HUMAN RIGHTS WATCH

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October 1997

HUMAN RIGHTS VIOLATIONS IN THE UNITED STATES

COLD STORAGE

Super-Maximum Security Confinement in Indiana

There's no way you can know what it's like for us in here.
Prisoner, the Maximum Control Facility (MCF)

If you have an animal in a cage, and you're constantly provoking him and hurting him and one day you let him out, you'll have a dangerous animal.
Prisoner, the Secured Housing Unit (SHU), Wabash Valley Correctional Facility

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
International Covenant on Civil and Political Rights

All prisoners shall be treated with the respect due to their inherent dignity and value as human beings.
Basic Principles for the Treatment of Prisoners

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INTRODUCTION

The management of prisoners who engage in dangerous or disruptive behavior while incarcerated challenges prison authorities worldwide. In the last decade, corrections departments in the United States have increasingly chosen to segregate such prisoners in special super-maximum security facilities. Although conditions and policies vary somewhat from facility to facility, their common characteristics are extreme social isolation, reduced environmental stimulus, scant recreational, vocational, or educational opportunities, and extraordinary levels of surveillance and control. Prisoners are locked alone in their cells between twenty-two and twenty-three-and-a-half hours a day. They eat and exercise alone. For years, except for the occasional touch of a guard's hand as they are being handcuffed when they leave their cells, they have no physical contact with another human being.

Prisons in the United States have always contained harsh solitary punishment cells where prisoners are sent for breaking prison rules. But what distinguishes this new generation of super-maximum security facilities are the increasingly long terms which prisoners spend in them, their use as a management tool rather than just for disciplinary purposes, and their high-technology methods of enforcing social isolation. No longer a matter of spending fifteen days in the "hole," prisoners classified as dangerous or disruptive can spend years in solitary confinement. Rather than looking for constructive ways to help these prisoners develop the ability to live peaceably with others, correctional systems in the United States have turned with a vengeance to what some call "high-tech cages," in the pursuit of total security and control.

Human Rights Watch has observed the burgeoning use of super-maximum security facilities with concern. As human rights groups are well aware, prisons by their nature possess great potential for abuse. That potential is even greater when authorities confront those deemed the most violent and anti-social of the inmate population. In the United States, the trend toward super-maximum security confinement parallels and is exacerbated by a political climate that encourages ever harsher, more punitive forms of punishment for criminals. With politicians vying for public favor by showing that they are "tough" on crime and prisoners, with the courts reluctant to interfere in correctional policies, and with public scrutiny impeded by distant locations and regulations limiting access, correctional authorities seldom face external pressure to insist that prisoners not be sent unnecessarily or arbitrarily to super-maximum security facilities, or to ensure that prisoners within them are treated humanely.

Human Rights Watch is particularly concerned that harsher conditions of imprisonment are being inflicted on those prisoners who are least able to cope with them. In the United States, increasing numbers of mentally ill people are being incarcerated. Unable to adjust to the myriad rules and powerful stresses of prison life, mentally ill prisoners often accrue disciplinary records that lead to their placement in super-maximum security facilities. Indeed, the population of many such facilities includes a high percentage of prisoners with serious psychiatric disorders. For this reason, the impact of super-maximum security conditions on mental illness is a subject deserving of urgent attention.

Some people in the United States believe that prisoners, especially those who have committed acts of violence while in prison, have forfeited their rights and deserve to be treated, as one Texan warden declared bluntly, "like animals." Such views betray a profound ignorance of internationally accepted principles regarding the fundamental rights of all human beings—principles to which the United States is legally and historically committed. Besides evidencing little respect for human dignity, such views are also unwise. Most inmates in super-maximum security prisons will one day be released back into local communities. If these people have been abused, treated with violence, and confined in dehumanizing conditions that threaten their very mental health, they may well leave prison angry, dangerous, and far less capable of leading law-abiding lives than when they entered.

In this report, Human Rights Watch reviews the operation of two super-maximum security prisons for men operated by the State of Indiana: the Maximum Control Facility at Westville, and the Secured Housing Unit at Carlisle's Wabash Valley Correctional Facility. We assess the extent to which they comply with the human rights

standards contained in international conventions to which the United States is a party and, in so doing, we hope to assist the people and government of Indiana evaluate their legality, wisdom, and impact.

We also hope to contribute to the debate, nationally and internationally, regarding the proper treatment of disruptive and dangerous inmates. The challenge faced by the Indiana Department of Corrections to securely and humanely confine these prisoners is shared by correctional authorities throughout the United States and, indeed, throughout the world. The appeal of super-maximum security prisons is readily understandable. But in corrections, as in other spheres of government, there are no easy solutions. Without guidance and control by principled authorities, super-maximum security prisons can become as lawless as the prisoners they confine.

Access and Methodology

Human Rights Watch has monitored and reported on prison conditions within the United States since 1980.[1] For our prison investigations, Human Rights Watch follows a self-imposed set of procedures, the key elements of which include an insistence on interviewing prisoners privately and on viewing all areas of a given facility. Thanks to the cooperation of the Indiana authorities, our inspections of the state's two super-maximum security institutions were conducted in accordance with these general rules.

At the outset, this generous grant of access appeared unlikely. Human Rights Watch originally sought permission to inspect the Maximum Control Complex (MCC), Indiana's first super-maximum security facility, in 1993. Our request was made at the urging of local activists and after we had received a steady flow of letters from MCC inmates alleging serious human rights abuses. The initial response of the Indiana Department of Corrections (Indiana DOC), then headed by Commissioner Christian Debruyn, was a flat denial of access. The commissioner's negative response was noted in the press, as well as by local religious, legislative, and civil rights leaders, who urged him to reconsider his decision.[2]

In May 1995, after settlement of a class action lawsuit challenging conditions at the MCC and replacement of its superintendent, the commissioner decided to grant access to our investigators, and a visit was arranged for the following month. By that time, a second super-maximum security facility had opened in Indiana—the Secured Housing Unit of the Wabash Valley Correctional Institution[3], known as the SHU. Our visit to the MCC convinced us that an investigation of both of Indiana's super-maximum security conditions was appropriate, and we visited the SHU the following year, in April 1996. The Indiana DOC granted us unrestricted access to all areas of both facilities, as well as to all the prisoners. (We were not allowed into inmates' cells for security reasons but were able to enter

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[1]*See, for example*, Helsinki Watch (now Human Rights Watch/Helsinki), "Prisoners' Rights in the United States," *A Human Rights Watch Short Report*, October 1980; Human Rights Watch, *Prison Conditions in the United States* (New York: Human Rights Watch, 1991); Human Rights Watch, *Modern Capital of Human Rights? Abuses in the State of Georgia* (New York: Human Rights Watch, 1996); Human Rights Watch Women's Rights Project, *All Too Familiar: Sexual Abuse of Women in U.S. State Prisons* (New York: Human Rights Watch, 1996).

[2]*See, e.g.*, Editorial, "Life Behind Bars," *The Times* (Muenster, Indiana), January 9, 1995; Editorial, "Monitoring Supermax," *Indianapolis Star*, September 22, 1994 (criticizing the Indiana DOC's denial of access and asking, "What is Indiana hiding at Supermax?"); BarbAlbert, "Human Rights Group Won't Get to Inspect Supermax Prison," *Indianapolis Star*, September 17, 1994; "Rights Group Denied OK to Inspect Prison," *Indianapolis News*, September 17, 1994; Matthew S. Galbraith, "Prison Conditions Shock Officials: Rights Advocates Ask for an Inspection," *South Bend Tribune*, September 11, 1994; Letter to Commissioner Christian DeBruyn from Rev. S. Michael Yasutake, Director, Interfaith Prisoners of Conscience Project, Sen. Anita Bowser, Rep. William Crawford, Rep. Vernon Smith, Rev. Franklin Breckenridge, Sr., President, Indiana State Conference, NAACP, Rev. Canon Robert Hansel, Episcopal Diocese of Indianapolis, Father Thomas Gannon, Director, Peace and Social Justice Office, Diocese of Gary, Rev. Charles Doyle, Indiana CURE, August 30, 1994.

[3]"Wabash Valley Correctional Institution" has since been renamed "Wabash Valley Correctional Facility (WVCF)".

cells in empty housing sections.) During our first visit to the MCC, we had short conversations through cell doors with approximately forty prisoners, a majority of the MCC population at that time, followed by more extended interviews in private rooms with approximately ten prisoners; our April 1996 visit to the SHU was similar.

In our visit to the SHU, we were struck by the number of severely mentally ill inmates confined there. In July 1997, with the cooperation of Physicians for Human Rights (PHR), we returned to the SHU and to the MCC, since renamed the Maximum Control Facility (MCF), with two psychiatrists experienced in evaluating mentally ill inmates. The psychiatrists, one of whom served as a PHR representative, conducted structured interviews that reliably and systematically assess the presence or absence of a broad range of psychiatric symptoms, using a rating scale that accurately evaluates the level of severity of such symptoms—methods that are widely accepted in the psychiatric field. These interviews, which ranged from twenty to forty-five minutes in length, were conducted with fourteen prisoners at the MCF and twenty-seven prisoners at the SHU. Human Rights Watch researchers spoke with several dozen additional prisoners.

During each of our visits, members of the Human Rights Watch delegations also spoke at length with staff members of both facilities, including line officers, supervisory staff, and mental health staff. Herbert Newkirk, the superintendent of the MCF, and Craig Hanks, the superintendent of the Wabash Valley Correctional Facility (of which the SHU is a part), were both extremely cooperative throughout our visits, as were all of the members of their staffs whom we met.

International Human Rights Standards Governing the Treatment of Prisoners

The chief international human rights documents binding on the United States clearly affirm the human rights of people in confinement. Indeed, the International Covenant on Civil and Political Rights (ICCPR), the most comprehensive international human rights treaty that the country has ratified, includes provisions explicitly intended to protect prisoners from abuse.

Several additional international documents flesh out the human rights of persons deprived of liberty, providing guidance as to how governments may comply with their international legal obligations. The most detailed guidelines are set out in the United Nations Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules), adopted by the Economic and Social Council in 1957. Other relevant documents include the Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment, adopted by the General Assembly in 1988, and the Basic Principles for the Treatment of Prisoners, adopted by the General Assembly in 1990.

It should be emphasized that even though the latter group of instruments are not treaties, they constitute authoritative guides to the content of binding treaty standards and customary international law. In the United States, where international law norms may inform the judicial construction of constitutional provisions,[4] the Standard Minimum Rules have been cited as evidence of "contemporary standards of decency" relevant in interpreting the scope of the Eighth Amendment to the Constitution, as well as the constitution's Due Process Clause.[5]

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[4]For a discussion of the incorporation of international human rights standards into constitutional law, see, for example, Gordon A. Christenson, "Using Human Rights Law to Inform Due Process and Equal Protection Analyses," *University of Cinncinnati Law Review*, vol. 52 (1983); International Law Association, Committee on Human Rights, "Report on Human Rights Law, the U.S. Constitution and Methods of Judicial Incorporation," *Proceedings*, 1984, pp. 56-65.

[5]*See Estelle v. Gamble*, 429 U.S. 97, 103-04 & n. 8 (1976); *Detainees of Brooklyn House of Detention for Men v. Malcolm*, 520 F. 2d 392, 396 (2d Cir. 1975); *Williams v. Coughlin*, 875 F. Supp. 1004, 1013 (W.D.N.Y. 1995); *Lareau v. Manson*, 507 F. Supp. 1177, 1187-89 & n. 9 (1980) (describing the Standard Minimum Rules as "an authoritative international statement of basic norms of human dignity and of certain practices which are repugnant to the conscience of mankind").

Except for the right to life, the most fundamental right of prisoners—and one that is often at risk—is the right not be subject to torture or cruel, inhuman or degrading treatment or punishment. This right is protected by both the ICCPR and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, another treaty to which the United States is a party.[6]

Article 1 of the Convention Against Torture defines torture as:

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information of a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the acquiescence of a public official or other person acting in an official capacity.

Neither treaty expressly defines the phrase "cruel, inhuman or degrading treatment or punishment." The predominant view among international authorities is that such abuse is of a lesser severity than torture, but that no clear line separates the two practices. Rather than clear categories, most experts see a continuum in which a number of factors are relevant, including the nature and intensity of the practice, its purpose, its duration and frequency, and the vulnerability of the victim. What may be torture if continued for an extended period of time, or if practiced upon a child or other vulnerable person, may be prohibited ill-treatment in other circumstances, or may even fall below the minimum level of severity.[7]

It is indisputable that torture and other prohibited ill-treatment may involve mental suffering as well as, or instead of, physical suffering.[8] It is also clear that solitary confinement, particularly for long periods and particularly when combined with extreme deprivation of sources of stimulation, may cause mental suffering severe enough to

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[6]The Eighth Amendment bars the infliction of "cruel and unusual" punishment. As its wording suggests, it overlaps considerably with the ICCPR's prohibition on torture and cruel, in human, or degrading treatment or punishment. Under the current judicial reading of the Eighth Amendment, however, courts hearing prison suits must focus in part on the state of mind of the relevant state officials. In cases involving prison conditions or policies, officials are only liable if they were deliberately indifferent to the risk of causing harm to prisoners. *See Wilson v. Seiter*, 111 S. Ct. 2321 (1991). In contrast, international human rights law's ban on cruel, inhuman or degrading treatment or punishment applies regardless of the official's knowledge or intent.

The Due Process Clause protects the rights of unconvicted prisoners (that is, pretrial detainees). Since such prisoners have not been convicted of a crime, they cannot, consistent with the U.S. constitution, be subject to punishment. *Bell v. Wolfish*, 441 U.S. 520, 535 n. 16 (1979) (stating that "[d]ue process requires that a pretrial detainee not be punished). In practice, however, the courts have generally interpreted pretrial detainees' due process protections as co-extensive with convicted prisoners' Eighth Amendment protections. Indeed, conditions are often worse in local jails, where detainees are held, than in prisons.

[7]For example, the U.N. Human Rights Committee, the authoritative interpreter of the ICCPR, has cautioned against attempts "to draw up a list of prohibited acts or to establish sharp distinctions between the different kinds of punishment or treatment," explaining that "the distinctions depend on the nature, purpose and severity of the treatment applied." U.N. Human Rights Committee, General Comment 20, Article 7 (Forty-fourth session, 1992).

[8]Under U.S. constitutional law as well, the Eighth Amendment's prohibition of cruel and unusual punishment applies both to mental and physical harm. "As the Supreme Court has made quite clear, we cannot, consistent with contemporary notions of humanity and decency, forcibly incarcerate prisoners under conditions that will, or very likely will, make them seriously physically ill. Surely, these same standards will not tolerate conditions that are likely to make inmates seriously mentally ill." *Madrid v. Gomez*, 889 F. Supp. 1146, 1261 (N.D. Cal. 1995).

violate international standards.[9] Nonetheless—given the inherent imprecision of the relevant standards, the many factors that must be considered, and the difficulty of measuring mental as opposed to physical suffering—it is no easy matter to determine when permissible disciplinary or administrative policies become prohibited abuse.[10]

All observers agree that solitary confinement and regimes of extremely limited social interaction merit extraordinary attention and concern. Because of these conditions' high potential for abuse, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment—the expert prison-monitoring body associated with the Council of Europe—"pays particular attention to prisoners held, for whatever reason (for disciplinary purposes; as a result of their 'dangerousness' or their 'troublesome' behavior; in the interests of a criminal investigation; at their own request), under conditions akin to solitary confinement."[11] Besides treaty prohibitions on torture and other ill-treatment, such restrictive conditions may also violate the ICCPR's rule that "[a]ll persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person."[12]

With regard to disciplinary and other forms of segregation, it should also be noted that the Standard Minimum Rules mandate that discipline and order be maintained with firmness, but with "no more restriction than is necessary for safe custody and well-ordered community life."[13] In particular, international human right instruments limit the punishments that prison officials can impose on prisoners who commit rule infractions. Besides barring torture and other ill-treatment, they prohibit corporal punishments and the use of physical restraints as punishment.[14]

International standards are not only aimed at preventing abuses; they also reflect the consensus of the international community that the period of imprisonment should be utilized to help inmates lead law-abiding and self-supporting lives upon release. The ICCPR, for example, requires that "the reform and social readaptation of

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[9]The U.N. Human Rights Committee has explicitly affirmed that "prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by article 7." U.N. Human Rights Committee, General Comment 20, Article 7. *See also* Basic Principles for the Treatment of Prisoners, Article 7, G.A. res.45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990) (stating that "[e]fforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged.").

[10]Illustrating the complexity of the topic are the seemingly inconsistent decisions of the international bodies responsible for applying the relevant standards. The U.N. Human Rights Committee has ruled, for example, that the ICCPR's prohibition on torture and other ill-treatment was violated when an Uruguayan prisoner was held in solitary confinement for over a month in a cell with twenty-four hours a day of artificial illumination. *Larrosa v. Uruguay* (88/1981), Report of the Human Rights Committee, GAOR, 38th Sess., Supp. No. 40 (1983). In contrast, European human rights bodies, interpreting a similar prohibition in the European Convention on Human Rights and Fundamental Freedoms, have generally been more tolerant of solitary confinement. Although the European Commission has acknowledged that "complete sensory isolation coupled with complete social isolation can destroy the personality," it has, for example, ruled that the long-term solitary confinement of terrorism suspects did not constitute prohibited ill-treatment, even though the suspects "were undeniably held in almost total isolation." *Krocher and Miller v. Switzerland*, App. No. 8463/78, Eur. Comm. H.R., Report of 16 Dec. 1982.

[11]European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), "Second General Report on the CPT's Activities," Strasbourg, France, April 1992, p. 15.

[12]ICCPR, Article 10(1), G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52; U.N. Doc A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976.

[13]Standard Minimum Rules, Article 27.

[14]Ibid., Articles 31 and 33.

prisoners" be an "essential aim" of imprisonment.[15] To this end, "the institution should utilize all the remedial, educational, moral, spiritual, and other forces and forms of assistance which are appropriate and available, and should seek to apply them according to the individual treatment needs of the prisoners."[16]

It should be emphasized, in this respect, that the treatment needs of mentally ill prisoners merit particular attention and care. According to the Standard Minimum Rules, prisoners who suffer from mental diseases or abnormalities "shall be observed and treated in specialized institutions under medical management."[17] The United Nations has also endorsed principles for the protection of the mentally ill which expressly affirm their right "to be treated with humanity and respect for the inherent dignity of the human person" and to be protected from "physical or other abuse and degrading treatment."[18]

Guided by the above standards, Human Rights Watch approached the task of evaluating conditions at the MCF and the SHU with several issues in mind. We investigated the degree of social contact and interaction allowed prisoners; the quality and amount of other sensory, intellectual, physical, and emotional stimuli provided them; the soundness of prisoner selection procedures and the nature of the inmate population that resulted; the length of time prisoners spent in restrictive conditions; the use of excessive physical force against prisoners, as well as other forms of guard harassment and abuse; the punitive use of physical restraints; the psychological impact of conditions, particularly on mentally ill prisoners; the mental health treatment and attention provided; and the quality of transition assistance given to prisoners before release from the facilities. Our focus was to gauge whether, and to what extent, prisoners are held in unduly harsh conditions of social isolation and reduced environmental stimulus for excessive periods of time. It was also to assess whether mentally ill prisoners were being punished, isolated, and otherwise mistreated for psychiatric problems over which they lacked all control.

II. SUMMARY AND RECOMMENDATIONS

In Indiana, as in many states, single cell confinement in harsh conditions in super-maximum security facilities is justified as necessary for certain inmates for reasons of "security." Security, however, cannot excuse conditions that are so harmful or repugnant as to constitute torture or cruel, inhuman or degrading treatment. As federal district Judge Thelton Henderson trenchantly observed, "Sedating all inmates with a powerful medication that leaves them in a continual stupor would arguably reduce security risks; however, such a condition of confinement would clearly fail constitutional muster."[19]

Prisoners in the MCF and SHU, many of whom are severely mentally ill, are confined twenty-two or more hours a day in solitary isolation in small cells, spend each day utterly idle, are placed in restraints whenever they are escorted from their cells, exercise alone, and remain shackled in front of their families during non-contact visits conducted behind plexiglass partitions. At both facilities—but particularly at the MCF during its early years of operation—prisoners have faced physical abuse, including beatings and unnecessary and excessive use of cell

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[15]ICCPR, Article 10(3).

[16]Standard Minimum Rules, Article 59.

[17]Ibid., Article 82(2).

[18]Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, Principle 1(2) and (3), G.A. res.46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49(1991).

[19]*Madrid v. Gomez*, 889 F. Supp. 1146, 1263 (N.D. Cal. 1995).

extractions carried out by five-member teams of guards, macings and placement in four-point restraints as punishment.

While cognizant of the Indiana DOC's legitimate security concerns, we conclude that subjecting prisoners to long periods of confinement in the MCF and the SHU is inconsistent with respect for the inherent dignity of each person. The conditions at these facilities are so extraordinarily harsh and potentially harmful that no person should be subjected to them for unduly lengthy periods of time. Many aspects of the conditions exceed what is required to meet reasonable security or other penological goals, and are simply punitive. No prisoner, of course, should ever be subjected to physical abuse.

