Who Lives in Super-Maximum Custody? A Washington State Study

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THE GROWTH OF super-maximum facilities in the United States can be traced to the experience of the Marion Federal Penitentiary in the early 1980s, when a series of assaults and murders led authorities to institute a "lockdown" regime characterized by single-cell housing, an absence of congregate activity, confinement for 23 hours per day, restrictions on commissary and other amenities, and the use of handcuffs and leg restraints when inmates are escorted to enclosed exercise areas, showers, or no-contact visits. These restrictions dramatically reduced the incidence of violence at Marion. With some local variations, they have been replicated in the new or retrofitted units that, as of 1995, had been established in 36 states. The pervasiveness of control in such units is established not only by security protocols, which are designed to minimize opportunities for assault, but by architectural and surveillance technologies that permit constant monitoring of what inmates are doing in their cells.

It is perhaps no coincidence that the rapid growth in prison populations since the 1980s has been accompanied by proliferating super-maximum facilities within prison systems, for both trends express the logic of incapacitation: To make the community safer, we lock away the dangerous and predatory in a place where they cannot harm us. Ward and Carlson describe the corresponding policy in prison management as "consolidation—the intentional concentration of the most aggressive, escape-prone, and disruptive prisoners in a single facility where the level of security and the overall regime is specifically designed to accommodate them." The authors go on to comment that "the consolidation strategy can positively impact the quality and life of other prisons in the system."[1]

Though the logic of incapacitation is intuitively appealing, the policy raises troubling issues. Perhaps the most salient problem from a prison management perspective is the difficulty of releasing an inmate who has been deemed dangerous back into a general population setting. If risks are avoided by transferring an inmate to an IMU, they are incurred anew when he is returned: the restrictions that prevent him from harming others while in solitary confinement also prevent his keepers from assessing confidently what he would do when restrictions are lifted. This concern is exacerbated by the possibility that the subject will have been embittered or debilitated by the experience, and more prone to lash out once released. Thus, recidivism by those returned to general population or the community, and fear of releasing others, may create rising demand for super-maximum capacity.

Not all super-maximum residents may raise the "tiger-by-the-tail" problem, but then questions arise about whether all inmates in them are there for good reason, and truly merit the degree of restriction these facilities impose. Such concerns are heightened by evidence that a disproportionate number of super-maximum custody prisoners have problems coping with prison due to mental illness, brain damage, or other factors; that needed treatment is not provided in such settings; and that vulnerable inmates are further damaged by sensory deprivation and other disorienting features of the environment. Finally, some studies of inmates in isolation indicate that even those who start out healthy can become withdrawn, incapable of initiating or governing behavior, suicidal, or paranoid.[2] Because of these concerns, the use of super-maximum confinement has given rise to litigation and has attracted a determined group of critics.[3]

Because these issues hinge on differing views of the purposes of corrections and the rights of inmates, there will remain issues of interpretation and grounds for disagreement that cannot be resolved by purely empirical methods. Defenders and critics of super-maximum facilities may agree, however, that it is important to devise methods of working inmates out of isolation, reducing repeated super-maximum placements, and preventing long-term solitary confinement of those whose ability to manage themselves is limited by mental illness or brain damage. To that end, systematic studies are needed of who lives in super-maximum custody, how they got there, and what effects it has on them.

To address the first of these questions—who lives in super-maximum custody—we conducted a study of all residents of Intensive Management Units (IMUs) in Washington state prisons. We used the Department of Corrections Offender-Based Tracking System (OBTS), the Department's electronic database for managing the classification and

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movement of inmates. From this database, we were also able to develop a typology of the patterns that led to inmates' placement in IMUs. A more extensive study including staff and inmate interviews and medical record reviews is underway.

The Washington State Study

In Washington, facilities elsewhere described as "super-maximum" are officially classified as maximum security, with a corresponding inmate classification of maximum custody. As of November, 1999, the four maximum-security IMUs in Washington held 222 inmates; an additional 10 inmates on maximum custody status were assigned to a high-security residential treatment program for mentally ill prisoners. These 232 male inmates were the subjects of our study. There were 171 (74%) with intensive management status: an administrative classification that assigns inmates to maximum-security settings for renewable 6-month periods, with the possibility of earlier release through informal interim reviews. The remainder were inmates assigned to IMUs for shorter-term disciplinary or administrative segregation or whose cases (and classification) were pending investigation.

