployed township woman, a single parent, whom they met in prison because she stole a chicken to feed her 3 hungry children, all under 10. She has been awaiting trial for more than 15 months. The cost : R26,000 pa.

To reduce the overcrowding the prison building programme aims, by 2001, to have increased the prison capacity by 14,500. How can we ever build ourselves out of a need of 50,000 units . . . and increasing. It is distressing that this figure includes accommodation ***for 1635 prisoners in long-term solitary confinement; in C-Max units.***

A startling figure considering the numbers in parliament who served jail time, the risks they took to improve prison conditions and their determination to stop the ill treatment of inmates. Even among ex-Robben Islanders there has been an about face. I quote, "Super-Max, the total isolation of prisoners for many years, is the solution to violent crimes". Not unreasonable, some say, if you take into account that parliamentarians are confronted by the pain of victims, and the anger and fear of constituents. SA has yet to reached the stage of the popular pre-election propaganda sound-bite "not soft on crime". That day may soon dawn.

LOCKDOWN may contain immediate violence, but does not rehabilitate. The R-word is **rage**. Long-term, the outcome is more violence.

Truth and Reconciliation Commission (TRC)

The TRC dealt with extreme cases of abuse. Torture and death in detention demonstrated how health care providers colluded and collaborated with political and security "masters". "NEVR AGAIN" captures the hope that the truth would limit, even eradicate, human rights violations and the abuse of citizen.

TRC recommendation to limit abuse are discussed within the framework of policy documents under review:

* the draft Health Bill
* re-organisation of part-time District Surgeons.

1) The Department of Health.

Closed institutions, away from public scrutiny are renound for the mistreatment of "patients" or "inmates". Prisons function by discipline and control. They present the doctor with the most ethically fraught and conflictual situations encountered anywhere. Doctors or caregivers who serves 2 masters (care and custody) regularly face treatment decisions dilemmas: does loyalty lie with patient care or prison security?
Remember, ethical codes and human rights demand clinical independence. This must extend beyond the doctor-patient relationship to include the health care team and they must all be accountable to the Department of Health. That alone will guarantee the doctor's advocacy role and the patient's right to a private consultation and confidential records; never again subject to security control.

2) Care in police custody

The role of the District surgeon is being phased out.

- Pro Deo work will fall to primary care clinics, quite logical.
- Who takes responsibility for prison medical care? Specifically trained prison doctors? Nobody knows.
- What about Forensic Services?

In line with United Nations Declarations, and to avoid a conflict of interest, forensic clinical work must be separated from forensic investigative work (pathology). For example, the doctor who performs a (grisly) post-mortem can in fairness not also take responsibility for the well-being of the suspect/accused. The policy document on the scope and function of the Forensic Medical Examiner (pathology) is a separate matter.
Some call the **forensic clinician** a "Police Surgeon". His duties include:

- medical care of suspects. Care comprises "*meeting basic requirements of food, drink, warmth, sleep, exercise: personal hygiene, protection and human contact . . . . . and all forms of medical intervention.*" It obviously includes examining rooms, equipment, storage and appropriate distribution of drugs, special diets, etc.
- care for victims of crime: violent assault, rape and child abuse. The recent report by Charlene Smith graphically illustrated the inhospitable care of rape victims and the

difficulties obtaining timeous treatment for STDs like HIV/AIDS; possibly also the morning-after pill. The hopeless predicament of gang raped children is perhaps worse.

- Clinical training. The Chief Police Surgeon trains junior doctors. Public education, raising awareness among the public and police is not on the SA agenda The police in particular are not trained about the hazards of clinical evaluation related to
    - # intoxication, but especially drug withdrawal and possible suicide
    - # the danger of head injury associated with intoxication
    - # guidelines to assess physical and mental stress.
    - # how to distinguish between psychological illness and intellectual impairment.

It would be unfair to dump this work on doctors at primary care clinics. Apparently prison and police medical work will fall under the DHS: - 9 separate policies can only spell disaster.

3) Teaching and training.

The training of caregives at all levels must include ethics and human rights. I feel passionately about training undergraduate students how to manage:

practical human rights issues on a daily basis. Abuse of all those marginalised . .on the street, disabled, orphaned, elderly, at schools, farmworkers and child farmworkers.

stressful, emotionally charged situation - domestic violence, rape, child abuse, loss and death, conflict and debriefing

Mental health training is essential for all prisons staff. It is even more important for custodial medical orderlies (nursing assistants) who act as gate-keepers to prison medical care.

4) Monitoring and peer review

We applaud the appointment of a Judicail Inspectorate , but it functions mainly reactively. This leaves space for pro-active action; for an ***independent prison NGO*** that:

* reports on prison activities (visits, health, rules, riots)
* forge links with the "outside" (buddies, pen friends, NGOs)
* scrutinise government policy - like C-Max and prison privatisation.

The Prison Reform Trust in Britain is a prime example. Its major contribution has been the Prisoners' Information Pack - a file setting out the rules and regulation that govern the daily lives and activities of inmates.

Peer review is equally important. First prize goes to regular audits for accreditation of prison health services based, in the US, on standards of care. The AMA, initiated this process, now under the NCCHC (National Commission on Correctional Health Care). It had compiled 3 volumes on

Standards of Health Services in Prisons; in Jails; in Juvenile facilities.

5) Influencing Policy

Academics and Administrators have a duty to concern themselves with policy formation; to ensure that laws related to health care meet international standards. They are ideally place to facilitate research at closed institutions; research that is at times blocked. They have a powerful (political) voice, they can influence policy. For example, it is time the prison health bill approved by the ***Correctional Services*** Portfolio Committee, May 1996, be dusted off.

In conclusion I must point out that 8 years ago this presentation would not have been possible; it was illegal. To-day health care providers must take advantage of the free-flow of information. I suggest UCT and others teaching institutions engage in an internal investigation into our Apartheid past as a matter of urgency, something like the WITS process. Somehow lower and middle level administration, the guards and implementers of policy, slipped through the investigative net. I appeal to them to come forward.

We shall remain forever guilty if we do not examine this past. How else will we develop a culture of vigilance? There is no choice. Or shall we in future stand accused of new forms of collaboration