The Indiana DOC is responsible for securely and humanely housing even its most disruptive and dangerous prisoners. It may be that some prisoners are so extraordinarily dangerous that they can only be safely confined in extremely restrictive conditions. The DOC, however, uses procedures and criteria for assigning prisoners to these facilities that do not necessarily identify the extraordinarily dangerous. There is a natural tendency, once super-maximum security facilities are built, to fill them; standards for selecting prisoners for whom harsh conditions are warranted get diluted in practice. There is also a tendency to keep difficult prisoners in super-maximum security facilities longer than is required in the interests of security and longer than is wise for the prisoners' well-being. In our judgment, conditions at the MCF and the SHU do nothing to encourage prisoners' ability to reintegrate successfully into the general prison population or society, and, at worst, risk their physical and mental health and enhances the likelihood of repeated criminal or disruptive behavior.

By choosing to subject hundreds of prisoners to prolonged periods in extremely harsh and potentially harmful conditions that cannot be justified as reasonably necessary to ensure security or to serve the legitimate goals of punishment, the Indiana DOC has violated the prohibition on cruel, inhuman and degrading treatment contained in the International Covenant on Political and Civil Rights and the United Nations Standard Minimum Rules for the Treatment of Prisoners.

The confinement of persons who are mentally ill in these facilities is particularly reprehensible. In Indiana, as throughout the United States, increasing numbers of mentally ill people are ending up in prisons that are not equipped to meet their mental health needs. Mentally ill people often have difficulty complying with rules, especially in prison settings where the rules are very restrictive and the stresses are intense. Many are aggressive or disruptive and, as a result, accumulate disciplinary records that land them in segregated confinement in super-maximum security facilities. While 5 percent of the general prison population have a serious mental illness, over half of the inmates at the SHU are mentally ill. For some mentally ill inmates, placement in super-maximum security conditions is a horror: the social isolation and restricted activities aggravate their illness and immeasurably increase their pain and suffering. In a tragic vicious cycle, their worsened mental condition leads to more rule infractions, such as self-mutilation, for which they receive the additional punishment of even more time in segregation. Compounding the tragedy of confinement in these conditions, Indiana's super-maximum security facilities are not equipped to provide appropriate mental health treatment for the mentally ill confined within them.

Warehousing severely ill and psychotic individuals under conditions that increase their suffering by exacerbating their symptoms, and in facilities that lack adequate mental health services, can only be characterized as cruel. In some cases, the suffering that results is so great that the treatment must be condemned as torture under international human rights law. We do not believe the Indiana DOC intends to cause such pain. But it places mentally ill and dangerous or disruptive prisoners in the MCF and the SHU because it has failed to create secure psychiatric facilities in which they can be safely confined and treated. That failure must be remedied.

As this report was being prepared for publication, we received word of a particularly egregious situation at the SHU that exemplifies the dangers of placing mentally ill prisoners in such facilities. Edgar Hughes is a thirty-five-year-old confined at the SHU who had been repeatedly hospitalized for psychiatric problems since his youth.

When we interviewed Hughes in July 1997, the psychiatrists on our team concluded that he was actively psychotic, very depressed, and extremely paranoid. He felt persecuted by the guards and apparently had a history of "bombing" them with excrement. He reported to his family that he had had physical altercations with guards. In the early morning of September 11, 1997, he suffered a mysterious head trauma that caused severe brain damage. SHU officials told Hughes's sister that he had fallen out of bed. Having seen the SHU cells and the low height of the beds, we do not find this explanation believable. According to Hughes's sister, the neurosurgeons who operated on Hughes told her that falling from his bed could not have caused the extensive brain damage he suffered, nor would a fall explain the lacerations on his face and shoulders. The current prognosis is that he will remain in a vegetative state. An official inquiry into the tragedy has been launched.[20] Based on the currently available facts, we cannot help but conclude that Mr. Hughes was the victim of one of two situations: he suffered severe physical abuse at the hands of guards, or he underwent a severe psychiatric breakdown in which he deliberately injured himself. Either way, his confinement at the SHU caused a terrible and seemingly irreversible tragedy. We call on the State of Indiana to ensure that the inquiry into this incident is thorough and that anyone responsible is held accountable.

Recommendations

Pressed by inmate litigation and persistent scrutiny from local, national, and international groups concerned about the treatment of prisoners at the MCF and the SHU, the Indiana DOC has acknowledged that the egregiously harsh conditions at the MCF and the SHU are not necessary for all inmates there and that conditions can be ameliorated without jeopardizing the goals of security and discipline. By changing the facility's management, the Indiana DOC secured a dramatic reduction in the use of excessive force at the MCF. It has initiated group recreation at the MCF and at the end of September, 1997 stated its intention to permit prisoners at the SHU with good behavior records to share out-of-cell recreation time in groups of two or three. It has committed to reviewing the length of confinement in supermax conditions and the proportionality of punishment for disciplinary infractions, and has agreed that many mentally ill prisoners do not belong in supermax units and that it needs to develop facilities geared to their psychiatric needs.

Human Rights Watch welcomes these limited steps and announced intentions. We hope that the Indiana legislature, the executive branch, and the public will support efforts by the Indiana DOC to improve conditions in the MCF and SHU. Some of the needed changes will not entail additional expenditures of any significance; others will be costly. We urge the State of Indiana to provide the financial resources necessary to bring its super-maximum security facilities into line with international human rights standards. Based on three years of observing conditions at these facilities, we offer the following recommendations:

1. Offer Treatment and Conditions of Confinement Appropriate for Mentally Ill Prisoners

The Indiana legislature should:

- Enact legislation that bars the administrative or disciplinary segregation in conditions of extreme social isolation and reduced environmental stimulus of seriously mentally ill inmates or of inmates who are at significant risk of suffering a serious injury to their mental health if confined in such conditions.

- Provide the Indiana DOC and/or the Department of Mental Health with the necessary financial resources to properly house and treat inmates who should not be confined at the MCF or SHU because of their mental health condition or histories.

[20]James Patterson, "Mentally Ill Prisoner Near Death," *Indianapolis Star*, October 4, 1997; Human Rights Watch telephone interview, Veronica Hughes, October 14, 1997.

The Indiana Department of Corrections should:

- Develop, or collaborate with the Department of Mental Health to develop, secure facilities to house and treat mentally ill inmates who cannot be confined in the general prison population because of the safety and security risks they pose, but who do not meet the existing criteria for in-patient hospitalization. These facilities should provide physical conditions and social interaction conducive to mental health and rehabilitation, and should be staffed by qualified mental health professionals.

- Undertake a comprehensive mental health evaluation of all inmates currently confined at the MCF and the SHU to identify those who should be excluded from segregated confinement because they are currently suffering from a serious mental disorder, have a history of severe mental illness or whose mental condition (e.g., brain damage, mental retardation, chronic depression) makes them vulnerable to deterioration if they remain in those facilities.

- Develop procedures to ensure that no prisoner sent to the MCF or to the SHU remains there for more than a brief period if they are persons for whom the risk is high that confinement in such facilities will cause serious mental health injury.

- Provide frequent monitoring by qualified health professionals of inmates at the SHU and MCF to identify those who need mental health services.

- Expand the range of mental health services available to inmates at the SHU and MCF, and grant inmates prompt access to such services.

- Provide sufficient staff to meet prisoners' mental health needs. It should also provide adequate custodial staff to enable prisoners to be escorted as needed to meetings in private with mental health staff, medical visits, meetings with visitors, and other activities conducive to their mental well-being and rehabilitation.

2. Reduce Periods of Solitary Confinement

The Indiana Department of Corrections should:

- Discontinue the policy of indefinite administrative segregation. Inmates should be assigned to administrative segregation for a fixed term that is not excessively long. Inmates should be able to reduce their time in administrative segregation through good behavior. No inmate should be assigned to an additional period of administrative segregation within three months of a prior period of segregation. Exceptions to this rule should only be permitted upon a finding, following a hearing, that the inmate constitutes a serious danger to prison safety and security and cannot be safely confined in a less restrictive setting. Such an inmate should also receive a mental health evaluation by an independent psychiatrist who must certify that the inmate is not suffering from severe mental disorders that would be exacerbated by continued segregation.

- Refrain from sentencing prisoners to disciplinary segregation at the MCF or the SHU for more than short periods of time unless they are guilty of extremely dangerous or violent actions, such as assaults against staff or prisoners causing bodily injury. Inmates should be able to reduce the period of disciplinary segregation through good behavior.

- Review disciplinary policies with the goal of instituting greater proportionality between sanctions for rules infractions and the type of infraction and, in particular, to reduce the amount of disciplinary time awarded for nonviolent infractions.

- Reduce the use of additional time in segregation as a punishment for violation of rules by segregated inmates. Explore alternatives that would serve the goal of promoting rule-abiding behavior by inmates

without prolonging their time in segregation (e.g., use of increased privileges contingent on good behavior, training in anger and impulse control, and increased mental health services).

- Establish equivalent policies governing transfer to, release from, and privileges for disciplinary segregation inmates at the MCF and at the SHU.

3. Improve Physical Conditions

The Indiana legislature should:

- Provide sufficient resources to the Indiana DOC to finance the modification of the physical plant at MCF and the SHU to eliminate egregiously harsh and harmful conditions.

The Indiana Department of Corrections should:

- Renovate the MCF and the SHU to create genuine outdoor recreation areas in which inmates are exposed to sunlight and can see outside of the facility, and indoor or outdoor recreation areas large enough to allow inmates to run at a reasonably high speed and to exercise with another person comfortably.

- Construct sufficient windows in cells at the SHU so that no prisoner is confined in a windowless cell for more than a very brief period.

- Replace the solid steel cell doors in use at the MCF with doors, such as those in use at the SHU, that allow prisoners greater opportunities for social interaction.

4. Eliminate Unnecessarily Harsh and Counterproductive Practices

The Indiana Department of Corrections should:

- Establish a program of increased privileges, including enhanced access to congregate activities and educational and vocational activities, to reward and encourage infraction-free and responsible behavior by inmates confined in administrative and disciplinary segregation.

- Encourage increased contact between inmates and their families and communities. The department should end the routine shackling of all inmates during visits and permit selected inmates to have contact visits with their families. It should also increase access of inmates at the SHU to telephones.

- Discontinue its practice of releasing inmates into society directly from segregated confinement. Prior to release from the MCF or SHU, all inmates should be provided effective transition programming to facilitate social readjustment.

- Reduce racial tensions in the MCF and the SHU by, among other things, undertaking aggressive efforts to recruit and train African-Americans as correctional staff, providing increased racial sensitivity training to staff, and emphasizing to staff through the use of internal disciplinary mechanisms that racial harassment and discrimination will not be tolerated.

- Enhance monitoring and supervision of correctional staff and utilize disciplinary mechanisms to prevent and punish the inappropriate, unnecessary, or excessive use of physical force.

The Indiana legislature should:

- Instruct the Indiana DOC to review conditions and practices at the MCF and the SHU to identify measures needed to better promote the rehabilitation of inmates and their ability to lead law-abiding lives upon release. The review should be undertaken with the participation of outside professionals with correctional, mental health and other relevant experience and with input from inmates and should result in a public report that includes findings and suggested reforms.

5. Monitor Conditions at the MCF and the SHU

The Indiana legislature should:

- Create a permanent independent ombudsman with the authority and adequate staff to monitor conditions in the MCF and the SHU; report its findings to the Indiana DOC, the legislature, and the public; and make recommendations for reform.

- Create a permanent independent review committee composed of qualified mental health professionals who are not employed by the Indiana DOC to monitor mental health care in the Indiana prison system.

III. THE DEVELOPMENT OF SUPER-MAXIMUM SECURITY CONFINEMENT IN INDIANA

The National Trend Toward Super-Maximum Security Prisons

The prototype for modern super-maximum security incarceration is the federal penitentiary at Marion, Illinois.[21] In the 1970s, federal prison authorities began directing the most dangerous federal prisoners to Marion, which was charged with providing "long-term segregation within a highly controlling setting" for these inmates.[22] In October 1983, after years of mounting tensions, Marion experienced a week of violence during which two guards were knifed to death, one inmate was murdered, and others were attacked. As an emergency response to the crisis, Marion was "locked down"—leaving prisoners confined to their cells twenty-three hours a day—initiating a large-scale experiment in solitary confinement.[23]

The Marion regime dramatically reduced the level of violence and disruptive conduct at the facility,[24] prompting other prison authorities to try to replicate it. Thirty-six states and the federal government currently operate a total of at least fifty-seven super-maximum security units, called "supermaxes," built either as annexes within

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[21]Marion, in turn, followed the model established by Alcatraz prison, the nation's first super-maximum security prison. Alcatraz, which opened in 1934 as the institution of choice for "the nation's most desperate criminals and the federal prison system's worst troublemakers," closed in 1963. At that time, its harsh conditions were anathema to prevailing penal philosophies: "rehabilitation, not punishment, was being espoused as the goal of imprisonment." David A. Ward & Allan F. Breed, "The United States Penitentiary, Marion, Illinois: A Report to the Judiciary Committee, U.S. House of Representatives," *Marion Penitentiary: Oversight Hearings before the Subcommittee on Courts, Civil Liberties, and the Administration of Justice of the Committee on the Judiciary, House of Representatives*, 99th Cong., 1st Session (1985), p. 2.

[22]Ibid.

[23]Interestingly, it was not the first time that the United States has experimented with large-scale solitary confinement of prisoners. In the early nineteenth century, solitary confinement was believed to be the most effective means of reforming criminals. The idea was that an individual, separated from others and forced to grapple with his conscience, would be "enlightened from within" and come to hate his crime. Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Pantheon, 1977), p. 236. Solitary confinement was largely discontinued later in the century, however, both because it was an expensive and therefore impractical method of incarceration, and because its detrimental effects on prisoners' mental health were recognized. *See In re Medley*, 134 U.S. 160 (1890), p. 169 (describing solitary confinement as "punishment of the most important and painful character").

[24]From February 1980 to the lockdown, there were fourteen escape attempts, ten group disturbances, fifty-eight serious assaults on other inmates, thirty-three attacks on staff, nine inmate murders and two guard murders. Michael Satchell, "In an Illinois Lockup, a Tough New Approach to Corrections That's Not So New," *U.S. News & World Report*, July 27, 1987. In contrast, in the six years following the lockdown, there were only three murders (none after 1985), no escape attempts or group disturbances, and thirty-four assaults. *See Bruscino v. Carlson*, 854 F. 2d 162, 165 (7th Cir. 1988).

existing prisons or as free-standing facilities. Construction under way will increase nationwide supermax capacity by nearly 25 percent. Although conditions and policies vary somewhat from facility to facility, they all utilize the basic model initiated at Marion: dangerous or disruptive prisoners are removed from the general population and housed in conditions of extreme social isolation, limited environmental stimulation, reduced privileges and services, scant recreational, vocational or educational opportunities, and extraordinary control over their every movement.

Inmates in super-maximum security facilities are usually held in single cell lock-down, what is commonly referred to as solitary confinement.[25] The more precise corrections terminology today for such confinement is segregation, which includes administrative segregation, protective custody, and disciplinary detention.[26] Inmates in super-maximum security segregation are not denied all human contact, but congregate activities with other prisoners are usually prohibited; other prisoners cannot even be seen from an inmate's cell; communication with other prisoners is prohibited or difficult (consisting, for example, of shouting from cell to cell); visiting and telephone privileges are limited. The new generation of super-maximum security facilities also rely on state-of-the-art technology for monitoring and controlling prisoner conduct and movement, utilizing, for example, video monitors and remote-controlled electronic doors. "These prisons represent the application of sophisticated, modern technology dedicated entirely to the task of social control, and they isolate, regulate, and surveil more effectively than anything that has preceded them."[27]

The rationale behind supermax facilities and units is rather simple: in an era of rampant violence in many prisons, the segregation of dangerous inmates allows inmates in other facilities to serve their time with less fear of assault;[28] the extreme limitations on inmates' freedom in such facilities protects both staff and inmates; and the harshness of supermax conditions is believed to deter other prisoners from committing acts that might result in their transfer there.

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[25]A strict solitary confinement regime entails extreme social isolation, including a ban on outside visitors, usually in an environment stripped of all but the basic necessities for maintaining life. One expert has defined the practice as: "an augmented form of detention where a detainee is kept alone, in a small place, without communications with persons other than staff for a long period of time." Paul Williams, *Treatment of Detainees* (Geneva: Henry Dunant Institute, 1990), p. 35. In other forms of segregated single-cell confinement, the level of physical control over inmates is essentially the same as in solitary confinement, but the isolation from human contact (guards, other inmates, and visitors) is generally less severe. See Note, "Solitary Confinement—Punishment within the Letter of the Law, or Psychological Torture," 1972 *Wisconsin Law Review* 223 (1972).

[26]The distinction between administrative and disciplinary segregation hinges not on conditions of detention, but on the route by which an inmate is segregated. According to the American Correctional Association, administrative segregation is a "form of separation from the general population administered by the classification committee or other authorized group when the continued presence of the inmate in the general population would pose a serious threat to life, property, self, staff, or other inmates or to the security or orderly running of the institution." Disciplinary detention is "a form of separation from the general population in which inmates committing serious violations of conduct regulations are confined by the disciplinary committee or other authorized group for short periods of time to individual cells separated from the general population. *See* American Correctional Association (ACA), *Standards for Adult Correctional Institutions*, 3rd edition (Washington, D.C.: St. Mary's Press, 1990), pp. 173, 175 (glossary).

[27]Craig Haney, "Infamous Punishment: The Psychological Consequences of Isolation," *National Prison Project Journal* (ACLU), Spring 1993, p. 3.

[28]For a discussion of modern prison violence and its causes, see Robert Johnson, *Hard Time: Understanding and Reforming the Prison* (Belmont, California: Wadsworth, 1987), pp. 45-51; John Irwin, *Prisons in Turmoil* (Boston: Little, Brown, 1980). The high levels of violence plaguing one Indiana prison in the early 1980s are documented in the findings of fact of a 1985 federal court decision. *See French v. Owens*, 777 F. 2d 1250 (7th Cir. 1985) (describing stabbings, bludgeonings, and rapes at the Indian Reformatory), *cert. denied* 479 U.S. 817 (1986).

Super-Maximum Security Confinement in Indiana

Indiana opened its first super-maximum security unit, then called the Maximum Control Complex (MCC), in April 1991. Although only a handful of prisoners were held at the facility during its first few months of operation, reports of harsh conditions, frequent beatings, and other abuses quickly began to circulate. By late September 1991, thirty-five prisoners were housed there, nearly half of whom had launched a month-long hunger strike to protest conditions.[29] Senator Anita Bowser, an Indiana state senator interested in prison issues, exercised her right as a state legislator to view the MCC during this period; shocked by conditions there, she publicly condemned the facility as "dehumanizing."[30] The hunger strike—the first of several—ended when prison authorities obtained a court order to force-feed the protesters. A few months later, in an even more dramatic attempt to attract outside scrutiny of the facility's conditions, an MCC prisoner severed his fingertip and sent it to the American Civil Liberties Union (ACLU).

In May 1992 the Indiana Civil Liberties Union, a local ACLU affiliate, filed suit challenging conditions at the MCC, as well as the criteria for inmates' transfer there.[31] The complaint in this federal class action charged numerous constitutional violations, including the arbitrary and excessive use of force by guards, the frequent use of physical restraints as punishment, and the misuse of chemical agents. Another hunger strike began at the MCC that month, with some inmates again lasting more than a month without food.[32]

In December 1993, a second super-maximum security facility opened in Indiana. Called the Secured Housing Unit (SHU), it was built as an annex of the Wabash Valley Correctional Facility in Carlisle, a $124 million "state of the art" prison facility that had opened the previous year. Again, reports of abuses were frequent, and inmates conducted long hunger strikes to protest conditions.

In February 1994, after months of negotiation, the class action suit was settled, with the parties accepting a comprehensive Agreed Entry that addressed many of the plaintiffs' complaints. A number of MCC prisoners rejected the Agreed Entry, however, because it did not end administrative segregation nor shut down the MCC. While the settlement would improve conditions, it left intact the fundamental premise and design of prolonged solitary confinement and social isolation as a management prerogative. Seven months later, the plaintiffs returned to court, claiming that MCC authorities were erecting obstacles to frustrate the terms of the Agreed Entry; the court agreed with regard to several of their contentions (regarding access to law library, legal materials and law clerks) but rejected others.[33]

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[29]The hunger strike, which began on September 23, 1991, initially involved sixteen prisoners. By mid-October, the group of hunger-strikers had shrunk to five; of these, one prisoner voluntarily abandoned the effort, while the other four were finally force-fed under court order after having gone thirty-seven days without food. Human Rights Watch interview, MCC prisoner, June 27, 1995.