It is important to bear in mind that intensive management status is an extended form of administrative segregation, which is justified on preventive grounds: concerns about escape risks, prison rackets, what the inmate will do to others, or what others will do to him in a general population setting. Disciplinary segregation, in contrast, is a time-limited sanction for a specific infraction. Not surprisingly, subjects with intensive management status were distinguished from the others by more violent crimes, longer prison sentences, higher infraction rates, and more violent infractions.

Case-by-case reviews of the Department's OBTS files were conducted to retrieve the following kinds of data:

- Demographics: age, ethnicity, offense, sentence;
- Disciplinary: major infractions, good time loss (the Department distinguishes between minor infractions, which are dealt with on living units, and major infractions, which require formal hearings and are recorded in OBTS);
- Housing: time spent in IMUs, segregation, various residential mental health units;
- Mental health status: indicators of serious mental illness, including diagnosis, where available, and narrative information in case management records.

OBTS also records narrative notes by Departmental case managers and others who supervise inmates, and some of the major infraction reports are accompanied by brief descriptions of the behavior that incurred the infraction. These notes suggest the issues that subjects posed and the basis for decisions about them. From these sources, we identified a small set of prison adjustment patterns among IMU inmates, which shed some light on the high variability we found among subjects.

Data were collected only for the current incarceration. In addition to distinguishing intensive management status inmates from other IMU residents, we defined a group of 77 chronic IMU inmates (33%) who had spent more than half of their current prison terms in IMUs. Some comparisons to the entire population of Washington inmates were based on data regularly collected and published by the Department's Office of Planning and Research.

IMU Residents vs. Other Prisoners

Compared to all Washington prisoners, IMU residents were younger, had been convicted of more violent offenses, had much longer prison sentences, and had much higher rates of major infractions.

- The average age of IMU residents was 30.5, vs. 34.5 for all Washington prisoners. There were 32 percent under 25, compared to 21 percent of all Washington prisoners.
- There were 33 percent of IMU residents convicted of homicide, vs. 13 percent for all Washington prisoners; an additional 38 percent had been convicted of other violent offenses, vs. 27 percent for all Washington prisoners (sex offenses were classified separately). Thus, the rate of violent convictions was 30 percent higher for IMU residents than for all prisoners.
- The median sentence of IMU residents was 156 months, the average sentence 224 months. The average sentence of all Washington felony offenders sentenced to prison in fiscal year 1996 was 47 months.[4] There were 27 IMU residents (12%) sentenced to Life Without Parole (23 cases) or Death (4 cases).
- IMU residents had committed an average of 7.7 major infractions per year, vs. 0.9 per year in a study of general population inmates.[5]

IMU residents were similar to all Washington prisoners in the proportion who were white (71%), but had a lower proportion of African Americans (18% vs. 23%) and a higher proportion of Native Americans (7% vs. 3%).

Correctional Profile of IMU Residents

Table 1 presents summary data on current IMU residents. Their youth, long sentences, and high infraction rates were noted earlier. Looking at the average and median values, there is little that is surprising about Table 1: Since they are young inmates with long sentences, many IMU residents have lengthy periods left to serve; since they are in IMUs because of concerns about their behavior, we may expect to find high infraction rates and considerable good time credit loss due to misbehavior.

What Table 1 also shows, however, is that there is no typical IMU resident. There was wide variety among subjects: many with short sentences, and others with very long ones; many with few infractions, and some with hundreds. For these reasons, Table 1 displays median (midpoint) values as well as means (averages). The means are higher than the medians because of a small number of inmates (not the same for each item) with counts or rates at the extreme high end on these variables. The standard deviations reflect the extent to which values were dispersed across the range for each item.

Based on these data and other studies of the disciplinary patterns of prison inmates, we might expect to find a considerable variety of issues raised by IMU inmates, particularly with respect to factors such as age and length of previous prison experience. Although the vast majority (146, 63%) are serving their first Washington prison terms, some have previously been incarcerated as often as 11 times and others for as long as 20 years.

