Patterns of Disturbed Behavior in a Supermax Population

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PATTERNS OF DISTURBED BEHAVIOR IN A SUPERMAX POPULATION

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Results of a systematic survey of the clinical status of supermax residents, showing the association of mental health issues with disruptive behavior, are followed by eight brief case studies. The survey covers 131 inmates selected at random from Washington's supermax facilities, representing almost half the residents. From interviews with 87 of these inmates, combined with reviews of medical and institutional behavior records, it is concluded that 45% of supermax residents suffer from serious mental illness, marked psychological symptoms, psychological breakdowns, or brain damage. With this empirical grounding, an argument is presented that the concept of disturbed behavior, notwithstanding its lack of a clear diagnostic reference, is needed if we are to understand interactions between prison settings and the mental health issues of prisoners. The clinical profile and histories of disturbed prisoners provide reasons to establish greater flexibility in prison classification and disciplinary procedures, especially those that determine how long prisoners stay in supermax. Institutional obstacles to flexibility are diagnosed, and the possibility of shrinking supermax populations is proposed.

Keywords: supermax; mental health; mental illness; prisoner; deterrence; custody

In 2003, a committee was formed to design a program for "behaviorally disturbed" prisoners in the Washington Department of Corrections (DOC). After some preliminary discussions—despite recognizing the need, few prisons sought the honor of hosting this population—a program site was selected. The veteran staff members on the design committee were quite aware of the challenges posed by the program's intended participants; they knew who they were talking about. Nevertheless, in the next stage of planning, a DOC psychologist raised a hurdle to defining the "target group." Undaunted by recent arrival at DOC—"people are people, and behavior is behavior"—and confident in the scientific credentials represented by a clinical PhD, the psychologist challenged the usefulness of the concept of disturbance, pointing out that it corresponded to no recognized clinical or operational category, neither DOC's definition of serious mental illness nor any *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994)

AUTHOR'S NOTE: *This article draws on data collected between 1999 and 2001 with funding by the Washington Department of Corrections (DOC) through the University of Washington–Department of Corrections Mental Health Collaboration. Access to inmates and records was enabled through the efforts of officials and administrators in the Department of Corrections at the time of the study: Joseph Lehman, secretary; Eldon Vail, deputy secretary; and Gary Jones, associate superintendent. I am also grateful to the other University of Washington members of the study team: David Allen, Kristin Cloyes, Cheryl Cooke, Susan Graham, and Lorna Rhodes. Understanding of the issues has been considerably advanced by discussions with Bruce Gage, Gregg Gagliardi, and Ron Jemelka, colleagues in past work at McNeil Island. Finally, this article is thoroughly permeated with ideas developed in conversations with Hans Toch and in reading his books and papers over the past 15 years. Please address all correspondence to David Lovell, University of Washington, Box 351271, Seattle, WA 98195-1271; e-mail: lovelld@u.washington.edu*

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Axis I diagnosis or Axis II diagnoses such as borderline or antisocial personality disorder. So the program was renamed Behavioral Change Unit, and its potential participants were defined very operationally as inmates who continued to accrue infractions after being placed in a supermax setting.

The Behavioral Change Unit has yet to be established. But this was for the usual reasons: funding shortages, leadership changes, shifting priorities. It was not because prison staff cannot identify the people they hoped to send there, that is, the people they hoped to send away from their own facility: the people who fight when there is nothing to gain, who want to rattle their doors till the rights they claim are restored, who mutilate themselves and contaminate the wounds, who not only smear their walls and flood their cells but do so for incomprehensible or seemingly trivial reasons. The syndrome was described in 1982 by Toch in "The Disturbed Disruptive Inmate: Where Does the Bus Stop?" In Washington, years before the discussion cited above, a counselor at one of the usual bus stops prepared a list of 40 problem inmates who, coincidentally, closely resembled Toch's description and displayed one of the primary indicators: shuttling back and forth between prisons and between disciplinary and mental health settings. The occasion for this listing was the DOC secretary's request to the University of Washington for help with "behaviorally disturbed inmates."

If the concept of disturbance has no clinical meaning, why is it readily recognized by administrators, and how was it possible for staff to list the people to whom it applies? Part of the answer, of course, is that a concept can have operational meaning for those who manage an organization, such as a prison, even if the behavior it covers is diverse and its causes contestable or mysterious. But that does not mean that causes are irrelevant, as implied by the simple behavioral criterion advocated by the psychologist: continued infractions after placement in supermax. There are two main problems with this operational definition. First, it does not distinguish those who are disruptive because they are disturbed from people whose disruptiveness is undertaken to settle a debt, honor a creed, or serve an alliance; for example, a "security threat group." Second, responding successfully to extreme behavior requires that we take its causes and objectives into account.[1] Such, at least, was the presumption of our team when asked to consult with DOC on the treatment of behaviorally disturbed inmates; so we undertook a systematic description of prisoners living in supermax units (SMUs).

Some results of this investigation have been reported in two studies:[2] a statistical profile of all prisoners living in Washington SMUs (Lovell, Cloyes, Allen, & Rhodes, 2000), based on electronic records and describing the diverse prison career patterns that characterize supermax prisoners, and an analysis of measures of psychosocial impairment (Cloyes, Lovell, Allen, & Rhodes, 2006), developed during an intensive follow-up study that used interviews and chart reviews as well as electronic records. This article further describes the clinical status of supermax residents. Data used in the previous study are recompiled, with the addition of measures of disruptive behavior. Causal and conceptual issues are explored by following up on eight cases that cover the useful range of the concept of disturbance, together with several additional cases, not classified as disturbed, that serve to demarcate the range from the other side of the boundary. Finally, the patterns of provocation and response observed in these cases—on the part of prisoners and keepers alike—are applied to policies for governing and improving disruptive prisoners and the places they live.

METHOD

DATA COLLECTION AND COMPILATION

Lists of SMU residents were provided by administrators as we prepared for site visits. In addition to interviewing inmates and staff, our team reviewed inmates' medical records and took notes on psychosocial histories, psychological evaluations, progress notes, and prescription records; not all of these were available in every record. DOC maintains an electronic offender tracking system from which we collected the following data:

numbers of Washington felony convictions;
prison admission and release dates;
assignments to mental health residential programs, segregation from other inmates, close observation units, and SMUs; and
a mental health screen for mental health professionals, indicating whether an inmate has been classified as seriously mentally ill and listing the most recent diagnosis.

Also available electronically are brief descriptions of major infractions and chronological narrative notes by prison classification counselors and mental health staff. Confidential medical information such as diagnosis and prescriptions is not included, but descriptions of behavior, conferences, and placement decisions can be found. To previously collected data, this article adds observations from the entire DOC history (to date) of eight prisoners who illustrate varieties of disturbance, including subsequent mental health screen entries and notes by DOC case managers who supervised these men after release from prison.

PARTICIPANTS

Our objective was to interview and assess 30% of intensive management unit residents, sampled at random in each of the three SMUs then operating in Washington's prison system, all of them for male inmates. Research was governed by protocols on human participants approved by the University of Washington and DOC, and a federal Certificate of Confidentiality was obtained. Interviews were tape-recorded and transcribed. Prospective participants had the right to refuse interviews, a right they exercised to varying degrees in the three facilities. When prospective interviewees declined to be interviewed, we proceeded further along the randomly ordered list of inmates until we had interviewed at least 30% of the unit population.

To ensure that our findings would be representative, we reviewed the charts of those who declined interviews as well as those who accepted. With these inmates included, the final sample comprised almost half the supermax population, and we may safely infer that the profile fairly represents supermax residents in Washington. The sample was composed as follows:

131 participants were solicited;
44 declined interviews or were unavailable;
87 were interviewed (the charts of 9 of these were unavailable at time of review); and
122 charts (131 − 9) were reviewed.