[30]Human Rights Watch interview, Sen. Anita Bowser, Michigan City, Indiana, June 26, 1995.

[31]The lead plaintiff in that suit was Kataza Taifa, the inmate who had cut off the tip of his finger.

[32]During this period, Human Rights Watch began receiving letters from MCC prisoners who reported serious abuses. We communicated our concerns regarding the prisoners' allegations to the Indiana DOC, urging the responsible officials to take steps to investigate the alleged abuses and, if based in fact, to remedy them. Letter to James E. Aiken, commissioner, Indiana DOC, from Joanna Weschler, director, Prison Project, Human Rights Watch, June 9, 1992; *see also* Letter to Christian DeBruyn, commissioner, Indiana DOC, from Hervé Berger, deputy secretary general, Amnesty International, December 4, 1992.

[33]*Taifa v. Bayh*, Cause No. 8:92-CV-429 AS (U.S. Dist. Court for the Northern District of Indiana, South Bend Div. Of Indiana, 1995).

In June 1996, the name of the MCC was changed to Maximum Control Facility (MCF). In October 1996, the Indiana DOC obtained a modification of the Agreed Entry to permit it to turn three-quarters of the MCF into a facility housing inmates serving long-term disciplinary sentences from around the state.[34] Because the Indiana DOC had to secure plaintiffs' consent to the modification of the Agreed Entry, it agreed to provisions governing the treatment of and conditions for disciplinary segregation inmates at the MCF that differed in certain regards from those in place at the SHU. For example, the modified Agreed Entry requires two hours of recreation per day for disciplinary segregation inmates at the MCF, compared to the half hour per day then provided at the SHU.

The history of litigation over super-maximum security conditions in Indiana is not limited to the class action lawsuit. Individual prisoners at the MCF and the SHU have brought dozens of lawsuits alleging unconstitutional conditions or practices. Although such suits are normally brought *pro se*—by prisoners acting as their own legal counsel—some of them have been successful. In 1995, for example, an MCC prisoner who was placed in four-point restraints for a total of fifteen days won summary judgment in his case against the MCC's superintendent.

IV. THE PHYSICAL ENVIRONMENT

Both the MCF and the SHU are new facilities, built within the last decade. With respect to their design, construction, and choice of building materials, the architectural truism that "form follows function" seems particularly apt. Even though they provide a temporary living space—or, in many instances, a not-so-temporary living space—for the hundreds of prisoners confined in them, the facilities offer few concessions to this aspect of their use. Instead, their fundamental and overriding concern is security, and even their most minor details are shaped with this function in mind.

Within the custodial portions of the two facilities, there is little to relieve the visual monotony of concrete and steel. "[D]esigned to reduce visual stimulation," their interiors are characterized by "a dull sameness in design and color."[35] The MCF has color-coded sections distinguished by different shades of pastel paint, and the SHU has green cell doors and pea-green detailing, but otherwise the two facilities lack decoration. In overall impact, they are cold, hard, and austere.

Layout

In their physical layouts, the facilities are designed to isolate prisoners into small, manageable sub-populations. Each one is divided into four cell blocks, called "pods," which contain cells, showers, recreation areas, medical examination areas, etc., as well as a central control booth for corrections staff. Since each pod is essentially a self-contained unit holding the same stock of equipment as any other pod, inmates rarely need to leave their pods, facilitating security and control by reducing inmate movement around the facility.

The MCF's four identical pods are designated as A-, B-, C-, and D-pod. Reminiscent of Jeremy Bentham's famous panopticon, each pod centers around a raised control room with glass walls. Ranged around the control room are four two-story housing sections; each of which has fourteen cells (including one cell reserved for use as a "satellite" law library) and two showers. Each pod also holds five indoor and two outdoor exercise areas, a medical examining room, and two small counseling rooms. The correctional officers stationed in the control rooms can see

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[34] *Taifa v. Bayh*, Entry Modifying Agreed Entry of February 14, 1994, October 8, 1996.

[35] *Madrid v. Gomez*, 889 F. Supp. 1146, 1228 (N.D. Cal. 1995). In *Madrid*, the federal court was describing the interior of a similar unit at Pelican Bay State Prison in California, but the court's words are equally appropriate with regard to the two Indiana units. Indeed, DOC staff said that Indiana's SHU was patterned after the Pelican Bay facility. Human Rights Watch interview, Assistant Superintendent Ron Batchelor, WVCF, April 22, 1996.

the corridors of each housing section, the front of each cell, and the interior of all recreation areas (through the areas' plexiglass walls). They can also operate the pod's electronically controlled gates but not the cell doors, whose separate controls are adjacent to them.

When Human Rights Watch first inspected the MCF, in June 1995, the facility held only level five prisoners.[36] A-pod held prisoners who had accrued at least twelve consecutive "vested months," that is, twelve months without any serious disciplinary infractions; D-pod held prisoners in medical quarantine and on disciplinary status (in two separate housing sections); C-pod held the remainder of the MCF population, and B-pod was not in use. When we returned in July 1997, the facility had filled up substantially due to the arrival of level four prisoners. At that time, only the A-pod held level five prisoners; the other three pods held level fours.

The SHU's four identical pods are somewhat larger than those of the MCF and are differently designed. Upon entry to the SHU one reaches a central corridor; in one direction lies the "A-side" of the SHU, with pods A-East and A-West located across from each other, and in the other direction lies the "B-side," with pods B-East and B-West. B-West differs from the other three pods in that it holds only WVCF inmates sentenced to short-term disciplinary segregation; the other pods hold inmates from prisons all over the state who have been sent to the SHU for long-term segregation. Although no pod within the SHU is formally classified as an "honor" pod or as a disciplinary pod, long-term inmates enter the SHU in B-East, which is considered the "difficult" pod. If they maintain a record of good conduct they may be transferred to the A-side, where it is considerably quieter and where a substantial number of inmates have televisions.

As in the MCF, each pod at the SHU centers around a raised control room. Radiating out from the control room are six separate two-story housing sections arranged in parallel pairs. Each housing section contains twelve cells—six in the upper tier and six in the lower tier—two showers, and, at the opposite end from the control room, an outdoor recreation area. A skylight covers each pair of housing sections, allowing a limited amount of natural light to filter down into the prisoners' living quarters.

Through the glass walls of the control room, correctional officers can see down the corridors of the housing sections, but not into the individual cells. They can also operate the electronically controlled doors of the cells and walkways, and can hear inmates through an intercom system. Although the officers cannot see into the exercise areas, which have solid walls, they can watch exercising inmates using video monitors. Besides the housing sections and the control room, each pod contains a counselor's office, a medical examining area, a dental area, a satellite law library, and a hair-cutting room.

Cells

The most striking thing about the cells at the MCF is their imposing doors. Made of solid steel, interrupted only by a small, approximately eye-level plexiglass window and a waist-level food slot, they effectively cut inmates off from the world outside the cell, muffling sound and severely restricting visual stimulus. "Boxcar" cell doors such as these have been reported at Marion and at other super-maximum security prisons, although not all such facilities use them.[37]

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[36]The distinction between level four and level five prisoners is discussed below.

[37]The most severe reported attempt to shut off inmates from outside stimulus in recent years occurred at the Massachusetts Correctional Institution at Walpole. Beginning in August 1979, the cell doors of the lower tiers of Block 10 of that facility were closed, leaving inmates isolated behind double doors: solid steel doors on the outside and barred doors on the inside. The average length of time that inmates spent in such conditions was two months, however, much shorter than even the minimum time inmates may spend at the MCF. *See* Stuart Grassian, "Psychopathological Effects of Solitary Confinement," *American Journal of Psychiatry*, 140 (1983): 1451.

Each rectangular MCF cell measures twelve feet ten inches by five feet eleven inches and has a concrete ceiling, walls and floor. Its main furnishing is a narrow poured concrete bed, stretching away from the door down the long side of the cell, and a mattress. At one end of the bed, across from the door, is a rudimentary concrete desk; to use it, the inmate must sit on the bed, where he lacks back support. Above the desk is an extremely narrow window, like those used for cross-bows in medieval castles: impossible for a person to fit through. Next to the desk, and facing the bed, is a stainless steel combination toilet and sink. On the wall by the other end of the bed, next to the door, is a high shelf for a TV. Below this shelf, a two-by-three-foot section of wall is marked off: inmates are permitted to affix pictures and posters within this space. Otherwise, the walls of the cell must be kept bare.

MCF cells have fluorescent lighting and stark walls, painted ivory. At present, inmates may turn off one light and darken the cell somewhat, but a seven-watt fluorescent bulb stays on twenty-four hours a day. Prior to an agreement reached in 1994 after litigation, this "night light" was twice as bright.

In contrast to the solid cell doors at the MCF, the cell doors at the SHU are made of a perforated metal screen. Although it is somewhat disorienting to look at people through the heavy screen, approximately 60 percent of an image can be seen through it. The main benefit of the screen, as compared to the steel doors at the MCF, is that it allows sound to travel more easily, so that prisoners can converse with a larger number of other prisoners.[38]

Numerous cells in the B-East pod of the SHU have a special protective covering. Called "lexan," it is a plexiglass-like transparent plastic shield that covers the entire front of the cell. These cells are colloquially referred to as "bubbles" and are used for inmates who have a history of throwing bodily fluids—i.e., urine or feces—or spitting.[39] The lexan shield makes it impossible for inmates to throw anything outside the cell; it also muffles sound. Lexan-covered cells become very stuffy inside, and are even more uncomfortable than other cells in the summer heat. According to one prisoner's description of living in such a cell: "It's stuffy in here. Your head can't get air. You don't breath. You can't think clearly."

SHU cells, which are approximately eighty square feet in size (seven by twelve feet), are shaped like a rectangle with one corner shaved off. They have no windows, leaving prisoners without any glimpse of the outside world. Each cell contains a concrete bed with a plastic-covered mattress, a shelf by the bed, a fixed table and stool with no back support, and a stainless steel combination sink and toilet. Inmates are not supposed to attach anything to the cell walls, although we noticed a great degree of leniency in the application of this rule.[40] The cell's forty-watt fluorescent light is located over the toilet. Between 9:00 p.m. and 5:00 a.m. the prisoner controls it; the rest of the time it is controlled by corrections staff, and is normally kept on. Even when the main light is turned off, however, a seven-watt "night light" remains lit.[41]

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[38]The advantage of increased social interaction is mitigated, however, by the drawback of increased noise. Several prisoners complained of occasionally "deafening" noise levels, particularly in B-East pod.

[39]Prison staff that we spoke to were enthusiastic about a law that went into effect in May 1995, which allowed inmates to be criminally prosecuted for the crime of "battery with bodily fluids." Human Rights Watch interview, MCF, June 26, 1995. By July 1997, when we returned to Indiana, a few SHU inmates had reportedly been prosecuted under the law, including one inmate who was convicted. Human Rights Watch interview, SHU prisoner, July 17, 1997.

[40]Some prisoners had written all over their cells; other had plastered them with pictures.

[41]Prisoners have complained persistently about the constant illumination and have urged the Indiana DOC to have guards use flashlights during nighttime cell checks. Although the Indiana DOC claims flashlights would be even more disruptive to sleep, it would seem reasonable to give inmates a choice: those who choose to have their lights off would be searched via flashlight.

Prisoners in both the MCF and SHU are allowed to keep a limited amount of personal property in their cells. Both facilities have written rules that set out precisely how many books, magazines, pens, etc., a prisoner is allowed to retain, as well as what kind of items are permissible. (Some of these rules are quite strict. Until recently, for example, prisoners at the SHU were only allowed to keep the flexible inner cartridge of ballpoint pens; their hard plastic shell was confiscated for security reasons.) Each cell has a property box in which to store such materials.

Recreation Areas

The MCF has both indoor and outdoor recreation areas, while the SHU has only outdoor areas. The differences between "indoor" and "outdoor" areas, however, are not as great as their names suggest. Because of their small size, meager array of equipment, concrete floors, high concrete walls, lack of outside view, and general sterility, both types of recreation areas provide little variation from confinement in a cell. Indeed, a number of prisoners at both facilities aptly described them as "oversized cells" or "dog runs." Outdoor recreation areas merit their name only to the extent that being outdoors is defined by a narrow view of the sky and a breath of fresh air. Standing in the outdoor area is akin to being at the bottom of a well.

The MCF's indoor exercise areas are irregularly shaped plexiglass boxes of roughly 150 square feet containing a rudimentary stationary bicycle (quite unlike the exercise bicycles found at health clubs) and a telephone. The outdoor recreation areas, which measure twenty-seven feet two inches by nine feet five inches, are roughly pie-slice-shaped and contain a pull-up bar, a sixteen-foot-high basketball hoop, and a basketball. Approximately a third of their walls are of plexiglass opening to the interior of the prison so that the guards in the control room can watch inmates exercise; the rest of their walls are of solid concrete. Since these walls are over two stories high, inmates have no view outside of the facility.

At the SHU, each range has an adjoining outdoor recreation area of approximately fifteen by twenty-four feet, with over two-story-high concrete walls and a concrete floor. High above, half of the area is covered with plexiglass and half with a mesh screen. Except for those outdoors at the right moments in the summer, most prisoners are rarely touched by the sun. In the winter, besides being freezing cold, the outdoor areas can get icy, and in icy weather the inmates' exercise period is canceled (to prevent injuries).[42] Because of such conditions, there can be long periods of time when the inmates have no possibility of out-of-cell exercise.

Like the MCF, the SHU has rudimentary exercise bicycles in its exercise areas, although these were installed only after the facility had been in operation for a few years. Besides these bikes, each exercise area has a sixteen-foot-high basketball hoop and a basketball.

Air, Light, and Climate

Except for their outdoor recreation areas, the MCF and the SHU are sealed environments. Inside the two facilities, there is little natural light and no fresh air, in violation of the U.N. Standard Minimum Rules.[43] Sometime in 1994, under the orders of former Superintendent Charles Wright, twenty-eight cell windows in the MCF were painted over because staff had complained of inmates' watching or harassing them from the windows. Because the paint exacerbated the facility's dearth of natural light, it was removed in April 1995 with the arrival of a new superintendent.

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[42]Prisoners complain that they are not provided hats or gloves in the winter. Instead, they are permitted to wear socks on their hands and may put a tee-shirt or towel over their head.

[43]According to Article 11(a) of the Standard Minimum Rules, "In all places where prisoners are required to live or work . . . [t]he windows shall be large enough to enable the prisoners to read or work by natural light, and shall be so constructed that they can allow the entrance of fresh air whether or not there is artificial ventilation." The SHU's total absence of windows is particularly inconsistent with this requirement, although the narrow sealed windows at the MCF are a little better.

An important environmental difference between the two facilities is that the SHU relies on fans for cooling while the MCF has air-conditioning. Prisoners stated that in the era of Superintendent Wright the air-conditioning was sometimes set extremely low (i.e., down to 40° fahrenheit) as a punitive measure, leaving prisoners shivering in their cells. The 1994 Agreed Entry specified that cell temperatures should remain between 68° and 75° fahrenheit, a rule that prisoners confirmed was followed.

Temperatures in the SHU, in contrast, may reach 100° fahrenheit in the summer; cell interiors, particularly in lexan-covered cells, are stifling. SHU administrators have stated that they plan to install air-conditioning; to our knowledge, however, this has not been done.

V. THE INMATE POPULATION

Prisoners are not sent to the MCF or the SHU because of the severity or heinousness of their original crimes. No judge ever sentences a defendant to serve time in either facility, and no one ever begins his prison sentence in one. Rather, prisoners are transferred to these units by the Indiana DOC because of the department's negative assessment of their conduct while in the prison system.

According to the DOC commissioner, MCF and SHU prisoners are "the most disruptive, violent, and unmanageable persons housed with the Department."[44] It is these inmates' extreme behavior that, in the DOC's view, justifies the facilities' correspondingly extreme security and control measures. Human Rights Watch, however, is unconvinced that the criteria and procedures employed in selecting prisoners for placement in these facilities actually separate out those prisoners in need of such extraordinary control measures. We are concerned, in particular, that the MCF and SHU house some prisoners who would more appropriately be confined in less restrictive settings. Moreover, although we were unable to ascertain the proportions of violent or dangerous prisoners, we did discover shocking numbers of severely mentally ill prisoners who are held in these facilities.[45]

Heightened scrutiny and safeguards should be utilized before a state subjects any prisoner to the harsh conditions of prolonged confinement in segregated housing. In addition, the placement of individuals in super-maximum security settings should be continually reviewed to ensure that no person is confined in such conditions longer than is necessary.[46] Inmates who are mentally ill or are particularly vulnerable to the mental health risks of segregated confinement should not be housed in such conditions at all. These basic principles are not observed in Indiana.

Criteria and Procedures for Assignment

Administrative Segregation at the MCF

The MCF was established as an administrative segregation facility. It is Indiana's only Level 5 institution, the state's highest security classification. Assignment to MCF Level 5 is not deemed punishment, nor is it imposed

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[44]Letter to Lotte Meyerson, coordinator, Northwest Indiana Coalition to Abolish Control Unit Prisons, from Edward L. Cohn, commissioner, Indiana DOC, September 3, 1997.

[45]In an effort to ascertain whether all the prisoners confined at the MCF and the SHU have histories of violent or dangerous behavior, we asked the Indiana DOC to provide us with copies of its classification memoranda in support of requests to transfer prisoners to these facilities (with identifying information deleted to protect inmates' privacy). Unfortunately, the Indiana DOC never gave us those memoranda, nor any other documentation specifying the nature of inmates' disciplinary records.

[46]International standards reflect the fundamental criminal justice principle of utilizing the least amount of restrictions necessary. *See* Standard Minimum Rules, Article 27.

upon conviction of rules infractions through a formal disciplinary proceeding. Consistent with the position that assignment to the MCF Level 5 is a management classification decision and not a disciplinary one, the Indiana DOC does not provide prisoners with an opportunity for a formal hearing regarding their proposed assignment to the facility.[47]

The class action lawsuit alleged that criteria for assignment to the MCF (then MCC) were excessively vague and discretionary and that DOC used transfer to the MCF as a method of retaliating against or punishing disfavored prisoners, e.g., politically active or litigious prisoners. The lawsuit also alleged that minor incidents such as throwing water on a guard could result in transfer to the MCF.

The negotiated settlement to the class action established substantive criteria for transfer to the MCF, greatly constraining the DOC's discretion. Under the terms of the Agreed Entry, the DOC can assign a prisoner to MCF Level 5 only if that person is not mentally ill and has a confinement history including at least one of the following factors: escapes with attempts to cause physical harm or serious property destruction; assaultive behavior against staff or prisoners causing serious bodily injury or death; rioting or inciting to riot; intensive involvement in violent gang activities; or aggressive sexual conduct or rape.[48] Although an inmate may contest his assignment, either in person to his classification supervisor, or in writing, and may appeal in writing a decision to transfer him to the MCF, he is provided no meaningful opportunity to present reasons and evidence supporting his claim the assignment is inappropriate.

Prisoners are assigned to the MCF Level 5 for an indefinite period of time. A prisoner's classification and assignment to the MCF Level 5 is supposed to be reviewed after twelve months; as part of that review, the Indiana DOC is to interview the prisoner and discuss with him information pertinent to the decision of whether or not to maintain him at the MCF. Inmates insist that the review is *pro forma* and, in their view, not a genuine effort to ascertain whether their continued confinement in Level 5 is necessary.

The total time a prisoner remains at the MCF depends primarily on the accumulation of "vested months": months in which the prisoner remains free of serious rules violations. Prisoners who have twenty-four consecutive vested months, or a total of thirty-six vested months (with the last six months consecutively), must be transferred out of the MCF. Prisoners may be awarded additional vested months for "exceptionally good behavior" and may lose accumulated vested months upon conviction of rules infractions.

Some prisoners never accumulate sufficient vested months to permit them to transfer out of the MCF. In the summer of 1997, for example, at least three prisoners had been there since the first year the facility opened.

Disciplinary Segregation at the MCF

Although construction of the MCF was considered necessary to house a growing population of dangerous offenders, when objective criteria for dangerousness were applied following the Agreed Entry, the facility remained largely vacant. Faced with this unoccupied space, the Indiana DOC obtained a modification of the Agreed Entry

[47]The U.S. Supreme Court has ruled that confinement in segregated prison housing does not automatically trigger due process protection. Under the Court's current reading of the Due Process Clause of the Constitution, prisoners can only challenge housing decisions that affect them when the new conditions imposes "atypical and significant hardship on the inmate in relation to the ordinary incidents of prison life. *Sandin v. Conner*, 115 S. Ct. 2293, 132 L.Ed. 2d 418, 430 (1995). As have most courts which have considered prisoner challenges to administrative classification decisions, an Indiana federal district court has ruled that conditions at the MCF are "within the range of confinement normally to be expected" and that, consequently, due process protections are not required. *Taifa v. Bayh*, Cause No. 3:92-CV-429AS (N.D. Ind. 1995).

[48]Agreed Entry, *Taifa v. Bayh*, Cause No. S-92-00429-M (January 5, 1994), p. 2.

allowing it to use three pods of the MCC, or 165 beds, as a Level 4 disciplinary segregation unit (DSU), housing inmates serving long terms of disciplinary segregation.