An earlier phase of this project was concerned to study and develop interventions for a specific sub-population of frequent IMU residents who may be described as "behaviorally disturbed": inmates whose behavior, while not a clear expression of classic mental illness, has extreme and irrational aspects that

TABLE 1
Summary Profile of IMU Residents
N = 232

Item	Mean	Median	Minimum	Maximum	S.D.
Age	30.5	29	17	66	9.3
Sentence (Months)	224	156	12	1,020	189
Months Served to Date	58	42	2	305	54
Months Left to Serve*	160	79	1	892	184
Months in IMUs	21	12	0	129	24
Good Time Lost (mos.)	14	10	0	97	16
Percent of time in IMU	40%	32%	0%	100%	28%
Major Infractions	34	20	0	258	43
Annual Major Infractions Rate	7.7	5.6	0	66	7.7

*To calculate months left to serve, terms of life without parole were assumed to end at age 75.

appear to reflect psychological disturbance. These inmates are of particular interest because their behavior may resist both the mental health and the disciplinary interventions normally applied in prisons. We reviewed the OBTS files of 40 inmates who had been identified by prison staff as fitting this profile, and developed a list of index infractions commonly found in this group: attempting or committing homicide, staff assault, inmate assault, fighting, throwing objects (generally urine or feces), threatening, destroying property, and self-mutilation.

In the current study, the prevalence of index infractions ranged from 10 (4%) who had committed or attempted homicide to 60% with infractions for fighting and 60% for threatening. Some IMU residents had many instances of particular infractions: e.g., aggravated inmate assault, 20 counts; threatening, 94 counts; throwing, 99 counts. (Aggravated assaults are those in which the victim was hospitalized.) There were none with multiple prison homicides or attempted homicides, and four who had committed two or three aggravated staff assaults.

Chronic IMU inmates (with more than half their prison terms in IMUs) were similar to other IMU residents in age, offense, and sentence length. There were particular index infractions, however, that were more prevalent among chronic IMU inmates: staff assaults (48% vs. 29%), throwing (53% vs. 33%), and destroying property (56% vs. 36%).

We also compared chronic IMU inmates with other (non-chronic) residents with respect to the numbers of infractions they tended to commit. Their infraction rates were not significantly different. To strengthen the power of the analysis, infractions were divided into two groups: those that indicate a disposition to violence (homicide or attempt, other assaults) and those that indicate that the inmate is disturbed though not necessarily assaultive: threatening, throwing, destroying property, self-mutilation. (Fighting was left out of the analysis because both its prevalence and the average number of instances were identical across groups of IMU residents; also, it does not necessarily reflect a proclivity for initiating violence). Chronic IMU inmates committed "violent" infractions at no greater rates than non-chronic inmates, but did tend to commit more "disturbed" infractions (Mann-Whitney, p=.012). These data support the contention that some chronic IMU placements reflect a subpopulation of behaviorally disturbed inmates.

Mental Illness Among IMU Residents

The criteria for mental illness are controversial in assessing a group of inmates whose conduct has resulted in IMU placement. As mentioned earlier, the setting itself may induce psychiatric symptoms. More generally, if we conceptualize illness in terms of conditions that hamper normal functioning, it may appear to the outsider that only the mentally impaired would put themselves into an environment as extreme as the IMU, and that disgust would prevent normal adults from handling and throwing feces. The understanding of mental illness employed here sidesteps rather than resolves these issues. Serious mental illness is conceptually defined as a major thought disorder, mood disorder, or organic brain syndrome that fits a well-established DSM-IV category, substantially impairs functioning, and requires treatment. Having stipulated this much, we still have the problem of recognizing mental illness in a population survey. This task is especially complicated in prisons.