MEASURING SERIOUS MENTAL ILLNESS AND DISTURBANCE

Our study defined mental illness conceptually as a major mental disorder that substantially impairs functioning and requires continuing treatment. A more detailed definition of "serious mental illness" was developed in Ohio and later adopted by DOC:

> A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or cope with the ordinary demands of life within the prison environment and is manifested by substantial pain or disability. Serious mental illness requires a mental health diagnosis, prognosis and treatment, as appropriate, by mental health staff. It is expressly understood that this definition does not include inmates who are substance abusers, substance dependent, including alcoholics and narcotics addicts, or persons convicted of any sex offense, who are not otherwise diagnosed as seriously mentally ill. (Ohio Dept of Rehabilitation & Correction, 2000)

This definition is not intended to cover all those who need mental health treatment but to delimit the class for whom DOC is legally obligated to provide treatment: those covered by federal court rulings establishing that, while inmates are wards of the state, the state has a duty to protect them from harm by providing medically necessary treatment (Cohen, 1993, 1998; Metzner, Cohen, Grossman, & Wettstein, 1998).

The rationale and principal elements of the concept of serious mental illness, in a prison context, are not difficult to grasp: legally required medically necessary treatment, major mental disorder, substantial functional impairment. Nevertheless, which prisoners are seriously mentally ill is controversial, and documented evidence of mental illness is often fragmentary or conflicting. As Kupers makes clear in his contribution to this issue, these problems are common. For a variety of reasons, including the peripheral role of contract psychiatrists in the classification of inmates, we sometimes found that psychotropic medications had been prescribed without a diagnostic record in DOC medical charts. Furthermore, medications were sometimes prescribed for prisoners with "adjustment disorders," or as a means of moderating disruptive behavior, without any particular diagnostic commitment. Moreover, not all evaluations (regardless of diagnosis) were followed or accompanied by significant administration of medications. Finally, some evaluations provided or cautiously indicated relevant diagnoses (e.g., schizophrenia) whereas others flatly contradicted them (e.g., malingering). For these reasons, we relied on multiple indicators of serious mental illness (SMI):

1. An "interview confirms SMI" assessment, recorded by a mental health professional in DOC's electronic offender database;
2. Prescription of antipsychotics, mood stabilizers, or antidepressants (weighted by type of drug and steadiness of prescription);
3. Diagnosis of a major mental disorder (schizophrenia, schizoaffective, psychosis not otherwise specified, bipolar, major depression, dementia and other organic mood or thought disorders, borderline personality disorder);
4. Assignment to a residential unit for mentally ill inmates for 30 days or longer.

The first was sufficient by itself for us to classify an inmate as mentally ill, as was steady prescription of antipsychotics or mood stabilizers. The other indicators had to be combined because of the vagaries of diagnosis and medication in prisons. When Cloyes subjected our findings to factor analysis (Cloyes et al., 2006), she found that "each of these variables contributes in a significant way to the reliable measurement of SMI as an underlying

construct. To exclude any of these four operational indicators would negatively affect validity and reliability" (p. 770).

To the information obtained from medical charts and DOC's electronic offender tracking system, our study added a new piece: the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962), a well-established, 18-item scale that measures psychiatric symptoms (such as depressive mood, hostility, disorganization, and agitation) observed in a brief, loosely structured, clinical interview. Factor analysis of total BPRS scores and scores on subscales (such as thought disorder) further confirmed the validity of our operational indicators of mental illness. The similarity in profiles between supermax and inpatient psychiatric populations suggested that the scores measured "psychiatric symptoms and not some other construct such as psychopathy, personality disorder, or character problems" (Cloyes et al., 2006, p. 775). In short, whatever we were measuring was something very like mental illness.

Nevertheless, there was incomplete overlap between the clinical documentation from which our criteria of serious mental illness were derived and the standard of marked or severe symptomology derived from the BPRS (marked: total scores from 24 through 35; severe: 36 and above). Among those inmates for whom we had data of both kinds, there were 11 who showed marked or severe symptoms but did not satisfy the SMI criteria and 6 who met SMI criteria but showed only mild or moderate symptoms in interviews. Systems for screening, assessing, diagnosing, and tracking prisoners into treatment programs are not advanced: Prisons tend to have other priorities, such as maintaining order, and people are missed for a number of reasons, described in this issue's companion pieces and illustrated in the next section. To maintain independence of assessments of inmates' personalities and clinical presentations, we conducted the interviews blind, that is, without prior inspection of electronic records or medical charts. It is possible that further probing would have elicited more symptoms, had we known about apparent psychological breakdowns that inmates chose not to disclose. To tabulate these issues, we coded evidence from chart notes and comments in prisoners' electronic tracking records:

Various forms of psychotic behavior. Hallucinations (14 cases), delusions (7 cases), or other behaviors such as withdrawal, hygiene issues, or disorganization (7 cases) were noted. Of 21 inmates with one or more of these signs, 3 met neither SMI criteria nor BPRS criteria of marked or severe impairment.

Self-injury. There were 11 inmates with past suicide attempts, and an additional 6 with lesser forms of self-injury. But 9 of these 17 inmates failed to meet criteria of mental illness.

Brain damage. Conclusive evidence was rarely available, but descriptions of symptoms in psychosocial histories or medical evaluations were found in 36 cases (30% of the 122 files reviewed). Of these, 17 involved head trauma; in 6 cases, no causes were cited; and the others involved seizures, pre- or perinatal damage, or substance abuse.

Table 1 summarizes the prevalence of four forms of disturbance or impaired functioning we have catalogued.

1. Serious mental illness, as defined by any one of the official DOC indicators;
2. BPRS total scores showing marked (24-35) or severe symptoms (36+);
3. Psychotic or self-injurious episodes described in electronic records or medical chart notes;
4. Indications of brain damage in medical charts.

TABLE 1: Forms of Disturbance or Impairment Among Washington Supermax Prisoners

Measure	n	*Percentage*
Documented SMI (*N* = 122)	26	21
BPRS symptoms (*N* = 87)	19	22
Self-injury or psychotic episodes (*N* = 122)	32	26
Brain damage (*N* = 122)	36	30

Note. SMI = serious mental illness; BPRS = Brief Psychiatric Rating Scale.

Rates are based on 122 file reviews, except for the BPRS measure, which is based on 87 interviewed inmates.

These four measures have been presented roughly in descending order, in terms of the reliability of the evidence they provide of conditions requiring medical treatment. Each of these measures, however, indicates substantial impairment in judgment or functioning; so each supports concerns about the responsiveness and realism of clinical and disciplinary interventions. Most of the 60 men detected by these indicators satisfied several criteria; all but 10 of 36 with evidence of brain damage, for example, had already been included by other measures. As mentioned earlier, however, the overlap is incomplete. Figure 1 displays rising rates of mental health issues with the addition of each indicator.

Taken together, these data indicate a high rate of mental health issues, variously conceived, among supermax inmates. Let us apply the working label "disturbed" to men who satisfy one or more indicators, pending further explanation of the conceptual and causal implications of the term. Members of this group were highly disruptive:

During the 5 years, on average, they had spent in prison on the current offense, their stays had been extended an average of 14 months because of loss of good-conduct time. They had averaged 21 months in supermax or segregation and 4 months in residential mental health units. They averaged 13 transfers between facilities.[3]

Their annual major infraction rate, at 10.5, was higher than the 6.1 annual rate of other study participants and much higher than the annual average of 1 infraction per year observed in a medium security prison (Lovell & Jemelka, 1996).