Under the terms of the modified Agreed Entry, any adult male prisoners who has been sentenced after conviction of infraction(s) at a disciplinary hearing by the Conduct Adjustment Board/Hearing Officer, and sanctioned to a minimum of six months of disciplinary segregation, can be sent to the MCF-DSU to serve his disciplinary time, with the exception of those who are mentally ill and actively psychotic. Prisoners cannot be confined at the MCF-DSU for longer than two years, unless they have been convicted of class A or B disciplinary offenses during that period. In other words, depending on their disciplinary record after transfer to the MCF-DSU, inmates can remained confined there in supermax conditions for an indefinite period.

Disciplinary Segregation at the SHU

The SHU is solely a disciplinary segregation unit. Under Indiana DOC policy, prisoners who have accumulated at least two years of disciplinary segregation time for rules infractions are eligible for transfer there.[49] The disciplinary time is imposed by conduct adjustment boards or by a hearing officer following a formal hearing with certain due process safeguards.[50]

The Indiana DOC does not have a published policy establishing a minimal threshold of violent or dangerous behavior for assignment to the SHU. Unruly or troublesome offenders can easily accumulate the requisite two years' segregation time without ever posing serious threats to prison safety or security. There is no requirement, for example, of a history of hostage taking, organizing or causing a riot; assaulting others with an instrument capable of bodily harm, or attempted escape. [51] A SHU administrator told Human Rights Watch that other institutions often send their "management problems" to the SHU even though they have not engaged in serious assaults or dangerous behavior. By way of example, he cited a prisoner sent to the SHU because he continually masturbated in front of female staff at his home facility. Such conduct should obviously not be condoned; but it is difficult to see how it justifies treating him the same as someone who has attacked guards with a knife.[52]

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[49]In its B-West pod, however, the SHU provides short-term segregated housing of prisoners from the Wabash Valley Correctional Facility.

[50]Indiana inmates charged with infractions of the disciplinary code are entitled to disciplinary hearings with only limited due process protection: the standard for guilt is "the preponderance of the evidence"; they are not guaranteed the right to call witnesses, to cross-examine witnesses or even know the identity of individuals furnishing adverse testimony; and they do not have the right to a lawyer or advocate of their choosing. While these disciplinary procedures may be acceptable for minor infractions, they provide scant protection with regard to such serious charges as battery or attempted homicide, offenses which can be sanctioned with up to three years of disciplinary segregation. No additional due process protections or special hearings are afforded prisoners prior to assignment to the SHU.

[51]National Institute of Corrections/U.S. Department of Justice (NIC/DOJ), *Disruptive Maximum Security Inmate Management Guide* (Washington, D.C.: NIC/DOJ, December 1988), pp. 39-40.

[52]The Indiana DOC has paid insufficient attention to ensuring reasonable proportionality between the underlying infraction and the amount of disciplinary time imposed. Under the Disciplinary Code, for example, Class B offenses, which can lead to imposition of twelve months of disciplinary time, include the refusal to take a urinalyses test for drugs, giving money to someone without authorization, disorderly conduct, being under the influence of alcohol, making sexual proposal to another; Class C offenses (three months' disciplinary time) include indecent exposure, insolence or vulgarity to toward staff, participating in any unauthorized gathering, making unreasonable noise, and tattooing. Even correctional supervisors acknowledged to Human Rights Watch that prisoners can be and are given too much lockup or segregation time compared to the seriousness of their offenses.

There is no limit on the amount of time a prisoner can be confined at the SHU. We interviewed prisoners at the SHU serving decades of accumulated disciplinary segregation time. No policies or court orders preclude the Indiana DOC from keeping them at the SHU for the entire period. In addition, whatever the original amount of segregation time to be served at the SHU, it can be extended because of infractions committed once there. Even if the infraction is relatively minor, or is the result of mental illness (as in certain cases of self-mutilating prisoners), it can result in additional segregation time.

Prisoners at the SHU and those being held in disciplinary segregation at the MCF are classified as Level 4 inmates. At the MCF, however, under the terms of the modified Agreed Entry, prisoners must be released from the DSU after two years there, barring conviction of any serious offense during that period. But prisoners can be confined indefinitely at the SHU, regardless of their conduct, until the end of the mandated disciplinary period.

In 1996, the DOC instituted a new policy permitting SHU inmates with twelve months of clear conduct history to apply or be recommended for early release. The decision whether to grant early release from the SHU is entirely discretionary, and there are no published criteria. At least one prisoner interviewed by Human Rights Watch expressed frustration at not having been given any useful explanation for why his request for early release had been denied. We do not have figures on how many prisoners have benefited from the new policy.

Confinement of Mentally Ill Prisoners

A substantial proportion of the prison population in the United States is composed of people with serious mental disorders.[53] Their illness makes it difficult, if not impossible, for them to comply with prison rules and to adjust to the unique strictures of prison life. Within the population of mentally ill, a certain proportion exhibit their illness through aggression, disruptive behavior and violence. The mentally ill are also exceptionally vulnerable to abuse by other prisoners, including sexual abuse.[54] For these and other reasons, mentally ill prisoners often accumulate long records of rules infractions and can pose very real security and safety challenges. The response of many prison administrators, including those in Indiana, is to confine them in super-maximum security prisons in which symptoms of their illness are treated as disciplinary infractions and mental health services are inadequate.[55]

Both the SHU and the MCF house prisoners who are seriously mentally ill. The problem is particularly severe at the SHU, where even the staff acknowledges that somewhere between one-half and two-thirds of the inmates are mentally ill.[56] These illnesses are not manifested in subtle symptoms apparent only to the discerning

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[53]"Estimates of the percentage of people in jail and prison who are seriously mentally ill—with schizophrenia, bipolar disorder, or severe recurrent depression—range from 6 percent to 15 percent, depending on the study and on the institution." Editorial, "Jails and Prisons—America's New Mental Hospitals," *American Journal of Public Health*, December 1995, p. 1612. *See also* C.J.A. Chiles, E. Von Cleve, R.P. Jemelka and E.W. Trupin, "Substance Abuse and Psychiatric Disorders in Prison Inmates," 41 *Hospital and Community Psychiatry* (1990).

[54]Victor Hassine, a Pennsylvania prisoner who wrote an extremely informative book about his prison experiences, described mentally ill prisoners as "pathetic and disruptive." He explains, "Their helplessness often made them the favorite victims of predatory inmates. Worst of all, their special needs and peculiar behavior destroyed the stability of the prison system." Victor Hassine, *Life without Parole: Living in Prison Today* (Los Angeles: Roxbury, 1996), p. 29.

[55] For example, one study has found that the prevalence of severe mental illness is higher among incarcerated offenders than among the general population, and that mentally ill inmates were more likely to be housed in solitary than non-mentally ill inmates. G. Cota & S. Hodgins, "Co-occurring mental disorders among criminal offenders," *Bulletin of the American Academy of Psychiatry and Law* 18, no. 3, pp. 271-81. Similar findings are discussed in Edward Kaufman, "The Violation of Psychiatric Standards of Care in Prisons," *American Journal of Psychiatry*, May 1980.

[56]Behavioral disorders and antisocial personalities also disrupt prison safety and security and raise difficult questions concerning the best correctional response to inmates with these problems. Our discussion of the mentally ill at the SHU and the

professional: prisoners rub feces on themselves, stick pencils in their penises, stuff their eyelids with toilet paper, bite chunks of flesh from their bodies, slash themselves, hallucinate, rant and rave or stare fixedly at the walls. The situation has been so intolerable that prisoners themselves have sought to bring to public attention the fact of the confinement of mentally ill prisoners at the MCF and the SHU and the impact of that confinement on those prisoners, as well as on the rest of the prison population.[57] Keeping the mentally ill out of the MCF was a major goal of the class action law suit, and prisoners at the SHU have released public statements and prepared lawsuits denouncing the fate of the mentally ill confined there. In a statement released to the public, one SHU inmate asserted that another inmate:

> has been beaten repeatedly by the guards here. The man obviously has some psychological problems because he defecates and rubs the feces all over his body. The guards think it is funny and continue to harass him daily.[58]

The Agreed Entry settling the class action lawsuit prohibits the administrative segregation of mentally ill inmates at the MCF. The Modified Agreed Entry also prohibits the incarceration at the MCF-DSU of inmates who are mentally ill and actively psychotic, but it permits the incarceration there of mentally ill inmates whose conditions are being controlled by psychotropic medication. The Indiana DOC has not fully complied with these restrictions. There are no regulations prohibiting or limiting the confinement of mentally ill prisoners at the SHU.

Among the two dozen MCF inmates interviewed in July 1997 by the psychiatrists on our team, at least five were mentally ill and not receiving medication or treatment. The following a re our psychiatrists' evaluations of two of these inmates:[59]

> Prisoner Jones[60] had two psychiatric hospitalizations as a teenager. He has a history of hallucinations and continues to hear voices occasionally at the MCF as well as presenting emotional flattening and paranoia—all signs of schizophrenia.
>
> Prisoner Smith is suffering from a paranoid delusional disorder. While in general population at his home institution, he had been treated with an anti-psychotic medication, but he is not being given any treatment at MCF. This inmate frequently verbally and physically assaults MCF guards; his behavior is clearly influenced heavily by his delusions, yet the only "treatment" he receives is additional punishment.

MCF excludes such individuals and focuses instead on inmates who have symptoms of schizophrenia, delusional disorders, schizophreniform or schizoaffective disorders, brief psychotic disorders, other unspecified psychotic disorders, major depressive disorders, and bipolar disorders I and II, as included in the Diagnosis and Statistical Manual IV (DSM-IV) Axis I.

[57]Indeed, to this day, one of the major complaints of prisoners at the SHU is the havoc wrought on the prison environment by the presence of many severely disturbed prisoners and the violence done to mentally ill prisoners by placing them in such inappropriate conditions.

[58]Written statement by James Wilson, April 2, 1995 (copy on file at Human Rights Watch).

[59]Although the two psychiatrists who visited the MCF and the SHU with Human Rights Watch in July 1997 were not able to review inmates' medical records nor discuss each inmate's medical history with mental health staff, they were able to conduct private interviews with inmates of sufficient length to be able acquire adequate information with which to formulate preliminary diagnoses.

[60]To protect prisoners' privacy, we are using fictitious names.

Mentally ill prisoners interviewed at the SHU include:

Prisoner Davis has had severe psychiatric difficulties since the age of six; prior to his incarceration he had been in a state mental hospital for five years. He is a severe self-mutilator who is compelled to cut himself by voices that tell him to do it.

Prisoner Johnson is actively psychotic. He hears voices and suffers from paranoid delusions that cause him to act out against guards. He was on a variety of psychiatric medications before coming to the SHU, but has refused them since coming there. His disciplinary infractions at the SHU appear to be directly related to his psychosis.

Prisoner Washington is psychotic. He is a severe self-mutilator with a history of brain damage and seizures. He self-mutilates in response to voices telling him to kill himself.

Prisoner Thomas is delusional and thought disordered; his speech is disorganized and tangential, with loose associations. He believes that he is "attached to an alien affiliation" and that he has been forced to commit treason against the United States. He also claims that he is a woman, but "they haven't found his vagina yet." He said that he shot his mother when he was three years old, but does not know if she died or not. He also reported that he believes that there is a radio in his nerves that is broadcasting. He often picks at his ear to see if the receiver is in there but can't find it. He still believes it is there. He also gets messages through "federal codes" in his cell.

Prisoner Brown has had seizures and psychiatric symptoms since childhood. He has bipolar disorder and a severe anxiety disorder, a phobia about being alone in a cell, and many features of chronic post-traumatic stress disorder. After he has been in his cell for awhile, his anxiety level rises to an unbearable degree, turning into a severe panic attack replete with palpitations, sweating, difficulty breathing, and accompanying perceptual distortions and cognitive confusion. He mutilates himself—for example, by inserting paper clips completely into his abdomen—to relieve his anxiety and to be removed from his cell (for medical treatment).

Prisoner Green is a severely ill individual who hears voices telling him that correctional officers are trying to kill him and that he should draw a circle on the floor with blood in it to make himself safe. He self-mutilates to relieve the pressure which builds up as a result of the voices. Most of his disciplinary reports have been for self-mutilating.

Prisoner White is severely mentally ill and has been since childhood. He began psychiatric medication at age thirteen. He finds being alone intolerable: it makes his auditory hallucinations worse and makes him paranoid. This causes him to either mutilate himself or to assault correctional officers. This inmate also appears to be at best borderline mentally retarded.

Prisoner Black has been on psychiatric medication since the age of ten years old for hearing voices and what he calls "psychological illusions." He has had several previous psychiatric hospitalizations. He describes visual hallucinations of seeing ghosts, animals, people and things move. Auditory hallucinations are outside of his head, they are sometimes about Jesus, they take up to 500 different forms and talk to each other. They sometimes command him to kill himself although he has not made any previous suicide attempts. He is obviously severely mentally retarded and appeared to be blithely indifferent to his conditions. Because of his profound impairment, it is doubtful that he can fully understand the consequences of his behavior or "learn a lesson" from disciplinary segregation.

Prisoner Hunt first saw a psychiatrist at age twelve because he had delusions that he was Jesus Christ. He remains psychotic, with delusions that he has been given a mission to kill people who do not believe in white supremacy.[61]

Prisoner Cooper is so severely mentally retarded that it was difficult to complete a psychiatric interview with him. His facial features are dysmorphic, and he appears to be microcephalic (these are related to a chromosomal or congenital condition which also causes his mental retardation), so that even without testing any physician would recognize that he is mentally retarded. In addition, his speech is dysarthric and severely impoverished. He cannot possibly understand fully the consequences of his actions and the rules that he is expected to follow in prison.[62]

VI. A DAY IN THE LIFE

Within the sterility and monotony of the physical environments of the MCF and the SHU, prisoners experience extraordinary social isolation, unremitting idleness, and few educational or vocational opportunities. With minor exceptions, a prisoner's entire life is circumscribed within the four walls of his cell. Prisoners' minimal physical requirements—food, shelter, clothing, warmth—are met, but nothing more.[63] Indeed, the Indiana DOC makes little claim that its penological goals at the MCF and the SHU extend beyond incapacitation and punishment. Neither facility offers a regime calculated to assist the inmate develop his ability to lead a peaceable life upon return to general population or upon release to society.

Many critics describe supermax conditions such as those at the MCF and SHU as sensory deprivation. It is more accurate to describe life in those facilities as one of extremely limited environmental stimulation, one in which perceptually informative inputs are limited.[64] Their world is cramped, claustrophobic, and austere. Inmates can spend years of solitary lives, surrounded by the noise of others but without the opportunity to develop normal social relationships. If they live in the SHU they can spend years without seeing any part of the outside world except a bit of sky through the screen covering half of the top of the outdoor exercise area,[65] indeed without seeing anything

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[61]This inmate was due to be released from the SHU directly to the outside world within two months of our visit in July 1997. Our team asked the SHU psychiatrist and medical director whether they intended to take any steps to have him civilly committed to a psychiatric institution because of his violent delusions. Their response was that taking such action was not their responsibility and that, in any event, they did not have the time to fill out the paperwork or go to court to testify for his commitment.

[62]The psychiatrist with our team who interviewed this prisoner said the following in his notes about the interview: "I believe I terminated the interview early because I was very uncomfortable with my own sense of horror and outrage that this inmate would be in the SHU."

[63]Medical care is also provided to prisoners at both facilities, but Human Rights Watch did not attempt to evaluate its extent and quality. We do note that complaints regarding medical care—or, more precisely, the lack of medical care—were almost universal. Prisoners stated that medical attention is difficult to obtain and slow to arrive.

[64]After having insisted that it would be impossible as a security threat, Indiana DOC officials have agreed to allow the slot in the door through which food is passed and prisoners cuffed up to be kept open during the day except for prisoners who abuse the privilege. This is one of the many small measures that can markedly improve conditions for prisoners without compromising security or other legitimate penological objectives. Human Rights Watch still urges, however, replacement of the solid doors with doors that permit greater communication such as those at the SHU.

[65]One inmate told us that once in a while he would "see a bird fly overhead."

farther away than the end of the pod. At the MCF, the benefit of the small window in each cell is outweighed for many prisoners by the solid steel door, which shuts each inmate into, as one called it, his "own little tomb."

Social Isolation

One of the defining features of super-maximum security confinement is its restrictions on prisoners' social interactions.[66] Regardless of why they were assigned to the MCF or the SHU, all inmates are confined alone in their cells twenty-two or twenty-three hours a day. While in their cells, they cannot see each other. They eat alone from food trays passed by guards through a narrow port in the cell door. Most exercise alone. There are no group classes, programs, or religious services. Even social interaction with guards is highly limited: guards avoid contact with prisoners except to serve them food through a feed slot in the door, handcuff and shackle them for time outside the cell, and, on occasion extract them forcibly from their cells (see discussion below).

Although ordinary social interaction—the varied experiences, gestures and exchanges of people living together in a community—is impossible, inmates nonetheless manage to communicate. They call out to immediate neighbors and pass notes using ingenious systems. Indeed, in their conversations with Human Rights Watch representatives, some inmates demonstrated considerable knowledge about the lives of other inmates.

In the MCC's initial months, more drastic forms of social isolation were imposed: a few prisoners were placed alone in pods, or placed in pods with only one or two other prisoners. Paul Komyatti, the second prisoner to be transferred to the MCC after it opened, remained in A-pod all alone for three weeks in July 1991.[67] At the SHU, similarly, two extremely mentally disturbed prisoners have been placed in a pod that is empty but for them; prison officials say they are kept away from other prisoners because other prisoners taunt them and encourage them to hurt themselves.

The atmosphere in the cell blocks is sometimes one of noisy anger, particularly at the SHU. To some extent, this reflects the presence of numerous mentally ill and disordered inmates with problems of impulse control and excessive anger. But the enforced lack of productive social contact also seems to stimulate considerable tension and animosity among prisoners. Prisoners yell and argue with each other. At the SHU, racial slurs abound.[68] Some prisoners expressed the view that the hostility and tensions build because prisoners know they harass their fellows and shout obscenities with impunity, given that the lack of physical contact between prisoners precludes retaliation. Prisoners also said that some prisoners even throw feces or urine into the cells of others when they are being escorted down the range, something that they would not do if they knew they would have to share space with each other, such as during group recreation. Prisoners at the SHU criticized the correctional staff for permitting the noise level at the SHU to reach excessive levels, interfering with the lives of others, and claimed that guards have at times deliberately permitted prisoners to throw human waste on others.

Prisoners have few opportunities to leave their cells. The MCF is required to release each Level 5 prisoner out of his cell for a total of only six hours a week. Prisoners may go to indoor or outdoor recreation for one hour a day six days a week. Time with visitors is taken from recreation time. They may take a ten-minute shower each day they have recreation. Prisoners at the MCF-DSU are allowed up to two hours a day of recreation; we were told,

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[66]Describing a somewhat comparable prison regime in Iceland, the CPT concluded that the inmates "benefited from no prison regime worthy of the name; they were simply stored in the establishment." CPT, "Report to the Icelandic Government on the visit to Iceland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 6 to 12 July 1993," Strasbourg, France, 28 June 1994, CPT/Inf (94) 8, p. 31.

[67]Human Rights Watch interview, MCC, June 26, 1997.

[68]During Human Rights Watch's 1997 visit to the SHU, a black prisoner called out that he wanted to "talk to the human rights person." A white prisoner ridiculed his desire to talk with us, saying "You're a gorilla, gorillas have no rights."

however, that because of limited recreation space and pressure on the staff's time, they do not all receive the requisite daily time outside their cells. When Human Rights Watch visited the SHU in 1996 and 1997, prisoners were allowed a half-hour per day of recreation time, as had been the facility's rule from the beginning. Prisoners complained that they were frequently denied the opportunity to have even that much recreation time. In October 1997 we were told that the recreation period at the SHU had been extended to one hour.

Men who are locked behind bars need access to vigorous physical exercise and athletic competition in the open air if they are to cope with the ordinary stresses of prison life.[69] Prisoners at the SHU and the MCF, however, although they live in the extremely stressful environment of solitary confinement, do not get the physical release required for physical and mental well-being.[70] The need for exercise goes beyond the ability to do push-ups or sit-ups, and it is not satisfied by pacing around a cramped enclosed space.[71] Yet the recreation areas are too small and too poorly equipped for much else. Worse, the "outdoor" recreation differs little from the indoor area: it offers neither space to run nor sunshine nor sight of the surrounding landscape.[72] SHU prisoners, who do not have windows, can spend years completely isolated from the natural environment and from most of its natural rhythms.