Although residential and outpatient mental health facilities have been established for some time, serious mental illness has been an official component of Washington's inmate classification system for only three years. Neither administrative procedures for assessment, nor electronic procedures for recording inmates' mental health status, have been fully carried out. There is therefore no single indicator in OBTS that can be relied upon to identify inmates whose functioning is severely impaired by mental disorder. Fuller assessments will require interviews and review of residents' medical charts. In the meantime, we have employed five proxy indicators, each of which provides reasonably strong evidence of serious mental disorder:

- Confirmed SMI: the inmate has been evaluated by a mental health professional and an assessment of serious

mental illness has been recorded electronically *(SMI yes)*.

- Multiple acute care admissions: three or more admissions to an acute mental health care facility at the state penitentiary, to which disturbed IMU residents may be transferred on a short-term basis *(Acute care user)*.
- Case management notes: mention of hallucinations, delusions, or prescription of psychotropic medications in narrative case management records *(Case mgt notes)*.
- Mental health residency: 30 or more days in one of the Department's residential mental health units *(MH residency)*.
- Diagnosis: an electronically recorded diagnosis of psychotic disorders, bipolar disorder, major depression, dementia, or borderline personality *(Diagnosis)*.

Table 2 displays the occurrence of these indicators among IMU residents. There are no significant differences between all IMU residents and chronic IMU inmates in the frequency of these indicators. From the limited electronic evidence, it appears that approximately 30 percent of IMU residents show evidence of serious mental illness. This is substantially higher than the 10–15 percent estimates of prevalence in total inmate populations.[6]

IMU residents whose OBTS files provided evidence of serious mental illness resembled other subjects in their crimes of conviction and sentence lengths. Yet they had significantly higher infraction rates (Mann-Whitney, p=.002), more violent infractions (p=.023), and more disturbed infractions (p<.001). This pattern is consistent with other findings that mentally ill inmates have greater difficulty coping with prison settings.[7]

Patterns of IMU Careers

We have noted above that there is no typical resident, and that our subjects show considerable variation on all the characteristics we have discussed. The following discussion of major patterns among IMU residents is intended to indicate reasons for the extreme variability. These patterns have been inductively derived from OBTS chart reviews—including narrative descriptions of inmate behaviors by mental health staff, custodial officers and case managers—in light of the statistical data generated in this study. Our approach to the behavior of IMU residents allows that people may change over time, and their actions cannot simply be explained by enduring individual attributes. While people are in prison their lives follow a trajectory that reflects their changing dispositions, the way they fit or fail to fit with their settings, and the expectations others have of them. Following Toch and Adams,[8] we mark this approach by using the term "career," and presume neither that patterns are deliberately chosen nor that they are forced upon the individual.

As mentioned above, IMU residents are generally younger than general population inmates. There were 25 (11%) under 20. Some were juvenile offenders, tried and convicted as adults, who have come to the IMU within one month of entering prison. Two overlapping patterns are typical of younger IMU residents:

- *Protection Issues.* Some younger inmates are formally on protective custody or are perceived by staff to be using IMU time as an informal strategy to achieve protective custody. That is, by committing a serious infraction within a short time of incarceration, they are thought to be avoiding a real or perceived problematic placement in general population. Once in IMU, they remain relatively infraction-free.
- *Impulse Control Issues.* There is also a subset of younger inmates who are described by staff as "explosive," "out of control," incapable of maintaining attention, and unable or unwilling to adhere to unit expectations. Mental health and case management information in these cases includes Axis I diagnoses of post-traumatic stress disorder and attention deficit-hyperactivity disorder, and histories of alcohol or drug addiction, special education, learning disability, intermittent explosive disorder, or psychiatric medication. These inmates tend to commit infractions at much higher rates, especially for fighting, throwing and threatening.

These patterns overlap because some younger inmates fear that older, tougher inmates will victimize them, and are unskilled at observing inmate and staff norms. In an attempt to prove themselves manly, they may escalate minor disagreements or perceived provocations into fights and infractions. Staff may also feel some of these young men are safer in IMU settings because fellow inmates find them so irritating.

TABLE 2

Indicators of Serious Mental Disorder Among IMU Residents (N=232)

Indicator	Number	Percent
Acute care user	22	9%
SMI yes	34	15%
Case mgt notes	29	12%
MH residency	45	19%
Diagnosis	29	12%
Multiple Indicators	38	16%
Any Indicator	67	29%

Among older inmates, there appear to be three very general IMU career patterns.