These 60 inmates had committed 135 assaults: 45 aggravated and 65 (including 5 aggravated) on staff. Four of them had infractions for homicide.

Less-violent forms of disruptiveness included 220 infractions for threatening, 168 for throwing objects (often urine or feces), 83 for destroying property, and 28 for flooding cells. Twelve men had been infracted for mutilating themselves, usually two or three times.

Serious mental illness can safely be attributed to at least 25% of supermax prisoners in this study, compared with a rate of 13% found with similar methods and criteria in a statewide survey of all major prison units (Lovell, 2003). As Cohen explains in this issue, serious mental illness has been the principal predicate for arguments that certain classes of inmates should be kept out of supermax. But for other purposes, the concepts of psychosocial impairment or disturbance track the issues at stake for supermax prisoners and staff better than illness. These issues are illustrated by the cases described in the next section.

DISTURBED INMATES AND THEIR VICISSITUDES

This is a story of people and places: eight men and five facilities with a critical influence on their prison careers. We begin with the places:

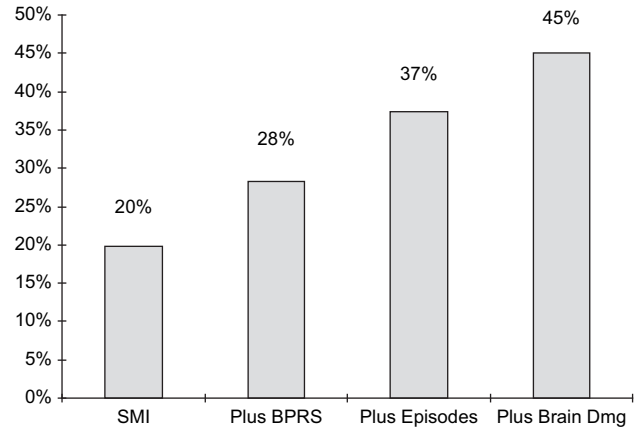

Figure 1: Cumulative Prevalence of Mental Health Issues Among Intensive Management Unit Residents as Indicators of Disturbance or Impairment Are Added (*N* = 131)
Note. SMI = serious mental illness; BPRS = Brief Psychiatric Rating Scale; Episodes = psychotic or self-injurious episodes; Dmg = damage.

Three SMUs, each located at a general population prison: (a) the penitentiary, the state's largest prison; (b) the remote facility, built in the days when few communities wanted a prison nearby; and (c) the reformed supermax, featured in the last chapter of Rhodes (2004). Some of the innovations pioneered at the reformed facility, such as weekly "walk-arounds" by prison officials to listen to supermax inmates' concerns, have recently been instituted statewide, but during 1999-2001, when we carried out site visits, the management of this unit was controversial.

Two mental health facilities: (a) the intensive treatment program, with high-security housing and a relatively rich level of mental health staffing, devoted to inmates with serious mental illness and more than twice as expensive to operate as any other facility, and (b) the McNeil Island program for prisoners with mental illness, a residential program in a medium-security prison,[4] with a small maximum-security wing and the opportunity for men with mental illness to go to meals, yard, or classes with other inmates.

In addition to its SMU, the penitentiary contained a 100-bed special housing unit for prisoners with mental illness and a close-observation unit. Whether disturbed and disruptive prisoners belonged in the mental health unit, the SMU, or (better yet) across the state at the intensive treatment program was a long-standing theme of prison management. The newer facilities—the McNeil Island program and the reformed supermax site—had more recently joined this engagement; the remote facility, because of its location, had scant mental health treatment resources and was a less active player.

The eight inmates described below are provided with alphabetical pseudonyms and are listed from the clearest case of serious mental illness to the most doubtful.

FINDING THE RIGHT PLACE TO LIVE

Conflicting evaluations of inmate behavior are common in medical charts and electronic case management files. The offensive or threatening nature of events associated with SMU placement—thrown urine or feces, assaults of staff, escape attempts, extreme violence—naturally arouses revulsion and skepticism about motives. Under these circumstances,

interpretation of inmate misbehavior—whether ascribed to illness or to malice—is inherently contestable. Much of the contest, illustrated in the case studies that follow, concerns where inmates should live.

1. Mr. Abbot, a 50-year-old man serving time for assault, had a long history of alcoholism, incarceration, hospitalization, and treatment for mental illness. He arrived in prison 2 years before we saw him and was promptly assigned to the intensive treatment facility, where he refused to attend classes or take medications, threw food and urine, flooded his cell, and issued obscene threats to male and female staff alike. He accumulated 100 infractions for threatening and 20 for throwing in a little more than a year, achieving the highest infraction rate of any of the SMU residents whose records we surveyed. He settled down for a few months and was diagnosed as schizoaffective but was soon transferred to the reformed supermax, where he seemed to fare better because he had no contact with other prisoners and got along well with the staff. He then moved to the McNeil Island program; after a few months in the maximum security unit, he was welcomed into the medium-custody mental health program and remained there, despite occasional outbursts and conflicts with teachers and supervisors, until his release. Back in the community, it seemed fortunate that he was assigned a correctional case manager with extensive mental health experience, who hooked him up with housing, medication, and mental health treatment, but 2 months later, he dropped out of sight.

Mr. Abbot would have tried the patience of staff no matter where he had been placed. The intensive treatment facility seemed appropriate because of its high security and numbers of mental health staff. At that time, however, staff and administrators were struggling to define how much leeway they could provide for disruptive behavior on the part of inmates with mental illness. About 15 years earlier, the uniformed custody chain of command had revolted against the administration, charging that security procedures were dangerously lax and pointing out that the Washington Administrative Code required write-ups of major infractions, regardless of mental health status. As a result of an eventual accommodation between the camps, infractions continued repetitiously to be imposed for misbehavior, serving more to document than to punish disruptiveness. More important than the symbolic issue of infractions was the cultural residue of the excruciating treatment versus custody conflict: some counselors and unit supervisors presumed that order would be undermined if inmates such as Mr. Abbot were given special consideration before learning to cooperate with staff. The reformed supermax and the McNeil Island program showed greater flexibility: the former because its determined and charismatic administrator insisted on it, and the latter because cell blocks were managed by nonuniformed staff, most of them former corrections officers attracted by the opportunity to teach and counsel inmates while they went about maintaining order.

2. Unlike Mr. Abbot, many mentally ill offenders can live quietly in prison. Mr. Baker would have fit this description for most of his prison term had he not insisted on two conditions: not to be troubled by mental health staff and not to be forced to live among dangerous men.

   Mr. Baker, a man in his 30s with well-kept long blond hair and a beard, was an avid reader who cheerfully claimed he was not capable of being lonely. But his history was far from cheerful. He had served previous prison terms in Washington, with a history of juvenile incarceration beginning when he was 11 and continuing through teenage years, when he often ran away because "Dad was beating on me." By his account, cocaine had made him desperate enough to commit robbery, and eventually psychotic; he was hospitalized and began hearing voices that commanded him to straighten up, turn himself in, and bring the message of God to people in prison. After his first bout of infractions got him transferred to the penitentiary, he announced that he would serve his time only in supermax. When told that was not his choice, he won the argument by running across the prison yard and scaling the fence, daring

officers to "go ahead and shoot me." After release from prison, Mr. Baker was arrested several times, hospitalized as suicidal, found using cocaine, and placed in community mental health treatment with a diagnosis of psychosis and depression. Evicted from his apartment because his landlord found him scary, he made a bomb threat and returned to prison, where he served his entire sentence in supermax. He was seen as dangerous by DOC staff because of his past "escape attempt" and his threats to "do whatever it takes to live in supermax," but his relatively nonviolent conviction history did not qualify him for postrelease supervision. Furthermore, although everyone found him delusional, his refusal of any mental health treatment had left no diagnosis or status as SMI on his DOC record. So on his recent release, he was taken by special transport straight from a supermax to a homeless shelter with no provision for monitoring or mental health care.