Originally, recreation at both facilities was strictly solitary. In another change indicating that not all measures rationalized as required for security were in fact necessary, limited group recreation is now permitted certain inmates. Inmates in disciplinary segregation at the MCF are allowed to go to indoor recreation three at a time; and two at a time for outdoor recreation. According to the Indiana DOC commissioner, the Indiana DOC is considering permitting group recreation for inmates in administrative segregation.[73] The Indiana DOC has been exploring the idea of group recreation. Hostility among inmates has built up to such a point at the SHU that there are inmates who have told Indiana DOC that they prefer solitary recreation. The Indiana DOC should nonetheless actively explore arrangements that would permit those inmates who can safely exercise with others to do so.

Ultimately, the principal limitations on congregate recreation may not be security and safety, but space. Following the prevailing solitary confinement model, the architectural design of both SHU and MCF did not include adequate space for inmates to spend time together outside their cells. The Indiana DOC must now identify practical ways to make changes in the physical layout of the facilities to permit a more human life within.

Contacts with the Outside

Paralleling the restrictions on social contact among prisoners are the restrictions on prisoners' contact with visitors. Both the SHU and the MCF allow only non-contact visits: the inmate, who is handcuffed and shackled, sits in a small cubicle separated from his visitor by a plexiglass partition, and the two communicate via telephone

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[69]Terry A. Kupers, M.D., "The Psychiatric Evaluation of Prison Conditions," unpublished manuscript, p. 8 (copy on file at Human Rights Watch).

[70]The U.S. Department of Justice has emphasized the importance of exercise and exposure to natural light and fresh air to the psychological and physical well-being of inmates confined in segregation. *See* Notice of Findings of Investigation: Maryland Correctional Adjustment Center, May 1, 1996, pp. 3-4, 8 (copy on file at Human Rights Watch).

[71]Federal district Judge Thelton Henderson's description of inmates exercising by walking around the edges of a recreational area at California's Pelican Bay super-maximum security prison is apt for the MCF and the SHU: "The image created is hauntingly similar to that of caged felines pacing in a zoo." *Madrid v. Gomez*, 889 F. Supp. at 1229.

[72]Article 21(1) of the Standard Minimum Rules calls for exercise in the open air: "Any inmate not employed in out of door work shall have at least one hour of suitable exercise in the open air daily if weather permits."

[73]Letter to Lotte Meyerson, coordinator, Northwest Indiana Coalition to Abolish Control Unit Prisons, from Edward L. Cohn, commissioner, Indiana DOC, September 3, 1997.

intercom. The non-contact and shackling rules are enforced regardless of the prisoner's record while at the facility or the reason for his confinement there.

The total absence of physical contact with family and friends clearly exacerbates prisoners' social isolation and emotional hardship.[74] Some prisoners said that they discouraged or even refused visits because the lack of contact made visits emotionally unsatisfying—more painful than comforting—and because they did not want visitors to see them shackled. Prison officials claim the measures are necessary to guard against the introduction of drugs or weapons into the prison. As with so many other supermax features, the non-contact rule exemplifies the preeminence of security concerns over human needs. Given that prisoners may spend years in these facilities, these restrictions are excessive, particularly for inmates who have long periods of incident-free behavior. Imprisonment naturally strains prisoners' ties with their family and friends; it is incumbent upon corrections authorities not stretch these ties to the breaking point.[75]

MCF prisoners are allowed daily visits lasting a maximum of one-and-a-half hours. The visitor must call at least twenty-four hours in advance to schedule the visit and must be on the inmate's approved visiting list, which holds a maximum of fifteen names. SHU inmates are allowed one visit every fourteen days, not counting attorney visits. The visitors must be on their approved visiting list, which holds a maximum of ten names, and they cannot be ex-felons. Visits normally last one hour, but if the visitor had to travel more than a hundred miles to reach the facility then the visit can be extended to two hours.

Prisoners at both facilities have limited access to telephones. Inmates in administrative segregation at the MCF have the most generous telephone privileges: they are allowed unlimited use of the telephone during their recreation period. Disciplinary segregation inmates at the MCF and at the SHU are allowed two calls per month. Such limitations are unduly harsh, particularly for prisoners facing years of segregated confinement, as the telephone is perhaps the principal way inmates can maintain regular contact with their families.

Prisoners' other means of access to life outside the prison walls include radios and restricted quantities of reading material. Some inmates have televisions.[76] The limitations on all of these sources of communication appear

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[74]Visits with family and friends are also impeded by the distance between prison facilities and home communities.

[75]International standards recognize the importance of preserving family relationships. *See* Article 23 of the ICCPR, which states: "The family is the natural and fundamental group unit of society and is entitled to protection by society and the State"; *see also* Article 79 of the Standard Minimum Rules, which states: "Special attention shall be paid to the maintenance and improvement of such relations between a prisoner and his family as are desirable in the best interests of both." Placing particular emphasis on this point, the CPT has explained that:

> It is very important for prisoners to maintain reasonably good contact with the outside world. Above all, a prisoner must be given the means of safeguarding his relationships with his family and close friends. The guiding principle should be the promotion of contact with the outside world; any limitations upon such contact should be based exclusively on security concerns of an appreciable nature or resource considerations.

CPT, "Second General Report," April 1992, p. 14.

The use of restraints during visits can humiliate a prisoner in front of his family. Recognizing this concern, the National Institute of Corrections' *Disruptive Maximum Security Inmate Management Guide* recommends that restraints be removed during visits "for reasons of personal dignity." p. 81.

[76]Inmates at the SHU and the MCF may receive mail, keep a limited number of books and magazines in their cells and can buy radios. Inmates at the SHU with sufficient good behavior records may have televisions in their cells if they can afford to buy them. Administrators at the SHU are considering increasing the availability of television to inmates, aware that it "would greatly increase our ability to bring meaningful, stimulating programming to the offender population [and serve as an] educational, entertainment, and management tool." Undated document prepared by SHU administration, "SHU Programming," p. 4.

to have arisen as much from punitive goals as from security considerations. In the view of Human Rights Watch, such controls are misguided: correctional authorities should encourage and promote as much reading, learning, and exposure to life outside the prison as possible, particularly with inmates in long-term segregation.

Other Sources of Stimulation

Prisoners at the SHU and the MCF spend most of their waking hours in enforced idleness. They have virtually nothing to do all day. The Indiana DOC makes scant effort to provide MCF and SHU prisoners with academic opportunities, provides no activities for the development of vocational skills, no work, and little programming that addresses in a meaningful way the behavioral, social, or educational problems that have contributed to prisoners' criminal and disciplinary records. We have been told, for example, that a high number of inmates in disciplinary segregation are functionally illiterate, but there is no literacy program. In the curious logic of prisons in which education is seen as a privilege, only SHU inmates whose good conduct places them in the A-side have access to GED programs. A contract teacher runs a program to help inmates pass the GED exam; fifty-nine inmates have taken the GED exam out of the 134 inmates who have participated in the program since its initiation in 1994. Enterprising and financially able inmates can arrange correspondence courses through outside colleges. There are no vocational programs; no arts and crafts or hobby materials are permitted except playing cards and, at the MCF, colored pencils. With the exception of eight range workers (janitors) at the SHU, there are no work opportunities at either facility. The behavioral clinician at the MCF offers limited substance abuse and anger management counseling. At the SHU, a therapist offers an anger management course and one in long distance parenting; the courses consist of assignments and meetings on a weekly basis with the therapist at the front of the cell.

The limited access to stimulating and beneficial activities at the MCF and SHU is said to be mandated by security needs—by a concern, for example, that prisoners would fashion weapons from crafts materials, or use time with other inmates to threaten them, or make disruptive plans with cohorts—and the fact that increased staff time that would be required to escort prisoners if the programming occurred out of cells. The lack of activities is also consistent with a punitive rationale that views prisoners in MCF and SHU as having forfeited privileges through their behavior. Prison authorities also want to make sure life at these facilities is sufficiently unpleasant to serve as a deterrent to other offenders.

None of these justifications is persuasive. The security rationale is overbroad. The deterrence justification ignores the fact that a high percentage of inmates who are disruptive are either mentally ill or, at the very least, suffer problems of volitional control over their behavior. The desire to punish because punishment is deserved, carried to an extreme is counterproductive, as well as contrary to norms of decency and respect for basic rights. In our judgment, the Indiana DOC has ignored the wisdom reflected in the Indiana State Constitution injunction to construct penal laws "founded on the principles of reformation, and not of vindictive Justice."[77]

Some super-maximum security facilities in the United States have established significant systems of incentives or rewards for good behavior. Neither the MCF nor the SHU, however, reward the achievement and maintenance of specified conduct with meaningful enhanced program participation and service access. At the MCF there are limited additional privileges conditional on good behavior. Radios are permitted upon entry to the facility, but prisoners may have a television in their cells only after three months of vested time; after six months of vested time the amount of time they may watch the television increases from twelve hours to twenty-four hours a day. At the SHU, any inmate can have a radio; after six months of clear conduct an inmate is allowed to get a television.[78]

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[77]Indiana Constitution, Article IX, § 4.

[78]For the first couple of years after the SHU opened, no radios or television were permitted.

We believe conditions at the MCF and the SHU would improve significantly if the Indiana DOC offered inmates more opportunities for constructive programming and behavioral change. The current regime of minimal programming

> may do more harm than good. It not only tends to increase idleness and resentment . . . but it also fails to get at the causes of disruptive behaviors. [Some correctional practitioners] think that prisoners who 'act out' benefit from learning and experiencing more acceptable forms of conduct. For example, they note the success of programs designed to teach techniques for reducing stress and controlling anger. And they promote counseling and academic education as means of enhancing self-esteem.[79]

In contrast, "the absence of programming results in idleness and boredom, which have been shown to be significantly related to disruptive incidents."[80]

Offering enhanced programming also would further the goal of enabling inmates to develop in such as way as to minimize recurrence of misconduct either when returned to general prison population or released to society. It is difficult to believe that anyone thinks simply caging a person twenty-three hours a day for years meaningfully increases his prospects for leading a responsible law-abiding life. Although the recidivism rates of inmates confined in super-maximum facilities and then released to the street has not been studied, anecdotal evidence abounds that suggests it is a wasted opportunity at best, and at worst it poses serious threats to the public.

VII. SECURITY, FORCE, HARASSMENT, AND ABUSE

As facilities that house the most disruptive and dangerous prisoners within the Indiana prison system, the MCF and the SHU exercise extraordinary control over prisoner's lives. In the limited time prisoners are allowed out of their cells, the practice has been to restrain and escort them. Situations arise in which the use of physical force —including cell extractions, the use of chemical sprays and restraints—is necessary. But the history of the MCF and the SHU also reveal the unnecessary and excessive use of physical force. The class action lawsuit filed against the MCF described chronic physical abuse, including the use of physical restraints as punishment, while a SHU prisoner's recent court papers alleged the unconstitutional use of "physical force, chemical agents, cell extractions, four-point restraints, and tranquilizer injections." Prisoners also described some guards as verbally abusive, indifferent to prisoners' needs, and extremely slow in responding to their legitimate requests.

Staff-Prisoner Relations

Conditions in super-maximum security prisons tend to foster unusually bad relations between prisoners and guards, and are, in the absence of particular vigilance, conducive to custodial abuse.[81]The simple fact that prisoners

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[79]NIC/DOJ, *Disruptive Maximum Security Inmate Management Guide*, p. 69.

[80]Ibid., p. 70.

[81]Allegations of physical abuse are common in litigation involving super-maximum security facilities in other states. Prisoners challenging conditions at Marion federal prison alleged, for example, that "guards frequently beat [them], conduct[ed] the rectal searches in an unnecessarily brutal, painful and humiliating manner, and generally behave[d] as lawlessly as the prisoners." *Bruscino v. Carlson*, 854 F. 2d 162, 166 (7th Cir. 1988). In *Madrid v. Gomez*, the court found pervasive custodial abuse at California's super-maximum security Pelican Bay prison—including incidents of shocking brutality—and appointed a special master to oversee reforms. 889 F. Supp. 1146. *See also* Letter to Parris N. Glendening, Maryland governor, from Deval L. Patrick, assistant attorney general, U.S. Department of Justice, Civil Rights Division, May 1, 1996, p. 10 (in describing unconstitutional conditions at a Maryland super-maximum security prison, stating that investigators had heard numerous allegations "that staff at Supermax are using excessive force against the inmates out of the range of Supermax cameras.").

in such facilities have been labeled the "worst of the worst" encourages correctional officers to view them in a dehumanizing way and to treat them more harshly than is necessary. Contributing to this tendency are the elaborate security precautions taken every time inmates and guards are in contact with each other. When guards escort a prisoner during his out-of-cell movements, the prisoner is placed in physical restraints, including handcuffs, a lead chain, and, often, leg shackles. As one inmate explained it, "When guards only see you in a cage or at the end of a chain, they just can't relate to you as a person."

In contrast with the normal prison setting, where prisoners and guards are physically intermingled and have limited social contact, the two groups are isolated from each other at the MCF and SHU. Guards inside the control rooms have little contact with inmates beyond controlling prisoner movements via electronically controlled doors. Other guards intermittently enter the housing sections to deliver prisoners' food, respond to problems, and escort prisoners to recreation, showers, or visits, but they do not routinely patrol the sections to check in on prisoners. Human Rights Watch noted that guards tended to remain by the control rooms, away from prisoners, when not engaged in specific tasks. Cells do not have intercoms by which prisoners in need of assistance can call guards; instead, to get attention, prisoners must shout and bang on their cell doors. Much of the time, they say, their calls are ignored.

Being protected from physical assault encourages a tendency that both guards and prisoners referred to as "steel door courage." The facilities' high level of security means that guards have little practical incentive to cultivate friendly relations with prisoners or to attempt to defuse hostile encounters with them. (As described above, this tendency is equally true with regard to inter-prisoner relations.) Instead, verbal confrontations are more apt to escalate into physical confrontations, and hostilities become personalized.

Undoubtedly, guards at both facilities have reason to feel provoked, particularly when prisoners throw urine or feces on them. Nonetheless, professional discipline requires that they respond appropriately. Whether in response to prisoner harassment, or, as some prisoners alleged, out of sheer animosity, some officers engage in unprofessional behavior. Human Rights Watch received numerous complaints, mostly from prisoners at the SHU, that guards are vindictive, petty, spiteful, and disrespectful toward prisoners; that they engage in various forms of harassment; and that they try to goad prisoners into confrontations that they then quell using excessive force. Prisoners acknowledged, however, that only a minority of guards—"a select few"—engage in such practices.

Security and Control of Prisoners

Correctional staff inside the MCF and the SHU do not carry firearms or laser gun, a practice consistent with international standards.[82] Sergeants are authorized to use stun devices in emergencies (and at the MCF, a stun shield), but to our knowledge such devices have not been used. Instead, batons and chemical sprays (mace and pepper spray) are relied upon in subduing inmates, and restraints such as handcuffs, leg shackles and four-point restraints are used to keep inmates under control. Neither facility employs restraining chairs or other such devices.

Movement of prisoners outside their cells raises the greatest possibility of threats to the safe and orderly operation of the facilities. Both the MCF and the SHU closely control prisoners whenever they are outside their cells. Prison administrators have decided, however, that the patterns of restraint and control used when the facilities opened can be relaxed somewhat without jeopardizing security. At the MCF, whenever a level 5 prisoner is taken from his cell, he is handcuffed before the cell door is opened (by means of a cuff-port in the door) and is escorted by two guards, one of whom holds a lead strap attached to the inmate, and the other of whom carries a baton. Until recently,

[82]*See* Standard Minimum Rules, Article 54(3) (stating that staff in direct contact with prisoners should not be armed). The facilities do have gas guns (which they keep locked up) that shoot non-lethal wooden blocks. This gun was used once at the SHU in 1994 against an inmate who destroyed his cell property and refused to leave his cell. Human Rights Watch interview, Assistant Superintendent Ron Batchelor, SHU, April 22, 1996.

level 5 inmates also had to wear leg shackles anytime they left their cells. At present, the MCF permits inmates with twelve vested months to move within the confines of their housing unit without leg shackles, unless they have a history of kicking. MCF level 4 inmates are accompanied by one guard, without a baton, instead of two guards.

At the SHU, a prisoner is placed in handcuffs before leaving his cell for a shower or recreation, and is escorted by two guards, one of whom maintains control of the prisoner by means of the lead strap, the other of whom carries a baton. This rule has been relaxed for inmates in the A-side, who are no longer escorted to the showers or recreation but simply released from their cells by guards in the control room who open the automatic cell doors.

At both facilities, the kind and number of security devices employed increases whenever prisoners leave their housing sections, and increases another degree when they leave their pods (for example, for visits or for court appearances). Leg shackles, which restrict the size of inmates' steps, are required whenever prisoners leave their housing sections. Out-of-pod movements require the use of leg shackles, a waist chain, and handcuffs attached to a "black box" that prevents arm movement (this combination of restraints is called "full trip gear").[83]

Describing them as "leashes" or "dog chains," prisoners at both facilities felt that the use of lead chains was humiliating. They also complained that guards sometimes deliberately jerked the lead chains to provoke them, occasionally making them fall.

Use of Force

When a dangerous situation erupts, correctional officers are justified in using proportionate and reasonable force to subdue inmates; indeed, the use of force may at times be required to protect the safety and security of inmates and staff. Indiana DOC policy permits the use of physical force by staff for self-defense, the protection of others, the prevention of self-inflicted injury, the protection of property, the prevention of escape, and for "the enforcement of direct orders for cooperation relating to violations of the disciplinary code."[84] It limits the extent of force that may be used to " the least amount of force necessary to ensure compliance"[85] and expressly prohibits the use of physical force "as a means of reprisal against or punishment of an offender." [86] International standards also mandate that "officers who have recourse to force must use no more than is strictly necessary."[87] These standards for the use of force rule has not always been observed in Indiana's super-maximum security facilities. Indeed, our research indicates that the misuse of force was rampant in the early years of both facilities, but especially so at the MCF.

Our research suggests that the first superintendent of the MCF, Charles Wright, encouraged and condoned the unnecessary and excessive use of physical force. Wright's operating philosophy was one of total control—a zero-tolerance approach to disciplinary infractions or even prisoner attitudes that he or his staff found offensive. Particularly in the first year or so of his tenure, Wright pursued his vision of total control with a single-minded and lawless intensity: beating prisoners into submission on the slightest pretext or provocation. The abuses that took place during the initial years of the MCF under Wright were far more serious and systematic than any that have since occurred at either the MCF or the SHU. For example, in July 1991, one prisoner was reportedly beaten by ten guards

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[83]*See* SHU Offender Handbook (copy on file at Human Rights Watch).

[84]Indiana Department of Corrections, "The Use of Physical Force," Policy No. 02-01-109, *Manual of Policies and Procedures* (effective December 17, 1991), p. 1.

[85]Ibid.

[86]Ibid, section 4.

[87]Standard Minimum Rules, Article 54(1).

as Superintendent Wright looked on.[88] Prisoners confined at the MCF facility during both the tenure of Wright, and that of Herbert Newkirk, the current superintendent who took over in mid-1995, acknowledge a striking change in their treatment by guards. As one prisoner said, "It's not a living nightmare anymore . . . . Newkirk is a professional."[89]

Although not so extreme, elements of the total control regime have been evident at the SHU as well, particularly in its first year. Current SHU administrators acknowledge that when the unit opened, staff took a much harder line with prisoners and guards were quick to use force—a practice condoned by their superiors. In an incident in September 1994 that is not atypical, a prisoner complained to guards that they had mistreated another prisoner, rousing the guards to come to his cell and spray him with tear gas (called OC). After they handcuffed him and took him to the shower to remove the chemicals, the prisoner asked why they had sprayed him—he has asthma and is particularly sensitive to OC. The guards' response was to hit him.[90] In April 1995, a verbal confrontation between one prisoner and a guard escalated when the guard, violating SHU rules, removed the prisoner's handcuffs and scuffled with him. The prisoner reported that the guard said to him, while taking off the handcuffs, "You think you're tough? Let's see how tough you are!" After the prisoner's handcuffs were off, two other officers jumped into the fight, beating the prisoner. The inmate was later found guilty of battery in a disciplinary hearing at which the hearing officer found "mitigating but not exonerating circumstances."[91]

Assistant Superintendent Ron Batchelor told Human Rights Watch that in the year-and-a-half since he took over responsibility for the SHU, he has transferred approximately thirty guards out of the unit "for being cowboys," that is, for being too eager to employ physical force and violence.[92] In contrast, prisoners at the SHU continue to voice complaints about excessively brutal cell extractions and other incidents of violence. Although many long-term SHU inmates state that the level of violence has declined since the facility's first years, they assert, nonetheless, that incidents of abuse by guards continues. They assert, for example, that cell extractions, mace, and pepper spray are still used unnecessarily, often in retaliation for minor infractions such as swearing at the staff, rattling or kicking cell doors, or refusing to shower. One prisoner reported that the was "goon squadded" in May, 1997 while he was in the shower: guards hit him, leaving him "bruised from head to toe" and then took him to a cell that had excrement on the mattress. He was strapped down on it for four hours, and then given a conduct report for refusing to give up his underwear and socks.