- *Paying the Price.* Some IMU inmates are experienced at doing time, are serving long sentences, and have extensive prison careers. Although they may have multiple admissions into IMUs during their current incarceration, they spend the vast majority of their time in general population. These inmates land in IMU for serious infractions incurred as "the cost of doing business" while living in general population, serve their IMU time with few or no infractions, and return to population.
- *Progressively Poor Adjustment.* Other inmates spend less time in general population, and a larger percentage of their time in IMU. This seems to reflect a general pattern of frequent but relatively short IMU admissions which become lengthier as the number of admissions increases. These inmates are often described by staff as socially inept, and as having difficulties negotiating their roles according to institutional and cultural codes. There appears to be an inverse relationship between the amount of time they live in IMU and their ability to maintain themselves in general population.
- *Stalemate.* Some inmates have become stuck in IMU and serve more of their time in IMU than in any other prison setting. These inmates are described by prison staff as being "at war with the system," and this is thought to explain their extremely challenging and apparently self-defeating

behaviors. The infractions that typify this career pattern include "violent" ones such as aggravated assault and destruction of property, and "disturbed" ones such as throwing and threatening. As these behaviors are interpreted by staff in the context of "war," they are often described as "strategic."

Another set of issues is represented by inmates with serious mental health issues, as demonstrated by the mental illness indicators described above. As mentioned above, rates of all types of infractions are higher for mentally ill inmates. Not surprisingly, IMU inmates who meet our mental illness criteria account for almost all those with recorded suicide attempts (5 of 6) or infractions for self-mutilation (21 of 24). They tend to divide their time between acute care housing, mental health residential housing, and IMU. Within this group we can distinguish two chronological patterns.

- *Route to IMU.* This pattern is characterized by movement between acute care and mental health housing for a time before being admitted to IMU, with IMU admission becoming an increasingly frequent event. In these cases, inmates are described as escalating in violence, unpredictability, or extremely bizarre behavior, and as difficult to manage in other prison settings. They are often recognized as psychotic or seriously mentally ill.
- *Route to Treatment.* The second pattern among IMU inmates with serious mental health issues is movement from IMU to acute care or mental health housing. Here inmates may be characterized by staff as decompensating, manipulative, or some combination of both.

Reflections

The variability in the profile of IMU residents displayed in Table 1, and the distinctive career patterns we have described, indicate that not all IMU prisoners pose the same management problem. Perhaps then not all of them should be subject to the same solution. The resort to a single solution to diverse problems is by no means unique to Washington. Its IMU population at the time of study represented 1.6 percent of a prison population exceeding 14,000, a rate below the average for states that acknowledge super-maximum facilities.[9] The progressive character of Washington's prison management is illustrated by its willingness to support this research. Our concluding remarks on the complexity of tailoring IMU responses to distinct problems raise policy issues of general application.

First, we must qualify the judgment that intensive management represents a one-size-fits-all response. It is reassuring that not all subjects were relegated to chronic IMU residency; the severity and persistence of assaults and threats evidently play a role in administrative decisions about length of stay. Furthermore, Washington's facilities have a level system by which inmates can earn greater degrees of privilege (e.g., in-cell televisions) through compliant behavior. Thus, there is already some variety in outcomes and conditions.

The architecture and procedures that define intensive management, however, were designed with one kind of case in mind. It is exemplified by a man whose record substantiated the comments he made to one of us:

> Personally, I'm beyond rehabilitation: I mean, I'm gonna do what I want to do when I want to do it, and anybody who gets in my way or says differently is gonna be dead. I'm spending the rest of my life in prison, I really have nothing to lose…

It is worth questioning whether restrictions that appear to respond to this sort of case are needed for inmates who mainly pose protection issues, or for those temporarily paying the price for misconduct in general population. It is further worth questioning whether standard expectations for compliant conduct, and for improving one's chances of leaving IMU, are realistic with inmates suffering from organic defects or mental illness. We may also be concerned about the extent to which the IMU regime itself contributes to the pattern of progressively poor adjustment.