3. Mr. Carson, a small, disheveled man in his 40s who "looked like Charles Manson," described himself as a loner; he had lived as a transient for many years and first appeared in DOC records for stealing an 18-wheel truck he came across while hitchhiking. "My assessment is he has some mental health issues," commented his probation officer. After arriving in prison on drug charges, he progressed to more and more restrictive settings because of threats, attempted assaults, and contraband (sharpened metal, instructions on how to make a bomb). His chart notes that "his poor social skills could be a danger to his health." The only clear points in his account of how he came to supermax were that he believed he had been set up and was going to take revenge on somebody: He indicated that he had connections to East Coast crime families and Manuel Noriega, the imprisoned former dictator of Panama. Mr. Carson spent the last year of his sentence at the McNeil Island program, mostly in the maximum security wing. Extensive and partially successful efforts were made to place him in housing and treatment on his release from prison. Supervised for a year after his release, and despite episodes of homelessness, incoherence, and cocaine, he maintained a cooperative attitude toward case managers and counselors: "He is really trying to stay clean and comply because he is fearful of going back to prison."
4. Mr. Davis, an eloquent and impassioned man in his 40s, was serving a 15-year sentence for a sex offense he could not believe he had committed. For many years he maintained that his conviction was going to be reversed, that it was a mistake or a conspiracy. Toward the end of his term, "he doesn't deny his offense but says he can't recall it." His file also recounts accusations of racism and other conspiracies, mentioning that "my people are dealing with [DOC secretary] Lehman about this"; he cited loss of his legal papers and neglect of medical issues (asthma, sleep disorders, depression) that required placement in a single cell or that prevented program participation. Despite these accusations, he said he saw racism as an impersonal force. He did not call staff rednecks, he did not take it personally: It was not the nature of the staff but their habits he blamed, specifically an institutional "culture of disdain" for inmates.

   Though Mr. Davis's claims to special treatment were regarded with suspicion, his medical issues were not imaginary. As a young man, he had suffered a head trauma that put him into a coma for 5 months, he had been taking anticonvulsants since his arrival in prison, and he later lost sight in one eye. He has spent the past 5 years at the intensive treatment facility, where he has generally gotten along well despite periodic lapses into paranoia. As his prison release date drew near, his counselors recommended him for a transitional assistance program for "dangerous mentally ill offenders" (DMIO), but the program admission committee, consisting of administrators from a network of collaborating social service agencies, did not deem him seriously mentally ill.
5. Mr. Escobar had spent most of his prison time, wherever he was, trying to be moved someplace else. Staff in mental health units were happy to assist because of his noisiness, poor hygiene, and overly intimate discourse with female staff, alternately beseeching and violently threatening. A small man nearing 40 but appearing rather older because of a lifetime of drug abuse, incarceration, and violence (including closed head injury), he told me he planned to go into the ministry after leaving prison and wondered whether I could help find someone to remove his tattoos. He claimed he was not able to breathe in supermax and mounted a fierce campaign to be transferred that included threatening suicide, assaulting staff, throwing feces, and spitting, so he spent 4 months under modified conditions that included wearing a spit

sock whenever he left the cell. Because of past serious violent charges in another state, he was seen as not only manipulative and obnoxious but dangerous, and it was argued that he was not SMI and should not be able to get out of supermax by the means he had adopted. Later, however, he was described as "back on his meds," and he remained stable long enough to be transferred to the McNeil Island program; then, after refusing medications and disrupting the program, he was moved to the intensive treatment facility. Meanwhile, he wrote letters to the Pope, the president of Mexico, and Elton John about his charitable plans after release. Placed in the DMIO program on release, he continued lying to case managers and using heroin, returning to jail briefly after a female friend, with whom he was using drugs, said he had thrown her down a stairwell. When his supervision ended, his case managers were happy to see him board a bus for California.

Like Mr. Abbot, Mr. Carson was eventually accommodated best at McNeil Island, with its variety of settings and its concomitant ability to sort people informally into the locations suited to their current behavior. Mr. Davis and Mr. Escobar, who were seen for much of their terms as manipulative rather than ill, fit better at the intensive treatment facility once their special needs were recognized. Mr. Davis needed its superior access to medical resources and may have been reassured that its security procedures would protect him against those who would victimize him because of his offense. Mr. Escobar, unlike the others, did not reliably improve his behavior in response to improved environments or attempts to help him—a pattern that continued when he left prison.

Mr. Baker said he had selected himself out of mental health treatment; the other four eventually made their way to a residential mental health program and seemed to belong there, but in each case, staff had previously found that they "weren't SMI."

Mr. Abbot: "There is some evidence of SMI, but not in need of care at [the intensive treatment facility]."
Mr. Carson "is not on any medications, is not SMI. No diagnosis showing on MH screens."
Mr. Davis: "He has no mental health concerns at this time. However, does have a healthy dose of paranoia. . . . He continues to blame others for his poor choices."
Mr. Escobar: "He is not 'suicidal' nor a mh case. He is, however, intensely manipulating the system and malingering to avoid the realities of segregated living."

The cultural and political pressures in prisons that encourage such misclassifications have been well described by others (e.g., Kupers, 2008 [this issue]; Rhodes, 2004; Toch & Adams, 2002). These men were also very challenging because they rejected interventions designed to treat whatever they had—assuming some label could be found—as well as interventions designed to teach them a lesson. So one may understand why mental health staff thought they should be sent someplace else. But it is frustrating for a researcher to read through case chronologies and realize that when the case was handed off, the new staff responsible for managing or classifying the inmate had not read them. Among the lessons conveyed by these cases is that history is likely to overrule judgments made without benefit of history.

MANAGING BEHAVIOR IN SEGREGATION

Understanding the last three stories requires a review of the options available to authorities for responding to prisoners, such as Mr. Escobar, who respond to supermax placement by intensifying their misbehavior. First, level systems are instituted that allow inmates who behave well in supermax to earn privileges, first a radio and then a television. In Washington, transfer out of supermax is generally available only to those who have reached

the television level. Second, there are punishments. Privileges can be reduced below the entry level (personal items are removed from the cell), and infractions can be sanctioned by isolation time. Inmates are restricted to their cells for 8 days in a row without showers or access to the exercise yard; they then have 3-day breaks during which showers and outside yard are permitted; this cycle is repeated until the days of isolation imposed at a disciplinary hearing have been served.[5] Finally, conditions of confinement can be modified to keep anything out of the cell that the prisoner might use to disrupt operations, attack others, or hurt himself: warm meals, books, paper, mattresses, blankets, sheets, even clothing.

Not all supermax administrators have been happy to rely solely on deterrence, for reasons illustrated in the next three stories. Trying to take account of the diversity of causes and responses associated with supermax placement, administrators at the reformed supermax promoted flexibility about advancing inmates through the levels and recommending them for release from supermax. More recently, the penitentiary and the remote facility have instituted stepdown programs: increasing levels of freedom and social contact are supported by counseling and psychoeducational courses designed to help supermax residents prepare for a successful return to the general population and eventually to society.