Cell Extractions

At the MCF and the SHU, as at every super-maximum security prison, there are times when it is necessary to forcibly remove a prisoner from his cell in a process referred to as a "cell extraction." Both the MCF and the SHU employ "quick response teams" to conduct cell extractions. The core of these teams is made up of at least five correctional officers wearing body armor, helmets with visors, neck supports, and heavy leather gloves. Accompanying them are other correctional staff, including a supervising sergeant, an officer with a video camera who records the extraction, and a medical assistant. Before conducting the extraction, the team holds a briefing in which each member of the five-person core group is assigned a part of the prisoner's body that he or she is responsible for immobilizing: one person is to hold the right arm, another the left, etc. The actual extraction is

[88]Human Rights Watch interview, MCC prisoner, June 25, 1995.

[89]Human Rights Watch interview, MCC, June 27, 1995.

[90]Human Rights Watch interviews, SHU prisoners, April 22, 1996.

[91]Report of disciplinary hearing, May 23, 1995.

[92] Human Rights Watch interview, SHU, July 16, 1997.

usually quick: the cell door opens, the team rushes in and gains control of the inmate, and each member of the team secures the specified body part and places it in restraints.[93]

An expert in the use of force in correctional systems as described the dangers of the process as follows:

> Because officers in a cell extraction are required to remove the inmate against his will, a cell extraction typically constitutes a major application of force, as staff gain control of a prisoner's arms and legs for the purpose of applying handcuffs (and sometimes leg irons). Moreover, because a cell extraction typically requires officers to gain this control in a small, confined space, a cell extraction poses the risk of injury (including potentially serious injury) to both staff and inmates. Given the level of force inherent in the cell extraction process, and the potential risk of injury that is entailed, cell extractions are highly susceptible to potential abuse, including the use of assaultive behavior by staff.[94]

Under DOC policy, cell extractions are appropriate "when harm to staff appears likely to result if other means of force are used or when an offender is violent or uncontrollable and consistently or flagrantly refuses to obey instructions from staff or barricades himself in a cell or other enclosure."[95]

Under former Superintendent Wright's tenure, cell extractions were frequent. Human Rights Watch was told that, by the official count, 579 cell extractions were conducted under the authority of Superintendent Wright.[96] The MCF's cell extraction records show that two or three cell extractions a day were not uncommon; there were also days when as many as eight cell extractions took place.[97] Cell extraction records for the SHU also indicate that in the early years of the SHU's operation, there were at least several extractions a week.[98] In both facilities, it appears that mentally ill prisoners were extracted the most frequently.

Staff at the MCF and the SHU confirmed to Human Rights Watch that in the past cell extractions were regularly undertaken when no force was required or when non-force alternatives had not been exhausted. If a prisoner refused to return his food tray or would not cuff up immediately, even if he was unarmed and not posing an immediate risk of harm to himself or the facility, a cell extraction would be ordered. [99] There was often little proportionality between the circumstances faced by the staff and the amount of force actually employed. Moreover, the cell extractions would be undertaken immediately, without waiting to see if the prisoner would change his mind.

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[93]Human Rights Watch representatives watched videos of cell extractions during our visits to the MCF and the SHU.

[94]Amended and Corrected Declaration of Steve J. Martin, *Madrid v. Gomez*, C-90-3094 the (JSB) (N.D. Ca. Oct. 7, 1993), p. 6

[95]Ibid., pp. 4-5.

[96]Human Rights Watch interview, Mike Scott, administrative head, MCC, June 27, 1995.

[97]Human Rights Watch has on file copies of the physical force reports of the MCF from July 12, 1991 to July 7, 1997.

[98]Human Rights Watch has on file copies of the use of force records for the SHU from January 1, 1994 through July 15, 1997.

[99]Faced with a similar staff justification for cell extractions in the secured housing unit of the super-maximum security facility at Pelican Bay, California, an expert in use of force issues pointed out: Assuming...the meal tray could be turned into a weapon and therefore had to be retrieved, the amount of force needed to effect this security interest is simply that needed to secure the meal tray itself." Amended and Corrected Declaration of Steve J. Martin, *Madrid v. Gomez*, p.13

Indeed, they would be carried out even if the prisoner finally agreed to comply. As one MCF administrator stated, "The mentality was that once guards 'suited up' for an extraction, it was too late to stop it."[100]

Numerous reports by prisoners have convinced us that cell extractions at the MCF under Superintendent Wright became an end in themselves. They were not undertaken as a judicious use of force calculated as necessary to protect an important security interest. Rather, they were imposed as punishment on inmates simply for refusing to obey an order, regardless of what the order might have been.

Instead of being conducted using the least possible force, cell extractions and other confrontations were often unnecessarily brutal. We have received numerous complaints by prisoners that guards used the occasion of cell extractions to deliberately hit, kick and even beat them under cover of trying to "secure" the prisoner. Moreover, anyone who was extracted was automatically placed in full restraints, even if the person posed no risk to himself or others. The MCF's use of force records indicate that prisoners who were cell extracted were frequently kept in restraints for a minimum of four hours. Prisoners also reported to us that many were placed in strip cells as additional punishment following an extraction.

In the past two years, the number of cell extractions at the MCF has dropped markedly. A review of the MCF's use of force records indicates that weeks have gone by during this period without cell extractions. The reduced number of cell extractions does not reflect a change in the behavior of prisoners confined at the facility. Rather, it reflects policy changes by the facility's administrators. The MCF was forced to institute those changes by the Agreed Entry ending the class action lawsuit against the MCC. Under its terms, cell extractions can only be undertaken after the prisoner had been given several opportunities to submit to being handcuffed. More important than the settlement terms, however, was a change of prison administration. When Herbert Newkirk replaced Charles Wright as superintendent, he brought with him a more reasonable approach to cell extractions.

Newkirk goes to considerable lengths to avoid cell extractions, conducting them only when unavoidable.[101] Under Newkirk, guards and supervisory personnel are instructed to try to talk the prisoner into compliance and to give him time (assuming there is no imminent security threat) to calm down. Until the last minute, even when the extraction team is standing at the cell door, the prisoner is given the opportunity to comply.[102]

Cell extractions at the SHU, while they are more frequent than at the MCF, are not nearly at the levels of the early MCC. Many of the inmates we interviewed at the SHU explained that they have never been extracted because they are careful to avoid getting into such a situation. They said it is the "hotheads"—younger prisoners—and the mentally ill who are extracted most frequently. The facility's use of force records indicate the cell extractions in 1996 and 1997 occur less frequently than in prior years. But they also indicate that the overwhelming preponderance of cell extractions involve individuals who are severely mentally ill. Indeed, the mentally ill prisoners noted above in this report appear with extraordinary frequency among the names of those subjected to cell extractions.

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[100]Human Rights Watch interview, Mike Scott, administrative head, MCC, June 27, 1995.

[101]He pointed out that to the extent they are used, cell extractions are more common in the DSU pods. Those pods house a higher proportion of younger prisoners, who tend to have greater difficulty acclimating to the MCF environment. Human Rights Watch interview, July 15, 1997.

[102]Charles Fenton, a U.S. prisons expert and former warden of Marion penitentiary, has expressly recommended such an approach. In his view, "While there is a reasonable possibility of avoiding the extraction without undue exertions, staff should talk to the inmate, be that for a period of six minutes or six hours." Declaration of Charles E. Fenton, *Madrid v. Gomez*, Case No. C-90-3094 THE (JSB) (N.D. Ca., Sept. 27, 1993).

Some prisoners at the SHU complained to Human Rights Watch that guards are unnecessarily violent during cell extractions. SHU officials denied the misuse of force during cell extractions. They pointed out that extractions are videotaped from the moment the team is called together, through the removal of the prisoner from his cell and his placement in another cell, until the team is debriefed before dispersing. Abuse, they say, would show up on the video. But prisoners claim not everything is captured on video. There were gaps in the tape in two of the three videos reviewed by HRW during visits to the SHU and the MCF.

Four-Point Restraints

The beds of some SHU and MCF cells are equipped with leather restraints that are used to immobilize prisoners by strapping and holding secure their arms and legs. The Indiana DOC policy on the use of physical force includes a section on restraints that permitted their use in an unduly wide range of circumstances, e.g., "if the history, present behavior, or emotional state of an offender indicates that bodily injury, property damage or escape might occur." [103] Under the terms of the Agreed Entry—which only covers administrative segregation prisoners at the MCF—four-point restraints may only be used if an offender presents himself as an imminent threat of inflicting serious harm to himself or others by assaulting a person, engaging in significant destruction of property, attempting suicide, inflicting wounds upon himself, or displaying other signs of imminent violence." Inmates may be placed in four-point restraints for up to four hours, but the period can be renewed. Restrained inmates must be checked at least three times an hour and allowed up attend to physical needs for fifteen minutes every four hours. Indiana DOC policies are also explicitly preclude the use of leather restraints "as a form of punishment . . . Leather restraints to control a prisoner in his cell shall be used only as long as necessary to control the prisoner."[104]

International law does not prohibit four-point restraints but limits their use to the control of prisoners who are a danger to themselves or others, and then only for so long as is "strictly necessary."[105] The use of restraints as punishment is expressly forbidden. Correctional standards contain the same principles: the American Correctional Association cautions that four-point restraints "should be used only in extreme instances and only when other types of restraints have proven to be ineffective." [106]

The standards governing use of restraints were not followed in the early years of the MCF. Under former Superintendent Wright, MCF prisoners were regularly placed in four-point restraints following cell extractions. The MCF's use of force records suggest that between July 1991 and October 1992, prisoners were never kept in restraints for less than four hours.[107] In the following years, until the end of Superintendent Wright's tenure, restraints continued to be used routinely following all cell extractions, but the amount of time prisoners were recorded as having been restrained ranged for the most part between one and four hours. Some prisoners were restrained as long

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[103] Indiana DOC, "Use of Physical Force" sec.7.

[104] Ibid.

[105] *See* Standard Minimum Rules, Article 33: "Instruments of restraint . . . shall not be used except in the following circumstances: as a precaution against escape . . . on medical grounds . . . by order of the director, if other methods of control fail, in order to prevent a prisoners from injuring himself or others or from damaging property." Article 34 specifies that "Such instruments must not be applied for any longer than is strictly necessary." For a review of the standards of medical, corrections and other associations regarding the use of restraints, see Physicians for Human Rights, *Cruel and Inhuman Treatment: The Use of Four-Point Restraint in the Onondaga County Public Safety Building, Syracuse, New York* (Boston: Physicians for Human Right, May 1993).

[106] American Correctional Association, *1996 Standards Supplement* (Lanham, MD: American Correctional Association, 1996), p.88.

[107] In some cases, the records do not note the amount of time in restraints.

as seven and eight hours. The routine use of restraints for a minimum of several hours is consistent with prisoner assertions to us that they were restrained as punishment, not because they posed danger to themselves or others for that period of time.

One MCF prisoner, Paul Komyatti, was held in four-point restraints for a total of fifteen days (five days, then a six-day break, then ten more days) in June 1992. Although this incident occurred when he was transferred to the infirmary of the Westville Correctional Center toward the end of a long hunger strike, it was former Superintendent Wright who gave the order for restraints.[108]

Komyatti filed a *pro se* challenge to this abusive treatment in federal court, which he won. As the judge said in his decision, "Nothing in the record indicates that Mr. Komyatti was restrained pursuant to a health professional's appropriate exercise of judgment," nor does it "permit the inference that exigent circumstances justified the initial use of four-way restraints in this action, let alone restraining Mr. Komyatti for five and ten days at a stretch."[109]

Under the current superintendent of the MCF, four-point restraints are used very infrequently, and then only for very limited periods of time. The MCF's use of force records indicate the prisoners who are cell extracted are not routinely placed in restraints. The records also indicate that prisoners who have been restrained are usually released relatively quickly, e.g., within half an hour.

Prisoners have also claimed that four-point restraints have been used abusively at the SHU. The SHU's use of force records indicates the frequent use of leather restraints but do not specify the total amount of time each prisoner was kept in restraints. Data included in the records suggests, however, that some prisoners—including many who are mentally ill—have been kept in restraints for periods ranging from eight hours up to one and three days. A few mentally ill prisoners have apparently been kept in restraints for even longer.

Prisoners report recent incidents suggesting restraints might have been used as punishment, or that for purposes of punishment prisoners were kept in restraints longer than necessary. For example, one prisoner reported to us that in June 1997, he had an altercation with a guard and that later in the day he spit on the guard. He was placed in restraints for four hours.[110]

Prisoners reported to Human Rights Watch that the SHU's psychiatrist frequently ordered them placed in restraints. The psychiatrist confirmed that he sometimes restrained prisoners, but he insisted it was always for medical purposes, and not as punishment.[111] He explained that he faced a situation at the SHU of dozens of inmates who needed medication but refused to take it, either because they denied being ill or because they are unwilling to accept the medication's side effects. When these prisoners became particularly disruptive or began to act in ways that suggested they posed a danger to themselves or staff, rather than following procedures for involuntary medication,[112] he would "encourage" them to take medication. This "encouragement" could amount to coercion.

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[108]Komyatti also said that the guards prepared food and ate in front of him during his hunger strike, after he had gone without food for thirty-four days. Human Rights Watch interview, MCC, June 26, 1995.

[109]*Komyatti v. Wright*, No. 3:93-CV-0687RM (N.D. Ind. Apr. 14, 1995) (memorandum opinion), pp. 10-11.

[110]Human Rights Watch interview, July 16, 1997.

[111]Human Rights Watch interview, July 16, 1997.

[112]New procedures governing the involuntary administration of medication were established under Executive Directive No. 97-22, dated May 16, 1997. The procedures call for a due process hearing prior to involuntary medication except in emergency situations.

It included restricting prisoner privileges, such as by placing them on bag lunches, threatening to house them in isolated ranges and placing inmates in four-point restraints, sometimes for long periods.

One prisoner reported to Human Rights Watch an incident in which he had been kicking his cell door in anger at a guard and the psychiatrist, who happened to be nearby, threatened to place him in four-point restraints. When the inmate responded with an obscenity, the psychiatrist made good on his threat and the prisoner was placed in restraints for twenty-four hours. According to the prisoner, every four hours, he was asked if he would be willing to take a shot of anti-psychotic medication.[113] Such reliance on restraints for reasons of coercion—to punish inmates for refusing to accept medication—is inconsistent with international rules restricting their use.

The psychiatrist also ordered mentally ill inmates who were on medication to be placed in restraints when he deemed it necessary in their best interests. In one particularly extreme case, he kept an actively psychotic, very depressed, self-mutilating inmate in restraints for over a month, progressively reducing the time in restraints as the prisoner's behavior improved. In our judgment, such an extended use of four-point restraints is a cruel and medically unacceptable practice. If a prisoner is severely ill and disruptive enough to require extensive placement in restraints, he should be placed in a hospital or other more therapeutic setting than a super-maximum security cell.[114]

Racial Harassment

Prisons are a fertile breeding ground for racial tension and animosity, with racial problems occurring both among prisoners and between prisoners and corrections staff. Prisoners at the SHU—though not the MCF—spoke convincingly of the facility's atmosphere of racial hostility. Numerous prisoners, most of them African-American but some of them white, claimed that SHU guards were often particularly aggressive and disrespectful toward black prisoners.[115]

Mirroring the racial makeup of rural southern Indiana, the great majority of correctional officers who work at the SHU are white. Outside of the prison setting they have had little exposure to urban African-Americans, a group that figures large in the prison population. At the MCF, in contrast, the corrections staff is much more racially diverse, with an African-American superintendent and a substantial number of African-American guards.

Racial harassment by SHU guards was said to take the form of slurs and confrontations. Several prisoners said that the epithet "nigger" was frequently used by certain guards. Another prisoner spoke of a recent incident where he was told that "all blacks look alike." During Human Rights Watch's 1996 visit to the facility, prisoners alleged that one guard had a swastika tattooed on his arm.

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[113]Human Rights Watch interview, July 16, 1997.

[114]*See, for example*, National Commission on Correctional Health Care (NCCHC), *Standards for Health Services in Prisons* ("Generally, an order for therapeutic restraint . . . should not exceed 12 hours"); Report of the Task Force on Psychiatric Services in Jails and Prisons, American Psychiatric Association, "Psychiatric Services in Jails and Prisons, Task Force Report No. 29, March 1989; K. Tardiff, *The Psychiatric Uses of Seclusion and Restraint* (Washington, D.C.: American Psychiatric Association, 1984) (stating that all other intervention possibilities should be exhausted prior to resorting to any form of restraint, and that lengthy confinement in seclusion without constant monitoring and therapeutic conversation is not permissible); Nancy Heveloff Dubler, ed., Standards for Health Services in Correctional Institutions (Washington, D.C.: American Public Health Association, ed., 1986), pp. 41-42 ("if after four hours in restraints the inmate remains in a highly agitated state . . . the staff should arrange for removal of the inmate to the hospital").

[115]Some white prisoners, however, insisted that the guards had a disrespectful attitude toward all prisoners—what black prisoners called racism, they called equal treatment. In their view, references to race were simply another weapon in the guards' arsenal of insults. Human Rights Watch interviews, SHU, July 16-17, 1997.

The racial tensions aggravating relations between prisoners and guards at the SHU are only a subset of a larger racial problem. Some white prisoners at the SHU are self-proclaimed white supremacists—indeed, at least one of them was incarcerated for a violent hate crime—while some black prisoners have black nationalist leanings; the two groups interact poorly. Prisoners claimed that guards sometimes try to perpetuate racial animosities by, for example, deliberately placing a black prisoner in a cell between two known white supremacists.

The way in which prisoner racism and guard harassment can intersect was demonstrated by a situation that Human Rights Watch representatives witnessed during our July 1997 visit to the SHU. Walking through a housing section in the B-East pod, we were startled to find an African-American prisoner in a cell covered with racist graffiti. Among the cell's more prominent markings was the slogan "White Power," which was scrawled on the wall in thick, four-foot-high black letters and interrupted by a large swastika; the phrase "fuck all niggers" scratched into the mirror, and an intricate drawing of a hooded Klansman poised over the bed. The prisoner stated that he had been transferred to the cell, which had been defaced by a prior occupant, six days previously in the wake of conflict with a guard.

When questioned as to why a black prisoner was forced to spend over twenty-three hours a day in a cell where he had little to do but contemplate racially offensive symbols and slogans, corrections officers said that the prisoner had been placed there purely out of space considerations: they needed a lexan-covered cell and none other was available. They first stated that a work order was on file requesting that the cell be painted, but then said that because the housing area was already due for general renovations the work order had not in fact been filed. When asked about the urgency of rectifying the situation, they stated that because it did not raise security concerns, it was "not a priority."[116]

Even if, as correctional staff insisted, this situation was not the product of deliberate and conscious racism, it demonstrated extraordinary insensitivity. Particularly given the racially polarized atmosphere evident at the SHU, guards should take pains to alleviate racial tensions, rather than exacerbate them. Although we were told that guards take a racial sensitivity class called "Shades of Grey" as part of their annual training,[117] it is obvious that more needs to be done.

Preventing Abuse

Patterns of excessive and unnecessary use of force reflect either toleration by prison administrators or an unwillingness or inability to property supervise and discipline staff. In the unusually fraught environment of super-maximum security prisons, firm guidance from prison authorities is particularly crucial "Environments in which one group of people is given near total control over another invariably degenerate into places pervaded by mistreatment and abuse," unless conscious steps are taken to prevent such abuse.[118] Preventive measures include intensive staff training, meaningful disciplinary sanctions for abusive staff, and—perhaps most importantly—strong leadership that sends the message that abuse will not be tolerated and that disciplinary sanctions will be applied.

The history of the MCF and SHU exemplifies the importance of adequate supervision and monitoring of the use of force. In both facilities, changed policies and approaches by management resulted in dramatic reduction in the use of force—and diminished, although by no means extinguished—complaints of abuse. It is worth underscoring as well that the experience of these facilities gives lie to the belief that "the worst of the worst" respond

[116]Human Rights Watch interview, two correctional officers, July 17, 1997.

[117]Human Rights Watch interview, Craig Hanks, superintendent, SHU, July 17, 1997.

[118]Declaration of Craig Haney, Ph.D., *Madrid v. Gomez,* C-90-3094 THE (N.D. Ca. Sept. 14, 1993), para. 29 (hereinafter "Haney declaration").

only to heavy-handed force. The dramatic decrease in forcible cell extractions and other incidents of force has not not resulted in increased incidents of violence or breaches of security by inmates.

VIII. PSYCHOLOGICAL IMPACT OF CONDITIONS

Concern about the psychological impact of solitary confinement has persisted as long as the practice. That concern has increased in the United States with the proliferation of super-maximum security prisons in which inmates can be held for years in administrative or disciplinary segregation. There is little doubt that prolonged confinement in conditions of social isolation, idleness and reduced stimulation is psychologically destructive. How destructive depends on each inmate's prior psychological strengths and weaknesses, the extent of the social isolation imposed and absence of activities and stimulation, and the duration of confinement in those conditions. For individuals with preexisting psychological disorders, it can be devastating. Under international human rights standards, the question arises whether the imposition of mental harm through conditions of segregated confinement constitutes torture or other cruel, inhuman or degrading treatment.