To cope with the diversity of issues presented by IMU inmates, a reasonable first step would be to institute systematic intake assessments. The purpose of such assessments would be twofold: first, to evaluate how severely restricted the inmate needs to be, e.g., whether he poses a security risk that warrants suspension of routine medical or dental visits; second, to begin developing a plan for release from IMU that would include behavioral contracts, programming, and planning his next placement with expectations for conduct or treatment there. The additional effort required for individual assessment and planning may pay off in terms of shortened stays and reduced levels of tensions in IMUs, as more inmates see some hope of working themselves out of the box.

The typology we have described here carries a number of risks for misinterpretation or misapplication. One likely misapplication could be made by planners impressed with contemporary methods of psychological assessment and classification: applying a schema like that presented in the previous section by devising research-based, actuarial methods to determine which type an inmate represents. Different sets of procedures and programs, perhaps associated with different IMU locations, could then be applied based on whether an inmate is a protection case, a progressively poor adjuster, and so on. It is important to be clear that like our work, this approach aims to recognize differences; but there is a critical conceptual distinction. The first asks, who is this individual and how do we respond to his issues; the second, which type does he belong to and which program do we apply.

The project of matching type of IMU program to type of IMU inmate is sprinkled with practical and conceptual snares. Consider, for example, the role of the IMU as a hidden strategy of self-protection. It would be at least mildly paradoxical for a Department to recognize this function formally, since the strategy so often takes the form of assaults which the Department's disciplinary and segregation procedures are intended to discourage. Furthermore, to classify one group of IMU inmates as protection cases and separate them from others, by program or location, would in effect label them as protective custody clients. By incurring this stigma, they would also incur the associated presumption, by other inmates, that they are probably snitches. As a result, their return to general population settings would be fraught with peril; recognizing this, the subjects of the intervention would be likely to resist it. We describe this knot of paradox not to argue that there is no way out, but to illustrate how pulling on one string in the IMU situation leads us back to questions about the larger prison setting: what options are open to inmates who feel threatened, and which are they willing to use?

A further difficulty with the project of matching type of IMU program to type of IMU inmate is the likely resistance of staff. Even if inmates are not classified by type but instead staff are enjoined informally to take account of who the inmate is, they may have difficulty accommodating the resulting com-

plexity. Both in IMUs and in the larger prison setting, a small number of officers are charged with controlling a great number of people who don't want to be there. Treating everybody the same regardless of who they are—as exemplified by the slogan, "firm, fair, and consistent"—is a simple way of conserving effort and avoiding the liability incurred if too much slack is mistakenly given to an inmate who then wreaks mayhem. In addition to concerns about efficiency and liability, staff also have convictions about fairness and accountability that may be offended by attempts to vary the regime according to the diverse issues that inmates present. These difficulties are not insuperable, but achieving flexibility in response will be a challenge given the methods of staffing and training that prevail in prisons.

The conceptual danger of formally matching IMU program type to IMU inmate type is that such classifications may misconstrue the different patterns inmates exhibit. First, they are not solely a function of individual behavior or character, but effects of interaction with a system. Second, they are neither mutually exclusive nor fixed. For example, a young and newly admitted inmate may raise protection issues, but also fit the study criteria for mental illness; over time, he may fall into an IMU pattern of progressively poor adjustment, or he may eventually work himself out of IMU and into general population. Even in the example cited above—where we may be glad both that the man is in prison and that he is away from other prisoners—we are glimpsing a particular stage in a career. He now presents his keepers with a stalemate, and returning him to population raises the tiger-by-the-tail problem described in the opening of this article; but we could find others "just like him" except that they are now living in other settings and avoiding violent conflict.

To construe patterns as a typology of individuals ignores not only the overlapping and evolving nature of the patterns, but the role of inmates' past and present settings and the conditions and practices that characterize them. Protection issues, as we saw above, reflect both the vulnerability of certain inmates and formal or informal arrangements for relieving threats in general population. The pattern of progressively poor adjustment demonstrates both the instability of some inmates and the repetitious nature of reactions (e.g., infractions for threatening) that feed the cycle. The careers of mentally ill IMU inmates implicate the accessibility and effectiveness of prison mental health programs, but also raise the question how such severely impaired individuals landed in prisons rather than hospitals. Considering another pattern, paying the price, one inmate now paying for his role in a prison drug ring is also paying a lifetime price for his heroin addiction, because of drug-related robberies that subjected him to "three strikes" laws.