6. Mr. Farmer was serving his third DOC sentence for drug-related offenses. Under supervision in the community, he appeared an elusive small-time hustler; he was considerably more prominent in prison because of his willingness to resort to extremes when he felt racial or religious persecution had violated his rights. Bouncing back and forth between segregation and the penitentiary's close-observation unit because of suicide threats, he was described by one psychologist as "a clever and purposeful inmate without serious mental health issues. . . . Malingers to gain special treatment . . . to avoid his segregation placements." When interviewed at the reformed SMU, he indeed showed few psychiatric symptoms, with a BPRS total of 12 points. Shortly thereafter, however, he was transferred back to the penitentiary to stand trial on additional criminal charges (setting fire to his cell). The SMU staff promptly restored the sanctions he had coming to him because of his previous misbehavior there: reduction in privilege level, isolation, and no possibility of having privileges restored until his days of isolation were completed. Interviewed at the penitentiary, he received the highest BPRS score in our study (57, 20 points above the "severe disturbance" threshold), with severe ratings on many items: somatic concerns, anxiety, depression, hallucinations, and blunt affect. Some months later, at McNeil Island's maximum security wing, he had settled down, with a BPRS score of 21. Mr. Farmer spent the last several years at the intensive treatment facility, where he finally acquired a diagnosis: major depression and borderline personality. Periods of calm and friendliness alternated with feces smearing and increasingly dramatic suicide attempts. Back under supervision after release, he at first appeared "cogent, articulate and well organized" but frequently relapsed, getting drunk, smoking crack, and occasionally seeking mental health treatment. By the end of his supervision period, he had found a job, but his record does not portend stability.
7. Mr. Gallagher was the friendliest man I interviewed. He had become a Christian and was living at the reformed SMU. A repeat offender with past sentences for burglary and most recently for first degree robbery, he acknowledged that his level of violence had been increasing. A large man coping with the prisoners' practice of testing each other for weakness, he said he had showed "an abrasive personality" and that "attacking worked for me"—a claim backed up by 10 infractions for assault. As a result, when I wondered whether his newfound faith might leave him vulnerable, he assured me with a smile that he was not worried about people picking on him. Not all of Mr. Gallagher's actions, however, could be classified as strategic. On one occasion, angry about being stopped for a minor infraction and possibly having to return to segregation, he sealed his fate by seizing an opportunity to punch the offending officer: "At first, I wasn't going to do it because there were so many guards there, but I did it anyway." The year before our interview, he incurred 80 infractions in a 3-month period; stripped of everything, his consciousness was consumed by gory and sadistic fantasies which he translated into blood-curdling threats involving

female officers and the wives and children of the men. It was at this point, he said, when he had reached the end of the line, that Jesus found him.

Eventually transferred into general population, Mr. Gallagher committed no further assaults but lost work assignments and incurred brief stays in segregation by exploding in rage when people frustrated him. Two years after release, he returned to prison for malicious mischief (kicking in two doors and breaking a man's nose). In the year after his next release, he gained and lost a job as a bouncer, gained and lost subsidized housing, and gained and lost a wife, who was fed up because drug abuse kept him losing whatever he had gained. He became suicidal and was placed in crisis care but absconded a week later. Back in prison for violating release conditions (i.e., possessing methamphetamine), he was sent directly to supermax.

8. Mr. Heller committed his first crime when he was 12, was first incarcerated when he was 13, and began his first prison term when he was 16. He threatened, swore at, and scuffled with officers, but he treated other inmates worse: assaulting them, taking their radios, urinating into their cells, squirting them with feces. Bitter and hopeless when interviewed in supermax, he said he had little to think about except doing more crimes. He was dismissive about mental health treatment but neglected to mention that several months earlier, he had temporarily been transferred to the close-observation unit. His accumulated isolation time meant that it would be another 8 months before he could even think about "working the levels" and earning his way out of supermax. So he shredded all the paper in his cell, smeared feces all over the wall, huddled in the corner under a blanket, and finally placed a sheet around his neck. All of this was seen as a performance to get himself out of segregation, an assessment he later corroborated. Since his release in 2001, Mr. Heller has been in and out of prison two more times; he was severely beaten when he defiantly declared his gang membership at a party full of rivals; he was stabbed in the chest and shoulder, which collapsed his lung; he was shot in the leg; and he led a group of inmates on a brief escape from a county jail. This stunt led to his third return to prison; as prisoners sometimes say, he was not arrested; he was rescued. After spending his adolescence and youth behind bars, he now says he saw enough of the broader world during his last stay in the community to begin thinking about something besides running with gangs and going to prison. So now, at the age of 27, he has had another first: asking for help to change his life.

DRAWING BOUNDARIES AND CHANGING RULES

CONCEPTUAL ADVANTAGES OF DISTURBANCE

The concept of serious mental illness has become a necessary part of lawful correctional practice because, within established constitutional precedents, it supports a right to treatment and sets boundaries to the discretion of prison authorities over conditions of confinement for some prisoners. The category of serious mental illness can protect its members, however, only if screening, assessment, diagnosis, treatment, and classification procedures are carried out reliably. And we have seen that breakdowns in this process are common even in a comparatively progressive state such as Washington (cf. Adams & Ferrandino, 2008 [this issue]; Human Rights Watch, 2003). But the fundamental problem with relying solely on the category of serious mental illness would remain even if such errors could be banished, perhaps by magic. Played out in our stories and statistics is the paradox that if a bright line is drawn around a protected class, the SMI, those deemed "not SMI" are presumed to need no special consideration. As a result, they have little recourse under an institutional regime that relies on incapacitation, deterrence, and increasingly severe responses to continuing misbehavior.

Although the concept of serious mental illness is necessary, it is not sufficient to cope with the mixture of psychological, cultural, and political predicaments embodied by supermax inmates, particularly the substantial number who dramatically fail to respond as they are supposed to. What is gained by adding the concept of disturbed behavior?

We identify disturbance by a person's presentation of self, in speech and behavior. In contrast, the concept of mental illness invokes medical terminology (diagnosis, course of treatment, prescription); it typically implies some interpretation of what the person's presentation means or represents (for example, schizophrenia); and the illness is usually referred to as something the person has (such as depression) rather than as something he or she does or expresses in a particular setting. The items in the BPRS—such as anxiety, hostility, grandiosity, and unusual thought content—belong to the disturbance category. The concept of disturbance has causal implications beyond a purely behavioral measure such as "continues to disrupt after supermax placement," but it accommodates a broader range of causes than mental illness normally does. Among these are causes built into the supermax setting and the rules by which prisoners are managed and classified.

Our sample scored highest on the following items, in order: suspiciousness, hostility, anxiety, tension, depression, and grandiosity. This finding will hardly surprise readers familiar with conditions of SMUs and the reasons for assigning inmates to them (Cloyes et al., p. 778). Supermax inmates are confined to a small space with only brief respites, are under constant surveillance, are deprived of normal conversation, are fed through a slot in the door, are not told how long they will be there, and are chained or bolted down on the rare occasions when they share the same room with others; one might therefore expect many of them to become suspicious, hostile, anxious, tense, or depressed. As to grandiosity, a fair amount of hyperbole about individual prowess or imperviousness to fear is common (though far from universal) among prisoners (Toch, 1992). One inmate, involved in a shoot-out with police and a determined escape attempt from prison, claimed that staff would be wary around him because "they know what time it is." We may consider his claim more realistic than Mr. Carson's claimed links with crime families and Manuel Noriega, but a common factor is that if people live in conditions of imposed helplessness, it may be consoling for them to reflect that they must be rather important for the authorities to take such pains to control them.