For many inmates at the MCC and the SHU, confinement in isolation is not a new experience. They have been confined in disciplinary segregation at their "home" institutions; some have been at the SHU or MCC before. Some told Human Rights Watch that they "know how to handle it" and insisted "it's no big deal." "Doing time is doing time." They manage to pass the time: they read—a few become avid students of particular subjects, play solitary chess games with handmade paper chess pieces, do legal research and prepare legal documents, write letters, sleep. A few prisoners told us they preferred the security and relative comfort of the restricted environments at the MCF and even the SHU to the bedlam and dangers of general population facilities and to what they claimed were appalling conditions in the disciplinary segregation units at their home institutions. Superintendent Newkirk told Human Rights Watch representatives that at least one prisoner at the MCF is so determined to stay there that he deliberately engages in disciplinary infractions every time his conduct record might otherwise require him to be transferred out. Some inmates, particularly those aided by their strong religious faith or staunch political convictions, impressed us with their strength of character and their apparent ability to continue to develop as human beings despite years of confinement in extreme conditions. Our interviews were too short, however, to ascertain what psychological and emotional scars they may also carry from the experience.

But given the opportunity to describe the experience of the MCF or SHU, most prisoners paint a stark picture of bleak lives, of useless tedium and tension. "Few people can take this type of isolation. I'm suffering, but I can deal with it." The MCF is "a tomb." "There's no way you can know what it's like for us in here." "I rarely write [to my family] . . . not much to talk about. I'm not part of the world." "I have even seem some [inmates] lose their grip on sanity due to the conditions here and due to treatment by staff . . . [T]he goal seem to be . . . to dehumanize and derange all men who encounter the SHU." The place is "psychological torture"that is "made worse by not being able to see trees or grass or birds."[119] True to the prison culture of not acknowledging weakness,[120] many prisoners we interviewed denied confinement was affecting them psychologically. But one acknowledged vicious mood swings and crying spells as a result of the isolation. Another insisted he was introverted so the isolation did not affect him much. They described feelings of anger and frustration.[121] One inmate claimed he could not tolerate the conditions

[119]Human Rights Watch interview, July 14-17, 1997.

[120]"As a rule, prisoners struggle to conceal weakness, to minimize admissions of psychic damage or pain. It is part of a prisoner ethic in which preserving dignity and autonomy, and minimizing vulnerability, is highly valued." Declaration of Craig Haney, Ph.D., *Coleman v. Wilson*, CIV S 90-0520 LKK-JFM (E.D. Ca.), para. 46.

[121]Psychologists have emphasized that the deprivations and restrictions of super-maximum security confinement can fill prisoners "with intolerable levels of frustration. Combined with the complete absence of activity or meaningful outlets

at the SHU: since he had arrived there his "whole world fell apart" and as a result he acts out by attacking the guards. The SHU, he claimed, "breeds monsters." Some inmates expressed concern that the experience of prolonged solitary confinement would make it harder for them to adjust to general-population imprisonment or life outside of prison.[122]

By its very nature, all "prison confinement may have a deleterious impact on the mental state of prisoners . . . Especially for those facing long sentences, 'depression, hopelessness, frustration, and other such psychological states may well prove to be inevitable byproducts.'"[123] But prolonged confinement in conditions such as those at the MCF and the SHU can have an adverse psychological impact far greater than the usual psychological effects of incarceration.[124] The literature on the effects of punitive isolation clearly establishes its potentially damaging consequences.[125]

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has reviewed a number of European prisons with conditions similar to those of supermax confinement in the U.S.[126] In these reviews it has affirmed that isolation can militate against reform and rehabilitation and can impair physical and mental health. According to the CPT, "It is generally acknowledged that all forms of solitary confinement without appropriate mental and physical stimulation are likely, in the long term, to have damaging effects resulting in deterioration of mental faculties and social abilities." [127] The CPT has criticized isolation units in which for extended periods of time inmates' activities consisted of spending time alone in their cells with little to occupy them and one hour of outdoor exercise each day.[128] It has insisted that solitary confinement be as short as possible[129], and it has emphasized the importance of activities in special security units to "counter the deleterious

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through which they can vent this frustration, it can lead to outright anger and then to rage. This rage is a reaction against, not a justification for, their oppressive confinement." Ibid.

[122]Numerous prisoners confined in the secured housing unit of California's super-maximum security prison at Pelican Bay expressed similar concerns during extensive interviews with psychologists. *See, for example*, Haney declaration.

[123]*Madrid v. Gomez*, 889 F. Supp. at 1262 (citations omitted).

[124]Concern about the psychological impact of rigid solitary confinement in U.S. penitentiaries in the nineteenth century contributed to changed regimes. Charles Dickens, who toured the United States in 1842, described conditions in the Philadelphia prison: "The system here is rigid, strict and hopeless solitary confinement . . . [The prisoner] is a man buried alive . . . dead to everything but torturing anxieties and horrible despair." Quoted in P. Liederman, "Man Alone: Sensory Deprivation and Behavior Change," *Correctional Psychiatry and Journal of Social Therapy* 8 (1962), p. 66.

[125]As one expert stated, "I know of no credible expert on corrections, human behavior in institutional settings, or psychiatry or psychology in general who would argue that confinement in [segregated solitary confinement] does not pose any significant psychological and psychiatric risks for prisoners." Haney declaration, para. 73.

[126]CPT, "Report to the Norwegian Government on the visit to Norway carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 27 June to 6 July 1993," Strasbourg, France, 21 September 1994, CPT/Inf (94).

[127]CPT, "Report to the Finnish Government on the visit to Finland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 10 to 20 May 1992," Strasbourg, France, 1 April 1993, CPT/Inf (93) 8.

[128]Ibid.

[129]CPT, "Report to the Swedish Government on the visit to Sweden carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 23 to 26 August 1994," CPT/Inf (95) 5.

effects for a prisoner's personality of living in the bubble-life atmosphere of such a unit." It has reminded European governments, "The principle of proportionality calls for a balance to be struck between the requirement of the situation and the imposition of a solitary confinement-type regime, which can have very harmful consequences for the person concerned. Solitary confinement can in certain circumstances amount to inhuman and degrading treatment; in any event, all forms of solitary confinement should last for as short a time as possible."[130]

In the United States, the psychological impact of prolonged confinement in conditions akin to those at the MCF and the SHU has been a focus of several lawsuits.[131] In the landmark case of *Madrid v. Gomez*, plaintiffs asserted, among other things, that conditions in the secured housing unit of California's super-maximum security prison at Pelican Bay caused such psychological harm as to violate the Eighth Amendment of the U.S constitution. Federal Judge Thelton Henderson concluded that the evidence before him proved that prolonged confinement in such conditions at best "may press the outer bounds of what most humans can psychologically tolerate."[132] At worst, the conditions have a high risk of provoking or exacerbating serious mental illness. "Although not everyone will manifest negative psychological effects to the same degree, and it is difficult to specify the point in time at which the destructive consequences will manifest themselves, few [long-term supermax inmates] escape unscathed . . . The psychological consequences of living in these units for long periods of time are predictably destructive, and the potential for these psychic stressors to precipitate various forms of psychopathology is clear-cut."[133]

Interviews of inmates at Pelican Bay's SHU documented the psychopathological effects of long-term segregation: the SHU prisoners possessed extraordinarily high rates of symptoms of psychopathology. The psychologist who conducted the study concluded that the SHU "was inflicting unprecedented levels of psychological trauma on the prisoners . . . and it is producing precisely the kinds of psychopathological effects that have been associated elsewhere with extreme and harmful levels of social deprivation."[134] The psychologist concluded that the SHU produced such extremely painful psychological consequences that it could be likened to "psychological torture."[135]

Dr. Stuart Grassian, a psychiatrist who has evaluated the psychological impact of several supermaximum security prisons, has identified a number of psychiatric symptoms frequently observed in prisoners confined in such facilities. His research has led him to conclude that solitary confinement can cause such symptoms as perceptual distortions and hallucinations, massive free-floating anxiety, acute confusional states, delusional ideas and violent or self-destructive outbursts, hyperresonsivility to external stimuli, difficulties with thinking, concentration and

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[130]CPT, "Report to the Icelandic Government on the visit to Iceland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 6 to 12 July 1993, Strasbourg, France, 28 June 1994, CPT/Inf (94) 8, p. 26. In reviewing the practice of solitary confinement in one of Iceland's prisons, the CPT notes that a report by the country's minister of justice states that "psychiatrists, psychologists and other specialists have stressed that solitary confinement as practiced [at the prison] has a harmful effect on prisoners' mental and physical health, particularly in the case of those detained for long periods."

[131]*See, for example, Eng. v. Coughlin,* 865 F. 2d 521 (2d. Cir. 1989); *Coleman v. Wilson,* 101 F.3d 705 (9th Cir. 1996); *Torres v. Dubois,* Civil Action No. 94-0270E (filed 1995), *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

[132]*Madrid v. Gomez*, 889 F. Supp. at 1267.

[133]Haney declaration, p. 5.

[134]Ibid., para. 55.

[135]Ibid., para. 118.

memory, overt paranoia, and panic attacks.[136] The conditions of confinement seem to cause symptoms that are usually associated with psychosis or severe affective disorders even though not all of the prisoners who exhibit these symptoms are actively psychotic. The clinical symptoms can be provoked even in healthy personalities, but prisoners who enter solitary confinement with pre-existing psychiatric disorders are at an even higher risk of suffering psychological deterioration and psychiatric decompensation.

A variety of individuals are especially prone to psychopathologic reactions to the reduced environmental stimulation and social isolation of supermax confinement. Professor Hans Toch's study of prison inmates led him to conclude, for example, that suicidal inmates can be pushed over the edge and pathologically fearful inmates can regress into a psychologically crippling panic reaction.[137] According to Dr. Grassian, "individuals whose internal emotional life is chaotic and impulse-ridden, and individuals with central nervous system dysfunction" are particularly unable to handle supermax conditions, yet among the prison population, these are the very individuals especially prone to committing infractions that result in segregation.[138] Even the expert in prison mental health care retained by the California Department of Corrections for the *Madrid v. Gomez* litigation acknowledged that some people cannot tolerate supermax conditions. "Typically, those are people who have a pre-existing disorder that is called borderline personality disorder, and there—there's a fair amount of consistent observation that those folks, when they'[re locked up in segregation] may have a tendency to experience some transient psychoses, which means just a brief psychosis that quickly resolves itself *when they're removed from the lockdown [segregation] situation.*"[139] Indeed, individuals with psychopathetic personality disorder are, by virtue of their condition, particularly unable to tolerate restricted environmental stimulation.[140]

Mental health experts also agree that individuals with histories of psychiatric illness are particularly vulnerable to increased mental suffering and injury from confinement in supermaximum security conditions. Based on his evaluation of the psychological effects of solitary confinement, Dr. Grassian has concluded that incarceration in supermax conditions can cause "either severe exacerbation or recurrence of pre-existing [mental] illness."[141] Another expert on the impact of super-maximum security confinement, Prof. Craig Haney, has concluded:

> [P]risoners who enter these places with *pre-existing* psychiatric disorders suffer more acutely from [the] psychological assaults [of solitary confinement]. The psychic pain and vulnerability that they bring into the lockup unit may grow and fester if it goes unattended. In the absence of psychiatric help, there is nothing to keep many of these prisoners from entering the abyss of psychosis . . . . [For mentally ill prisoners to be] confined in a lockup unit that inflicts levels of social deprivation, virtually complete enforced idleness, totality of surveillance and control, and an absence of

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[136]Human Rights Watch interview, Dr. Stuart Grassian, Newton, Massachusetts, June 19, 1997.

[137]Fred Cohen, *Legal Issues and the Mentally Disordered Prisoner* (Washington, D.C.: NIC/DOJ, November, 1988), p. 92. *See also* Hans Toch, *Men in Crisis: Human Breakdown in Prison* (1975).

[138]Declaration of Dr. Stuart Grassian, *Eng v. Coughlin* (80-CV-385S, undated) (hereinafter "Grassian declaration").

[139]Testimony of Joel Dvoskin, quoted in *Madrid v. Gomez*, 889 F. Supp. at 1216 (emphasis added by the court).

[140]Grassian declaration, citing H. Quay, "Psychopathic personality as pathological stimulation seeking," *American Journal of Psychiatry* 122 (1965), pp. 80-83.

[141]Grassian declaration, p. 7.

> meaningful psychiatric treatment . . . poses very serious risks of psychological deterioration and psychiatric decompensation.[142]

Many mentally ill prisoners suffer from "a combination of psychiatric disorders predisposing them to both psychotic breakdown and to extreme impulsivity . . . [S]uch individuals [tend] to be highly impulsive, lacking in internal controls, and [tend] to engage in self-abusive and self-destructive behavior in the prison setting, and especially so when housed in solitary . . . . [T]hey are among the most likely to suffer behavioral deterioration" in supermax confinement.[143]

In *Madrid v. Gomez*, a federal district court ruled that it constituted cruel and unusual punishment in violation of the U.S. constitution to confine in the secured housing unit (SHU) of Pelican Bay prison

> those who the record demonstrates are at a particularly high risk for suffering very serious or severe injury to their mental health, including overt paranoia, psychotic breaks with reality, or massive exacerbations of existing mental illness as a result of the conditions in the SHU. Such inmates consist of the already mentally ill, as well as persons with borderline personality disorders, brain damage or mental retardation, impulse-ridden personalities or a history of prior psychiatric problems of chronic depression . . . . Such inmates are not required to endure the horrific suffering of a serious mental illness or major exacerbation of an existing mental illness before obtaining relief . . . [S]ubjecting individuals to conditions that are 'very likely' to render them psychotic or otherwise inflict a serious mental illness or seriously exacerbate an existing mental illness cannot be squared with evolving standards of humanity or decency . . . A risk this grave—this shocking and indecent—simply has no place in civilized society.[144]

Summarizing his findings, Judge Thelton Henderson trenchantly observed that placing mentally ill or psychologically vulnerable people in such conditions "is the mental equivalent of putting an asthmatic in a place with little air to breathe."[145] Just as individuals who are prone to severe psychiatric disorders are more likely than the average person to break down in an environment of sensory deprivation, so a person who has a tendency to confuse fantasy and reality, or to regress when stressed or traumatized, or to lose the sense of time in a relatively unstructured situation, is more prone than the average person to break down when placed in an environmental as stressful as a super-maximum security unit.

Solitary confinement cells are "grossly inappropriate for the mentally ill" because of the need severely disturbed people have for supportive relationships and meaningful, productive activities.[146] For example, mental health practitioners carefully structure each day in residential treatment facilities to ensure that patients do not stay in bed too long or are too idle and that treatment plans include intensive interpersonal interactions (individual and

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[142]Haney declaration, para. 56.

[143]Grassian declaration, citing G. Cota & S. Hodgins, "Co-occurring mental disorders among criminal offenders," *Bulletin of the American Academy of Psychiatry and Law* 18, no. 3, pp. 271-81.

[144]*Madrid v. Gomez*, 889 F. Supp. at 1265-66 (citations omitted).

[145]Ibid. at 1265. Another one federal court had earlier explained, "[E]xperts concurred that the use of isolation for disturbed inmates violates all modern treatment practice and is potentially destructive and physically dangerous. Disturbed persons need at a minimum to be observed and not to feel isolated and abandoned. Isolation is counterproductive in terms of treatment." *Laaman v. Helgemoe*, 437 F. Supp. 269, 280 (D.N.H. 1977).

[146]Edward Kaufman, M.D., "The Violation of Psychiatric Standards of Care in Prisons," *American Journal of Psychiatry* 137, no. 5 (May 1980), p. 567.

group psychotherapy, meetings to discuss activities, and so forth) as well as vocational training, supervised athletic or arts and crafts. A large amount of empirical research demonstrates that the longer an acutely mentally disordered individual remains acutely disturbed, the worse the prognosis. Rapid and intensive treatment of acute psychiatric disorders offers the best chance for rapid recovery and serves to minimize long-term symptomatology and disability.

The problem of mental breakdown and disability in super-maximum security units is thus two-fold: First, the conditions of confinement tend to exacerbate pre-existing psychiatric disorders to cause decompensation in individuals who are psychologically vulnerable under duress. Second, with continued confinement in these same conditions—particularly in the absence of meaningful psychiatric services—the afflicted prisoner's condition tends to deteriorate even further, and the long-term prognosis worsens.

As noted above, our team's psychiatrists in July 1997 identified many prisoners, particularly at the SHU, who were suffering from serious mental disorders with a range of psychiatric symptoms. It appears that most of them had previous histories of mental disorder prior to super-maximum security confinement. That is, we cannot say that confinement at the MCF or the SHU caused them to become mentally ill. But their condition was exacerbated by confinement at the MCF and SHU. For example, one psychotic inmate at the SHU interviewed by our team's psychiatrists has acute panic attacks in solitary confinement that he relieves by self-mutilation. He insisted to us that the opportunity to be taken out of his cell for medical attention, even if only temporarily, was worth the pain.

Some of the mentally ill inmates are well aware of the risks to their sanity from supermax confinement. One actively psychotic prisoner described the effect of being at the SHU in the following terms: "The walls close in on you, it really scares me. You really can't sleep at night, for weeks at a time, and then you sleep all the time for another two weeks—you can't really tell whether it's day or night. Then you get paranoid, and angry." Another inmate plagued with hallucinations told us the SHU made him "violent and confused." Another, who is delusional and schizophrenic, told us: "You have angry thoughts. They won't leave your mind. You want to get back at someone who's hurt you. On the outside, you can walk away and find your composure. Here you can't walk away or hide."[147]

Disciplinary Infractions by the Mentally Ill

Mentally ill people often have difficulty complying with rules, especially in prison settings where the rules are very restrictive, the stresses intense, and there is scant assistance to help the prisoners' manage their disorders. Those whose psychiatric disorders are reflected in aggressive or disruptive behavior can accumulate long histories of disciplinary infractions that land them in administrative segregation or disciplinary detention. Once confined at the MCF or the SHU, the infractions continue. We reviewed official disciplinary records for a number of the actively psychotic prisoners at the SHU whom we interviewed in July 1997. We found, for example, histories of sixty-nine disciplinary "write-ups" in two years at the SHU; ten in two months; forty-eight in two years; thirty-nine in seventeen months. The records we reviewed suggest that mentally ill inmates are most frequently charged with self-mutilation, refusing orders, making threats, throwing urine and feces, assault, battery, disorderly conduct, physically resisting a staff member, destruction of state property, and insolence and vulgarity.

In some cases, it appears the rate of infractions increases once a mentally ill prisoner is transferred to the SHU. For example, one prisoner accumulated a total of thirty-eight conduct reports in nineteen years of incarceration, but in less than three years at the SHU he had received thirty. We do not have sufficient information to know whether this increase is due to a worsening of the underlying psychiatric disorder—and, if so, whether that deterioration was caused by the conditions of confinement—or whether because of the disorder the prisoner has an even harder time adjusting to the highly restrictive conditions and social isolation of supermax confinement.

[147]Human Rights Watch interviews, MCF and SHU prisoners, July 14-17, 1997.

MCF and SHU staffs do not distinguish between rules violations by the mentally ill and those by healthy prisoners: disruptive or aggressive behavior by the mentally ill receives conduct reports and sanctions. The mentally ill, however, account for the most pressing disciplinary problems that are resolved with use of force, cell extractions, and placements in four-point restraints. Human Rights Watch reviewed official use of force records from 1994 through June 1997 provided to us by SHU officials. The preponderance of names that appear—and appear time and again—are those of mentally ill individuals, including people whom our psychiatrists found to be actively psychotic and suffering from such severe psychiatric disorders as schizophrenia and manic depression.[148] The names of mentally ill individuals also appear regularly on the MCF's use of force reports.

The net result of the mentally ill prisoners' inability to adjust to segregation is usually more time in segregation, through the imposition of additional sanctions and the loss of earned time credits. One psychotic inmate, for example, received a sanction of an additional three years in segregation (in addition to verbal reprimands and a six-month loss of telephone privileges) for throwing human waste on the staff. The situation was aptly summarized in a recent story in the Indiana press:

> [Wayne Morris, a paranoid schizophrenic confined at the SHU,] spends his time alone in [his] cell, where he sometimes spies devils lurking or hears disembodied voices commanding him to rape women and kill himself. The DOC has twice sent Morris, now 20, for brief stays in its outdated psychiatric unit at Westville, returning him each time to [the SHU]. DOC officials say they intended Morris' time in solitary at the Wabash Valley disciplinary unit as a temporary measure to break his habit of mutilating himself, leaving nasty scars on his neck and along the inside of his right arm. But Morris responded to the isolation by tossing feces and urine at guards and spitting. He says his captors taunted him. In due course, Morris reaped a stack of conduct violations thick enough to keep in solitary for a long, long time.[149]

Although they are not given specialized training in the handling of mentally ill prisoners, some guards react to prisoners' illness, including bizarre or outrageous behavior, with understanding and compassion. We were struck, for example, by the genuine sympathy which Captain Royal, the officer in charge of the SHU, displayed in talking about certain psychotic prisoners. But we also received numerous reports of mentally ill prisoners who have been kicked, beaten, taunted and harassed by guards. In particular, mentally ill inmates who throw excrement report numerous physical confrontations with guards. In a particularly notorious case, a mentally ill prisoner at the MCF engaged in a range of bizarre behavior, including smearing feces all over his body, and was aggressive towards the staff. To control his habit of spitting at the guards, he was forced to wear a hockey mask on his face whenever he was taken out of his cell. According to other prisoners, he was also beaten by the staff on more than one occasion.