The last cases recall the connection suggested in the opening of this article, between the processes that feed expansion of prison populations and those that increase reliance on super-maximum facilities within prison systems. Our findings show significant differences between general population and IMU inmates, but also support doubts about whether the IMU solution is imposed rationally upon all of them. Like IMU staff, prison workers are confronted with individuals posing a variety of complex issues but are afforded a narrow range of methods to "fix the problem." While responding to this challenge, they may also be troubled by the feeling that not all of their clients belong in this restricted setting. Locating problems solely within the individuals that present them is one means of setting such doubts aside. Both within prisons and in the larger criminal justice arena, a single solution is applied to individuals reflecting a diversity of issues. In both cases, doubts about the fairness of policies can be displaced by the powerful image of the predator, and the concomitant fear of appearing to excuse him or ignore the threat he represents. In both cases, humane and effective practice requires that we resist the hold of this image and encourage open discussion of where we go from here.

Endnotes

[1] David Ward and Norman Carlson, "Super-maximum custody prisons in the United States: why successful regimes remain controversial," *Prison Service Journal,* Vol. 97 (1995), p. 28.

[2] Craig Haney, "'Infamous punishment': the psychological consequences of isolation," *National Prison Project Journal,* Spring 1993, 3–7, 21; Stuart Grassian and Nancy Friedman, "Effects of sensory deprivation in psychiatric seclusion and solitary confinement," *International Journal of Law and Psychiatry,* Vol. 8 (1986), 49–65.

[3] In addition to Haney and Grassian, critics include: David Harrington, "Caging the crazy: 'supermax' confinement under attack," *The Humanist,* Jan/Feb 1997, 14–19; *Cold Storage: Super-Maximum Security Confinement in Indiana* (Human Rights Watch, 1997); *Out of sight: super-maximum security confinement in the United States* (Human Rights Watch, 2000); Roy King, "The rise and rise of supermax: an American solution in search of a problem?" *Punishment and Society,* Vol. 1 (1999), 163–186; Bruce Porter, "Is solitary confinement driving Charlie Chase crazy?" *New York Times Magazine,* November 8, 1998, pp. 52–58. The principal court case is *Madrid v. Gomez,* 889 F. Supp. 1146 (N.D. Cal 1995).

[4] *Adult Felony Sentencing: Fiscal Year 1996.* State of Washington, Sentencing Guidelines Commission, 1996.

[5] David Lovell and Ron Jemelka did a study of infractions committed at a medium security prison in the latter half of 1994 ("When inmates misbehave: the costs of discipline," *The Prison Journal,* Vol. 76, 1996, 165–179). Because of differences in methods of calculation, the general population major infraction rate of 0.9/yr is not strictly comparable to the IMU resident data, but does indicate that the rate among general population inmates is much lower than among IMU residents.

[6] H. Richard Lamb and Linda Weinberger, "Persons with severe mental illness in jails and prisons: a review," *Psychiatric Services,* Vol. 49 (1998), 483–492. In *Mental Health and Treatment of Inmates and Probationers* (7/99), the Bureau of Justice Statistics reports a 16% rate of self-reported prior treatment or mental or emotional problems among state prison inmates.

[7] Hans Toch and Kenneth Adams, "Pathology and disruptiveness among prison inmates," *Journal of Research in Crime and Delinquency,* Vol. 23 (1986), 7–21; Hans Toch and Kenneth Adams, with J. Douglas Grant, *Coping: Maladaptation in the Prison,* New Brunswick, N.J.: Transaction Books, 1989; David Lovell et al., "Evaluating the effectiveness of residential treatment for prisoners with mental illness," *Criminal Justice and Behavior,* in press.

[8] Cf. the Introduction to *Coping,* cited in (7).

[9] Comparative data from Roy King, cited in (3). The IMU population in Washington may have been slightly depressed at the time of our study, and is due to increase with the opening of a fifth facility at a new prison nearing completion.