DRAWING BOUNDARIES

The problem with serious mental illness as the sole issue in mental health classification is that it appears to be a matter of identifying which people have and which people do not have something: to list, for example, the necessary and sufficient conditions for ascribing hepatitis or gallstones. When inmates are described as disturbed, however, it is a classic instance of family resemblance (Wittgenstein, 1958). Solitaire is a game, though it has only one player; tag is a game, though there is no defined winner. Still, the things we call games resemble each other, even though there are no features common to all that distinguish them from things that are not games. Mr. Heller was not mentally ill as we have defined the term, but impulsive, prone to violence, and incapable of controlling his words or his temper when it was in his interest to do so. Likewise Mr. Gallagher, whose behavior could not be so readily attributed to immaturity or gang affiliations but whose imagery was more vividly disconcerting. Mr. Farmer resembled Mr. Gallagher in his repertoire of threats and extreme responses to frustration, but he physically attacked himself rather than others and eventually was seen to require medication. Like Mr. Farmer, Mr. Escobar was demanding, egregious, and unwilling to negotiate, but more disorganized, naively delusional, and inclined to plead for sympathy. And Mr. Escobar, with just a few degrees of conceptual separation from Heller, was admitted into a release program for offenders with serious mental illness.

The problem with describing disturbance as a family resemblance concept is that we risk failing to draw any line whatsoever between prisoners who do and do not deserve the "disturbed" label, consequently depriving the term of operational and causal significance. We may approach the boundary from the other side by describing three contrasting cases.

1. Toch refers in this issue to the phenomenon of the legendary prisoner. One of these was Derek Janson, "a dangerously strong and willful prisoner" (Rhodes, 2004, p. 63), who became an emblem in DOC because of his notorious cunning and intransigence. "What would happen if a Janson came along?" served for years as a reliable counter to any proposal to increase the flexibility of SMU regulations. Janson would have met the psychologist's operational standard (continues to disrupt while in supermax) but only because it served his purpose, as on the famous occasion when he escaped his cell and led an enormously destructive riot; not long afterwards, the controversial reform regime (Rhodes, 2004) was established at this SMU. Unlike Mr. Gallagher, whom he otherwise resembled in reputation and willingness to inflict injury, Janson was usually well mannered when there was nothing to be gained.

   For Janson, resistance to the prison's authority was required by his creed, his honor, and his loyalties; although declaring such a position is no proof of sanity, the point is that Janson acted for articulate reasons that were neither trifling nor purely personal. And when administrators worked out a ceasefire, it was because they treated his claims as those of a rational adversary rather than as symptoms of mental disorder.
2. Henry Kohler was previously cited (Lovell et al., 2000) as a paradigm case of a prisoner who belongs in supermax, if anyone does, because of his lethality and his declaration that he was beyond rehabilitation, that anyone who interfered with his doing what he wanted "is going to be dead," and that he had nothing to lose because he was doing life without parole. Recently, much changed in demeanor and enrolled in the SMU stepdown program at the remote facility, he has disavowed the man he used to be. But he retains his flair for vivid expression. Like Gallagher, Kohler had reached the end of the line but did not require divine intervention: he saw that "if I keep going like this, I'm going to spend the rest of my life in a cage. . . . You just come to a point when you realize that's fucking retarded." Mr. Kohler says you need to have some hope—for a package, a visit, a relationship—and now he has signed up for the program because "it may help me get to a place I'm going in my head to where I won't be such an asshole."

   Mr. Kohler may serve as a walking advertisement for both the preventive need for and the deterrent benefits of the supermax regime. But even here, there was more to it. Kohler has no prospect of ever living outside prison. But somebody from his past saw his name on a Web site for prisoners who need pen pals and got in touch with him. So now he has some hope, and if he does get to that place in his head, it may survive the next disappointment.
3. A final contrasting case, Damian Lincoln, may usefully be compared with Mr. Heller because he also had to fend for himself as an adolescent and was serving an adult sentence for violent offenses committed as a juvenile. Like Mr. Heller, he was committed to violence as a method of coping with prison, believing that when you fight, you need to put your opponent in the hospital so that others will keep their distance; and like many younger inmates, he had not learned to hold his tongue when he felt staff members were not paying him enough respect. As our discussion continued, Mr. Lincoln revealed, almost by accident, that he did not like anyone to touch him—not even his young daughter, whom he missed.

Mr. Lincoln may have had something that would qualify as a psychological condition. That it was even discussed, however, shows Mr. Lincoln as far less guarded and suspicious than Mr. Heller. Most important, Lincoln was not distressed, bitter, hopeless, or desperate when he was interviewed on his way into supermax; he understood that he had earned his supermax status and that authorities were going to keep him there until they had grounds to believe he would refrain from further serious assaults.

If there is a genuine concept of psychological disturbance underlying the statistics and stories recounted here, we should be able to distinguish it from its operational indicators. Confidence that nearly half the supermax population qualifies as disturbed does not imply that our indicators were 100% sensitive and specific. Several men who did not qualify as disturbed according to study protocols—such as Mr. Inman, who had been depressed and often medicated, serving a life sentence for a weirdly sadistic sexual offense—might have been viewed otherwise had they been interviewed in depth by clinicians familiar with their records. On the other hand, Janson and Kohler were both counted as "disturbed" by the survey's algorithm of indicators because they showed a marked level of symptoms in the BPRS, largely due to hostility and suspiciousness. If one takes a richer view of their history as (mostly) deliberate warriors on behalf of their group and their creed, however, they would not qualify as genuinely disturbed as the term is used in this article. There were just two other inmates who met the study's "disturbed" indicators by virtue of levels of hostility and suspiciousness that tipped their BPRS scores into the "marked" category, and one of them was Mr. Carson. So Janson and Kohler may be viewed as outliers whose exceptional status proves the existence of a rule.

The argument here is not about clichés: shades of gray or where to draw lines. Prisoners classified as disturbed had shown, some more chronically than others, patterns of thinking and feeling that were poorly adapted to their settings, and the predictable responses of the institution were sufficiently distressing that these prisoners resorted to measures that only made their predicament worse. When an inmate tries to hang himself or spends days in a corner of his cell covered by a blanket, clearly there is something driving him to desperate measures. That the inmate may hope to gain something by such actions—and how would this make him different from the rest of us?—does not erase the desperation. And it is this desperation, combined with seemingly irrational maneuvers to cope with their settings, that earned the label "disturbed" for men in our study who showed no other symptoms of mental illness.

CHANGING RULES

The first part of this article presented results of a systematic survey and analysis of the clinical status of supermax residents, showing credible evidence of serious mental health issues in 45% of the inmates. The label "disturbed" was used for this substantial portion of the supermax population because not all of them qualify as seriously mentally ill. This group is characterized by high levels of disruptiveness, diagnostic ambiguity, and concomitant frequent transfers between settings. Given the article's opening challenge to the clinical and operational utility of the term *disturbed*, a conceptual analysis was offered. Grounded in survey findings and chronological narratives, the analysis argued that although its criteria are loose, the term *disturbed* has meaningful boundaries. Included within its boundaries is the proclivity of disturbed inmates for psychological breakdowns or escalating misbehavior in response to the methods and conditions of a supermax regime. Therefore, the statistic that 45% of supermax inmates are psychologically disturbed is a statistic about which something should be done.

In commenting about what should be done, let me stipulate that the widespread use of supermax confinement to maintain prison order is an institution to which many objections have been raised on grounds of utility as well as justice.[6] By means of this stipulation, the

principled argument against proposing reforms in such an institution—that one only perpetuates a fundamentally unjust practice by making it more palatable—is momentarily sidestepped, but not dismissed. Like Cohen in this issue, let me also stipulate that there are some inmates, including several described in this essay, who at some point declared by word or deed that they stood ready to attack and seriously injure other inmates or staff. In such an event, prison authorities are perfectly justified, indeed obliged, to prevent injury. If the first response is to remove the apparent source or target of danger from general population—to insulate, as Cohen puts it, at least while the situation is being sorted out—there is no point in second-guessing. Where criticism should be focused is not on this first response but on ensuing or surrounding processes: Hearings are held, records are reviewed, decisions are made to classify some prisoners to extended control (i.e., supermax status), policies and procedures are established, and making exceptions to those policies and procedures is seen as contrary to doctrine.

MAKING EXCEPTIONS

Sources of the expansion of supermax populations can be located at each step after the first preventive reaction to an apparent threat. Punitive or scolding attitudes in a hearing officer can solidify rather than resolve the initial conflict, and as we have seen, when inmates are classified without taking account of their full history, causes of disruptive behavior are misread, along with the inmate's likely response to the strictures of a supermax regime. Let us focus here on the problem of making exceptions. To narrow the focus further, the exceptions at issue are exceptions to classification and disciplinary procedures. In his companion piece, Cohen usefully explains the policy role of these terms and distinctions. Classification focuses principally on where a prisoner lives, custody levels, and program assignments; within a program such as supermax, classification also concerns steps or level assignments. Classification is linked to disciplinary policy: Temporary segregation is one of several disciplinary measures (along with loss of good-time credit), and repeated infractions trigger demotions from minimum to medium to close custody. Automatic classifications based on criminal history or infractions can be overridden for specified reasons, such as mental illness. Assignment to supermax status is a classification decision.

Case histories illustrate that regardless of diagnosis, the symptomatic behavior of disturbed inmates responds to nonclinical features of settings, in particular how much flexibility is allowed for responding to the particular issues of each inmate. We have seen that the inmates described in this article fared poorly when handled purely according to doctrine. Although modifying Mr. Escobar's conditions of confinement may have limited his opportunities to disrupt operations in supermax, it did not improve him. Mr. Heller was not mentally ill, but his subsequent history shows that imposing isolation in response to his misbehavior also failed to improve him. Indeed, by his account, it was the attempt to teach him a lesson that provoked the extreme response. Repeated infractions for Mr. Abbot did not reduce his disruptiveness, and Mr. Farmer deteriorated sharply when the penitentiary reimposed the isolation time his past supermax misbehavior had earned.

The policies in place at the reformed supermax were controversial precisely because the administrator, John Larson (a pseudonym) in Rhodes's (2004) account, insisted on finding a pragmatic solution to the problem posed by each inmate rather than relying on doctrine. Larson had difficulty winning over his own staff when he reached a resolution with inmates and quickly promoted them to radio or television status: As one lieutenant put it, someone

who had recently caused a ruckus "had nothing coming to him." Mr. Farmer might be an example of such an inmate. Indeed, another administrator cited the laxity shown to Mr. Farmer at the reformed supermax as undermining a coherent supermax program—despite the effect on Mr. Farmer of reimposing his isolation time when he was transferred. Although such reactions may appear to fly in the face of what works, institutional resistance to pragmatic, individualized decisions when discipline is at stake has deep and legitimate roots in the exigencies of prison management.

No doubt it would be risky, in security matters, to expect corrections officers in a single large unit to let some inmates yard together or move without restraints while others exercise only in private and are escorted in shackles. Not only would the less privileged object (why him and not me?), causing headaches for anyone trying to answer such questions, but there is a probability that somebody will make a mistake and put the wrong inmates together or let the wrong person walk unimpeded down the corridor. This does not mean all hell would break loose, however, if some inmates in segregation are given a radio even though it has been only 3 weeks since their latest tantrum. The risks and stakes of classification procedures (Adams & Ferrandino, 2008 [this issue]) can be distinguished from those of unit security procedures such as the management of gates, cell doors, yard access, and movement. The distinction is difficult to maintain at an operational level because security is the principal objective of classification and disciplinary policies. This may be why the relaxed procedures in Scotland, described by Toch in this issue, would astound prison managers in the United States.

The risks posed by wily inmates are commonly cited in arguments against flexibility, but as Rhodes (2004) has demonstrated, beneath the discourse of risks and prevention, prison life is pervaded by a cultural ethic of fairness to those who behave themselves and punishment for those who deserve no better: hence the "firm, fair, and consistent" message promoted in prisons and especially in supermax regimes. It is probably impossible to banish a deeper discourse of morality, responsibility, and punishment from the thought and practice of prisoners and their keepers, and perhaps we should be grateful that this is so. But our case studies also illustrate that humility is needed when we judge what aspects of their behavior people are responsible for, and that fairness is not embodied in an implacable insistence on applying the rules, come what may.

ESCAPING DETERRENCE

One consequence of the grip of a discourse of deterrence is that when inmate and staff reach a stalemate, staff may feel that any concession to the inmate, even if it would solve the immediate problem—for example, moving Mr. Escobar to a mental health unit—would reward manipulative behavior and undermine the deterrent objectives of policy. As an administrator, John Larson cut the knot by offering the inmate what he needed—not because he was demanding it, or because he had earned it, but because it was needed—and gaining in return a reversal in the downward spiral of the relationship. To apply this lesson on a broader scale, it is necessary to recall the rationale for extended administrative segregation or supermax status: It is not punishment but a preventive response to likely anticipated harm if an inmate is left in general population. Cohen (2008 [this issue]) discusses the American Bar Association's review of standards for extended control units; among these is the principle that extended control should be used only for prevention, not punishment (Joseph Lehman, personal communication). What is really at work, of course, is not

the fantasy that punishment is an old-fashioned idea that our culture has left behind but the recognition that the deprivations of supermax status could not be justified as punishment but only as a measure absolutely needed to serve a compelling interest in the physical safety of inmates and staff.

To take such a recognition seriously as a matter of institutional policy means that decisions to assign people to supermax and, more important, to keep them there must be individualized, preventive, and selective.

1. Individualized. People should not be assigned to extended control based on a general policy that whenever such-and-such occurs, extended control is the result. What they have done is relevant, but only because it provides evidence of a particular risk.
2. Preventive. The particular risk concerns what they will do, not what they have done. So the evidence justifying the classification has to have forward-looking implications.
3. Selective. Extended control is an extreme response to an extreme situation, not a routine response to the standard problems of managing difficult people who often do not like being in prison, do not like staff, and do not much like each other.

From the very first hearing, and through all subsequent encounters, the focus must be on (a) what specifically got the prisoner in there, (b) what must both parties—prisoner and staff—do to change this situation, and (c) what happens after the prisoner gets out. (There is not always an optimistic answer, as when someone says, "When I get out I'll stab the first corrections officer I can corner.") Mandatory minimums, such as "You must be infraction free for so many days or complete this program before you move to this level," should be recast as guidelines because they need to be waived whenever they fail to serve these objectives. There is no guarantee that a prisoner will get out if he goes through the levels nicely, because he may still be a threat or a target in general population. By the same token, if an immature inmate continues to mouth off, this does not mean that he continues to pose the kind of threat that justifies extended control. Programmatic interventions such as the "walk-arounds" pioneered at the reformed supermax, adequate mental health staffing, and step-down initiatives may be needed to carry out the primary objective of returning the inmate to a social setting as soon as it is safe to do so. Supermax status must be reviewed frequently because once the risk has diminished, there can be no further justification for holding someone in supermax.

What would happen to the U.S. supermax archipelago if such policies could be carried out? John Larson allowed himself to hope that if his methods could be applied throughout the system, the need for large-scale use of supermax would wither away. One may be permitted the hope that Larson's hypothesis will be tested, because for all the reasons assembled in this issue, it is the right thing to do. Among other accomplishments, making the test would transform the problem raised by the substantial portion of supermax inmates who are psychologically disturbed: how to maintain the deterrent integrity of supermax procedures if exceptions are made to take account of the particular problems of these inmates. Giving disturbed and disruptive inmates a chance to live comfortably in their cells, to transfer to other units for mental health treatment, and to escape supermax status as soon as possible would no longer constitute exceptions to policy. Rather, the exceptions would consist of the rare occasions when as a last and temporary resort, people with serious mental health issues are kept in solitary confinement.

NOTES

1. Cf. Toch, 1997, p. 159: "The notion is that the fact that the prisoners are disruptive is related to the fact that they are disturbed, and that one cannot address their disruptiveness without taking into account their psychological condition."

2. This investigation was also one of the sources for Lorna Rhodes's remarkable ethnography, *Total Confinement* (2004), as well as several of her subsequent essays.

3. As noted in Lovell, Cloyes, Allen, and Rhodes (2000), the diversity of the supermax population warrants caution about statistical averages. For example, the majority of the "disturbed" group had spent no time in mental health units when data were collected, and their median prison stay was 33 months, substantially less than the mean stay of 5 years.

4. Described in a series of articles: Lovell, Allen, Johnson, and Jemelka, 2001; Lovell and Jemelka, 1996, 1998; Lovell, Johnson, Jemelka, Harris, and Allen, 2001; O'Connor, Lovell, and Brown, 2002.

5. The 3-day breaks are designed to keep operational policy in line with the Washington Administrative Code, which requires access to out-of-cell time and outdoor exercise, consistent with security concerns, for offenders in administrative segregation or extended control status.

6. Human Rights Watch (2000, p. 1) concluded that "state and federal corrections departments are operating supermax facilities in ways that violate basic human rights." Credible evidence of psychological damage and suffering has been reported widely (Grassian & Friedman, 1986; Haney, 1993, 2003; Human Rights Watch, 1997, 2000; Pizarro & Stenius, 2004; Scharff Smith, 2006; Toch, 2001). Such evidence has been accepted by courts, although as Cohen points out in this issue, rulings against the use of supermax have been limited to special populations, such as the seriously mentally ill (*Jones'El v. Berge*, 2001; *Madrid v. Gomez*, 1995). As to effectiveness, the best that can be said is that the systematic studies needed for a benefit–cost analysis have yet to be conducted (Kurki & Morris, 2001; Lawrence & Mears, 2004; Mears & Reisig, 2006; Mears & Watson, 2006). Where there is systematic evidence, it indicates that supermax is not always used selectively (Lovell et al., 2000), that evidence of enduring benefits to prison order is missing (Briggs, Sundt, & Castellano, 2003), and that keeping people in supermax until release from prison harms community safety (Lovell, Johnson, & Cain, 2007).

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Briggs, C., Sundt, J., & Castellano, T. (2003). The effect of supermaximum security prisons on aggregate levels of institutional violence. *Criminology*, *41*, 1341-1376.

Cloyes, K., Lovell, D., Allen, D., & Rhodes, L. (2006). Assessment of psychosocial impairment in a supermaximum security unit sample. *Criminal Justice and Behavior*, *33*, 760-781.

Cohen, F. (1993). Captives' legal right to mental health care. *Law and Psychology Review*, *17*, 139.

Cohen, F. (1998). *The mentally disordered inmate and the law*. Kingston, NJ: Civic Research Institute.

Grassian, S., & Friedman, N. (1986). Effects of sensory deprivation in psychiatric seclusion and solitary confinement. *International Journal of Law and Psychiatry*, *8*, 4965.

Haney, C. (1993). 'Infamous punishment': The psychological consequences of isolation. *National Prison Project Journal*, Spring 1993, 3-7, 21.

Haney, C. (2003). Mental health issues in long-term solitary and "Supermax" confinement. *Crime & Delinquency*, *49*, 124-156.

Human Rights Watch. (1997). *Cold storage: Super-maximum security confinement in Indiana*. New York: Author.

Human Rights Watch. (2000). *Out of sight: Super-maximum security confinement in the United States*. New York: Author.

Human Rights Watch. (2003). *Ill-equipped: U.S. prisons and offenders with mental illness*. New York: Author.

Jones'El v. Berge, 164 F. Supp2d 1096 (W.D. Wis. 2001).

Kurki, L., & and Morris, N. (2001). The purposes, practices, and problems of supermax prisons. *Crime and Justice*, *28*, 385-424.

Lawrence, S., & Mears, D. (2004). *Benefit-cost analysis of supermax prisons: Critical steps and considerations*. Washington, DC: Urban Institute.

Lovell, D. (2003). *Identification of offenders with serious mental illness in Washington Department of Corrections facilities*. Olympia, WA: Department of Corrections.

Lovell, D., Allen, D., Johnson, L. C., & Jemelka, R. (2001). Evaluating the effectiveness of residential treatment for prisoners with mental illness. *Criminal Justice and Behavior*, *28*, 83-104.

Lovell, D., Cloyes, K., Allen, D., & Rhodes, L. (2000). Who lives in super-maximum custody? A Washington state study. *Federal Probation*, *64*, 33-38.

Lovell, D., & Jemelka, R. (1996). When inmates misbehave: The costs of discipline. *The Prison Journal*, *76*, 165-179.

Lovell, D., & Jemelka, R. (1998). Coping with mental illness in prison. *Family and Community Health*, *21*, 54-66.

Lovell, D., Johnson, D., Jemelka, R., Harris, V., & Allen, D. (2001). Living in prison after residential mental health treatment: A program follow-up. *The Prison Journal*, *81*, 497-514.

Lovell, D., Johnson, L. C., & Cain, K. C. (2007). Recidivism of supermax prisoners in Washington state. *Crime & Delinquency*, *53*, 633-656.

Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995).

Mears, D. P., & Reisig, M. (2006). Theory and practice of supermax prisons. *Punishment & Society*, *8*, 33-57.

Mears, D. P., & Watson, J. (2006). Towards a fair and balanced assessment of supermax prisons. *Justice Quarterly*, *23*, 232-270.

Metzner, J., Cohen, F., Grossman, L., & Wettstein, R. (1998). Treatment in jails and prisons. In R. M. Wettstein (Ed.), *Treatment of offenders with mental disorders* (pp. 211-264). New York: Guilford Press.

O'Connor, R., Lovell, D., & Brown, L. (2002). Implementing residential treatment for mentally ill prison inmates. *Archives of Psychiatric Nursing*, *16*, 232-238.

Ohio Department of Rehabilitation & Correction, Bureau of Mental Health Services. (2000). *Policy 319-11*. Columbus, OH: Author.

Overall, J., & Gorham, D. (1962). The Brief Psychiatric Rating Scale. *Psychological Reports*, *10*, 799-812.

Pizarro, J., & Stenius, V. (2004). Supermax prisons: Their rise, current practices, and effect on inmates. *The Prison Journal*, *84*, 248-264.

Rhodes, L. (2004). *Total confinement: Madness and reason in maximum security*. Berkeley: University of California Press.

Scharff Smith, P. (2006). The effects of solitary confinement on prison inmates: A brief history and review of the literature. In M. Tonry (Ed.), *Crime and justice: Vol. 34* (pp. 441-528). Chicago: University of Chicago Press.

Toch, H. (1982, Fall). The disturbed disruptive inmate: Where does the bus stop? *Journal of Psychiatry and Law*, 327-349.

Toch, H. (1992). *Mosaic of despair: Human breakdowns in prison*. Washington, DC: American Psychological Association.

Toch, H. (1997). *Corrections: A humanistic approach*. Monsey, NY: Criminal Justice Press.

Toch, H. (2001). The future of supermax confinement. *The Prison Journal*, 81, 376-88.

Toch, H., & Adams, K. (2002). *Acting out: Maladaptation in prisons*. Washington, DC: American Psychological Association.

Wittgenstein, L. (1958). *Philosophical investigations* (3rd ed.; G. E. M. Anscombe, Trans.). New York: MacMillan.

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