We do not believe the DOC has intended to cause mentally ill inmates increased pain and suffering by placing them at the MCF and the SHU. Rather, the DOC confines mentally ill and dangerous or disruptive inmates at these facilities because it has not created alternatives. The MCF and especially the SHU are essentially institutions of last resort for inmates who present severe management problems for correctional officials, regardless of the mental health origin of those problems. The Indiana DOC must develop secure facilities in which appropriate mental health

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[148]Prisoners whose names regularly appear on the use of force reports may also be suffering from "intermittent explosive disorder as defined by the DSM-III-R" or persistent intense anger. Verbal and physical assaults secondary to these disorders are characterized by impulsivity, lack of premeditation, inability of the individual to modulate his behavior, disproportionate response to the perceived provocation, and remorse after the acting out. They should be distinguished from deliberate and purposeful attacks. These disorders and their accompanying behavioral expressions should not be automatically, simplistically, and solely considered as symptoms of antisocial personality disorder which are managed by punishment and physical restrictions alone. NIC/DOJ, *Prison Health Care*, pp. 149-150.

[149]Kevin Corcoran, "Sick Justice: A Plea for Help," *The Times* (Munster, Indiana), September 14, 1997.

treatment could be provided to mentally ill and dangerous or disruptive inmates who do not meet current criteria for acute-care inpatient hospitalization but who require intensive long-term mental health treatment.[150] It cannot, consistent with fundamental decency and international human rights, continue to respond to inappropriate behavior at the MCF and the SHU "as the occasion to increase punishment, rather than as a reflection of the destructive effects of conditions that they themselves created, and a manifestation of psychiatric problems that they refused to adequately treat."[151]

Mental Health Treatment

The cruelty of housing mentally ill inmates in conditions that are likely to be psychologically destructive is compounded by the failure of the DOC to ensure they receive adequate psychiatric treatment. The insufficient mental health services provided at the MCF and the SHU are cause for scandal.[152]

Staffing

The mental health staff at MCF in July 1997 consisted of a behavioral clinician with a Masters degree in counseling psychology, who also served as the superintendent's administrative assistant—a position that left him unable to devote much time to his mental health responsibilities. There was no psychiatrist on staff; the psychiatrist in charge of the inpatient unit at Westville was called upon to provide psychiatric services, but his schedule left him little time to visit the MCF.

At the SHU, a psychiatrist was under contract with the Indiana DOC to provide care at the SHU four days a week. In addition, a psychologist (working twenty hours a week), and four part-time mental health professionals (including a masters-level psychologist, a social worker and other therapists) provided a total of eighty hours a week to service both the SHU and the entire WVCF facility (a total of approximately 1,000 prisoners;). The WVCF medical director stated repeatedly and with exasperation to Human Rights Watch that the facility lacked enough mental health staff to provide adequate support and services for the number of mentally ill inmates sent to the SHU.

Subsequent to our visit to the MCC and the SHU in July 1997, new medical and mental heath staffing was instituted. A new psychologist has joined the staff at the MCC, replacing the behavioral clinician assigned to the

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[150]The DOC operates a psychiatric facility at Westville for inmates requiring acute psychiatric hospitalization. It does not provide secure care for dangerous or disruptive mentally ill inmates who do not need hospitalization. We were told of several instances of prisoners sent to Westville from either the MCF or the SHU who were subsequently returned to those facilities after a finding that they did not require hospitalization or after a brief period of treatment. This problem is not unique to Indiana. "All too often, self-mutilating inmates and the aggressive mentally ill are shuttled back and forth between regular prison units and inpatient psychiatric facilities. Unit staff keep referring them for treatment because they do not know how to manage them, and staff at the psychiatric facility keep refusing them because they do not meet standard criteria for inpatient care. Often, the default option for such inmates is placement in restraints or administrative segregation, neither of which serves either the inmate or the institution well." NIC/DOJ, *Disruptive Maximum Security Inmate Management Guide*, p. 147.

[151]Declaration of Craig Haney, Ph.D., *Coleman v. Wilson,* para. 80.

[152]An Indiana newspaper, *The Times*, recently published a stunning indictment of the treatment of mentally ill prisoners in Indiana. The eight-part series by reporter Kevin Corcoran, titled "Sick Justice," ran from September 14 to 20, 1997. One article explained:

> Growing evidence points toward an inescapable conclusion: Indiana's prisons soon will displace state mental hospitals as the dominant long-term institutional care for the seriously mentally ill . . . The Indiana Department of Corrections, by blunt admissions of its top administrators, is not suited to the task of preparing sick inmates for their eventual return to society . . . Treatment takes a back seat to the primary mission of keeping inmates locked up while protecting prison workers . . . [A psychologist] describes care given Indiana's mentally ill prisoners as "absolutely atrocious by any standard."

Kevin Corcoran, "Prison Mental Health Care: 'Absolutely Atrocious,'" *The Times* (Munster, Indiana), September 19, 1997.

unit. As of September, medical services at both facilities were being provided by a private health corporation, Prison Health Services. Our review addresses conditions as we found them prior to these changes.

Screening and Monitoring

Neither the MCF nor the SHU provide appropriate mental health screening and monitoring of inmates.[153] Adequate corrections practice includes mental health screening upon admission to supermax housing.[154] At the MCF, there was no screening at all of the inmates transferred for disciplinary segregation. The behavioral clinician claimed that he screened inmates who were transferred there for administration segregation, but the presence at the MCF of psychotic individuals with histories of psychiatric disorders suggests that the screening was inadequate.[155]

The monitoring of the mental health status of prisoners in super-maximum security confinement is crucial because of the well-known possibility that the stresses of such confinement can precipitate or exacerbate psychiatric symptoms.[156] Effective monitoring permits prompt identification of problems and timely intervention.[157] Under the

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[153]According to the National Commission on Correctional Health Care (NCCHC), an accreditation body, all inmates in disciplinary segregation should be evaluated by qualified health personnel "prior to placement in segregation and daily while in segregation . . . Inmates placed in segregation who have been receiving mental health treatment should be evaluated by mental health personnel within 24 hours of being placed in segregation. The evaluation should be documented and placed in the health record." Standard P-43. NCCHC, *Standards for Health Services in Prisons* (Chicago: NCCHC, 1997), p.53.

[154]*See, for example*, NIC/DOJ, *Disruptive Maximum Security Inmate Management Guide*, p. 74. Human Rights Watch was not able to review prisoner medical records and cannot comment on the nature or thoroughness of mental health evaluations undertaken before transfer to the MCF or the SHU. Our research suggested, however, that mechanisms may be inadequate for forwarding information about the mental health of transferred inmates. For example, although the front sheet of each inmate's medical file reports psychological problems detected at the intake psychological evaluation, subsequent diagnoses or treatment initiated after the inmate was incarcerated apparently are not always incorporated into the inmate's records and forwarded to the new facility. One inmate, for example, arrived at the MCF having been on antidepressants at his prior facility. Although his file included a record of the prescription, there was no diagnosis or notes from the prescribing psychiatrist that would assist other doctors in understanding his condition.

[155]According to the behavioral clinician, his "screening" to make sure mentally ill prisoners had not been transferred to the MCF consisted of asking inmates a few questions at their cell door, for example, whether they had thoughts of suicide. He did not review their medical and psychiatric records prior to meeting with them and did not do a formal mental status exam or thorough psychiatric history with the inmates. Most of his meetings with the inmates are conducted at the front of the cell where the presence of guards and other inmates discourages forthcoming responses to questions of a sensitive nature. Records of the information communicated in these meetings were not kept routinely. Human Rights Watch was shown an MCF publicity video showing a new inmate being given a psychological evaluation in a private room upon transfer to the facility. The dialogue on the tape also indicated that a formal evaluation was written for each inmate with recommendations to the staff for how to deal with him. The behavioral clinician acknowledged to us, however, that private evaluation meetings and written reports were rare.

[156]The NCCHC requires that inmates in administrative segregation should be "evaluated by qualified health personnel at least three times a week." NCCHC, *Standards for Health Services in Prisons*, Standard P-45, p.55. The ACA requires that a "qualified mental health professional personally interviews and prepares a written report on any inmate remaining in segregation for more than thirty days. If confinement continues beyond thirty days, a mental health assessment by a qualified mental health professional is made at least every three months -- more frequently if prescribe by the chief medical authority." ACA, *Standards for Adult Correctional Institutions 3rd Edition*, Standard 3-4244, p. 81.

[157]"It is well established in the case of people who are suffering from psychotic decompensation that the sooner the gross symptomatology is controlled by an appropriate medication regimen and other mental health treatment modalities, the better the eventual prognosis. Thus, leaving a psychotic or seriously depressed inmate alone in a cell to suffer for long periods of time...is quite cruel and is likely to cause significant deterioration in their mental condition over time." Declaration of Terry Kupers, M.D., *Coleman v. Wilson*, CIV S 90-0520 LKK-JFM (E.D. Ca. Feb. 16, 1993), p. 41.

terms of the Agreed Entry and its subsequent modification, inmates in administrative segregation at the MCF were to be monitored for mental health every thirty days. Inmates in disciplinary segregation on medication were to be monitored "appropriately," and any "prisoners who displays signs of mental disturbance as determined by the mental health staff shall receive a mental health evaluation." These requirements were not met. The behavioral clinician acknowledged to us in July 1997 that he had not been able to fulfill his monitoring responsibilities for several months and that he never monitored inmates in disciplinary segregation. But inmates and guards told us that even administrative segregation inmates at MCF inmates had never had regular meetings with the behavioral clinician for purposes of psychological monitoring.

The absence of monitoring for DSU inmates was particularly egregious. Those inmates received no pre-transfer mental health screening—which makes monitoring even more important. Moreover, the modified Agreed Entry permits the Indiana DOC to place in disciplinary segregation at the MCF prisoners who are mentally ill inmates and receiving psychotropic medication. Such a population requires close monitoring of the symptoms of the illness, the efficacy of medication, and any negative side effects.

At the SHU, the psychiatrist visits new inmates within a week of their arrival at the facility to determine whether they require mental health treatment, i.e., whether they were on or need to be on medication. After the initial meeting at the prisoner's cell door—which lasts between a few minutes and an hour—there is no regular, timely monitoring of each inmate's mental health status. Mental health staff simply lack the time to provide such monitoring, acknowledging that they are not even able to appropriately monitor all the prisoners on medication.

Treatment and Care

The treatment of mentally ill inmates at the MCF and the SHU is egregiously deficient. There are too few qualified mental health professionals to attend to the large number of seriously mentally disordered prisoners, and there are too few therapeutic treatment options.[158] Too many seriously ill inmates go untreated or undertreated because their symptoms are dismissed by staff as faking or manipulation. The physical design and the rules of social isolation and forced idleness at the MCF and the SHU also preclude treatment measures that would help mentally ill inmates. In other words, the very conditions that can exacerbate mental illness also impede treatment and rehabilitation.

The staff's insistence that they will not respond to manipulative behavior creates serious problems for the delivery of adequate mental health care. For instance, at the MCF the behavioral clinician is responsible for screening inmate requests for meetings with a psychiatrist. He acknowledged to us that he rarely refers inmates to the psychiatrist; he believes most inmates are faking their symptoms and do not need medication. Thus, for example, he ignored a written request to see a psychiatrist by an inmate who stated that he had a history of schizophrenia and needed to be put back on his medications because he was becoming increasingly suicidal and psychotic. Without ever having met with the prisoner or reviewing his records, the behavioral clinician told us that he thought this inmate was malingering and was not schizophrenic. He also noted gratuitously that the prisoner was a "known homosexual," as though that justified ignoring his psychiatric concerns.

The behavioral clinician at the MCF also expressed to us the view that even most cases of self-mutilation reflected no more than an inmate's desire to be transferred out of the MCF. There is no question that behavior such as self-mutilation can be manipulative. But it can also be a symptom of a major psychiatric disorder or a self-reinforcing behavior that requires a psychiatric response. In facilities in which the staff lack either the time or the inclination to pay close attention to prisoner complaints, the only option left to a prisoner is to manipulate in some

[158]Article 62 of the Standard Minimum Rules states that "The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end."

way—for instance by creating a disturbance or exaggerating his pain—if he is to get any attention at all. The less attentive the staff, on average, the more manipulative the prisoners have to be to get attention, and this is true for prisoners who are suffering from serious medical or psychiatric ailments as it is for those who are not ill but merely want attention. In other words, seriously ill prisoners are also frequently "manipulative."[159]

Absent careful evaluation through diagnostic work-ups, it is impossible to determine whether a self-mutilating individual has genuine psychiatric problems—for instance, he might be commanded by hallucinatory voices to cut himself—which, in turn, he may be exaggerating in order to receive needed help. The situation at the MCF appears to be one in which the "prevailing apprehension among custody and clinical staff [is] of being manipulated into delivering psychiatric services . . . The suspicion of malingering and its accompanying withholding of services are particularly acute in the management of self-mutilation and explosive disorders."[160]

The consequences of this attitude are predictable: seriously mentally ill inmates receive very little professional help. For example, one inmate who had been intermittently under psychiatric care since the age of four, was unable to tolerate solitary confinement and was one of the worst self-mutilators in the history of the MCF. He was repeatedly deemed free of psychiatric disorders and received no treatment. He was eventually sent to the SHU, where we interviewed him. Despite a regime of psychotropic medication, he was still actively hallucinating, displayed other symptoms diagnostic of schizophrenia, and was very depressed. Another MCF inmate requested a meeting with a psychologist upon arrival at MCF because he was upset about the recent death of a sibling and because he would "get angry for no reason." He quickly accumulated a record of numerous disciplinary infractions at the MCF which resulted in several cell extractions. At the time of Human Rights Watch's July 1997 visit, two months after this prisoner's transfer to MCF, he was actively psychotic and manic depressive. Despite a total of three requests for help, he had still not been visited by the behavioral clinician. (The clinician first denied having relied any requests for a meeting, and then, after checking his files, acknowledged that a request had been made by that he had not yet responded.) This inmate should not have been sent to or kept at the MCF. But many, if not most, of his disciplinary problems at MCF might have been avoided if he had received the mental health treatment he sought.

A similar counter-therapeutic attitude prevails at the SHU. The psychiatrist there told us that many of the inmates receiving psychotropic medications were faking psychotic symptoms "to make an excuse of mental illness." In some cases, the psychiatrist labeled as "manipulative" symptoms that in our judgment, based on interviews with the individual prisoners, were clearly signs of serious psychiatric disorders. But we were also disturbed by his stated willingness to give psychoactive medication to prisoners who are not psychotic. He justified this practice to us with the explanation that while not psychotic, the prisoners did have a mental illness, usually an affective disorder. He admitted that it was not standard medical practice to prescribe antipsychotic medications to treat such disorders. Because many inmates would not take medications willingly, he gives them long-acting intramuscular injections, and the only medications available in this form are antipsychotics.[161] We concluded that he prescribed the medication primarily to control the behavior of disruptive inmates and to reduce aggressive acting out.

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[159]Dr. Terry Kupers, a member of the Human Rights Watch delegation that visited the MCF and the SHU in July 1997, has seen several cases of successful suicides in prisons in other states where the prisoner's chart contained a notation by mental health staff, days before the death, to the effect that the prisoner was merely manipulating to get attention.

[160]NIC/DOJ, *Prison Health Care: Guidelines for the Management of an Adequate Delivery System*, p. 148 (quoting from correspondence from Walter Y. Quijano, December 3, 1990).

[161]We were concerned at the willingness of the psychiatrist to forego perhaps more medically appropriate medication in pill or liquid form in favor of injectables because of his concern about prisoners hoarding them to overdose or for sale. We were rather surprised, if not incredulous, at his claim that prisoners would "cheek" (i.e., store in their mouths) liquid medicine, and were dismayed at the assertion that the nursing staff which distributes medication does not have the time and is not authorized to watch the inmates to make sure they take their medication.

Some of the inmates at the SHU are self-mutilators. According to the psychiatrist, these inmates were hurting themselves in order to be sent out of the SHU to a hospital where conditions, presumably, were less onerous. After insisting that the severe self-mutilation of one particular inmate was not related to mental illness, he was at something of a loss to explain why that inmate received high doses of three different antipsychotic medications. (In our judgment, the inmate was psychotic and suffering from schizophrenia.) The psychiatrist also dismissed complaints of side effects from medication as "faking." He could offer no rationale, however, for why inmates would choose to fake such well-known psychotropic side effects such as akathisia (which includes restlessness and persistent, involuntary muscle movements).

At both facilities, prisoners suffering from severe and chronic mental disorders were underdiagnosed and undertreated. The behavioral clinician at the MCF has limited therapeutic responsibilities. He provides a substance abuse treatment course to a few inmates and meets with prisoners who ask to talk with him for counseling purposes. While the discussions with him may well be helpful, the behavioral clinician is not trained to provide—and no one else comes to the facility to provide—individual psychotherapy or treatment to severely ill individuals. No psychiatrist regularly attends to MCF inmates.

At the SHU, the psychiatrist had a list of 130 inmates requiring mental health attention. He told us that he was able to visit all of them at least once a week. According to numerous inmates we interviewed, the visits were fleeting: the psychiatrist stopped at their door, asked how they were doing, and moved on before they had time to respond with more than a word or two. The psychologists had somewhat longer visits with a small number of prisoners. But many prisoners complained to us that they had been unable to meet with psychologists, despite repeated requests, because they were so overbooked, a problem the psychologists confirmed.

Most of the inmates' meetings with the SHU mental health staff occur at the cell door within earshot of guards and other prisoners. For security reasons mental health staff do not enter the inmate's cell, but there are not enough custody staff to apply handcuffs and chains and to escort each prisoner who wants to meet with psychologists in a private room. The lack of privacy precludes one of the fundamental prerequisites for meaningful therapy. It has other unfortunate consequences as well. For example, one inmate told a member of the mental health staff about being raped as a child. The conversation, which took place at his cell door, was overhead by correctional officers, who reportedly spread the word around the prison, exposing the inmate to harassment and humiliation.

The SHU's psychiatrist told us that he developed a treatment plan for each of the inmates he was caring for and the prisoner's progress would be reviewed in the weekly team meetings of himself, the psychologists, custodial, nursing and other staff. Treatment consisted primarily of medication, although it also included limited meetings at the cell doors and confinement. In our judgment, mentally ill inmates require additional treatment options. In the community, mental health treatment programs employ a variety of interventions besides pscyhopharmacology, including group therapy, private individual therapy or counseling, milieu meetings, training in the skills of daily living, psychoeducation aimed at teaching patients about their illness and the need to comply with medication regimes, educational programs, vocational training, other forms of psychiatric rehabilitation, family therapy, supervised recreation, and so forth. In an adequately effective mental health treatment program, some or all of these components play a crucial part in restoring or improving mental health or, at the very least, in preventing further deterioration in the patient's psychiatric condition.

Human Rights Watch does not recommend particular forms of mental health treatment. Rather, we wish to emphasize to the Indiana DOC that there is a consensus among mental health practitioners that simply confining the mentally ill and prescribing medication is not an adequate treatment plan. Yet, with the exception of medication, the MCF and the SHU do not make available additional effective treatment options. Psychotherapy and counseling are frustrated by the lack of privacy and the lack of staff with whom mentally ill prisoners could have the frequent and meaningful interaction necessary for successful therapeutic interventions. We also wish to underscore the fact that certain treatment options are precluded by rules at the MCF and the SHU which mandate social isolation and

idleness. These rules fly in the face of the medically accepted fact that most mentally disordered people need to interact with other people, even if only in incremental socialization. They benefit from group therapy and psychiatric rehabilitation activities. They need structured days. If a person is too disturbed or angry to be with others, he needs a treatment plan that will slowly move him in the direction of socialization. We recognize that security considerations are significant at both facilities, but we believe the Indiana DOC has not sought to develop ways of providing appropriate mental health treatment options within the context of reasonable security precautions.

In July 1997 there were seventy-three inmates at the SHU receiving psychotropic medication. Not having access to prisoner's medical records nor being able to review each case with the SHU's psychiatrist, we cannot reach firm conclusions about the medication being given to SHU inmates we interviewed. For some of the inmates, the medications seemed to control their symptoms reasonably. But a sizeable number of prisoners on antipsychotic medications continued nonetheless to have very significant symptoms. This suggests that they may be refractory to standard antipsychotics. In cases where the standard medications do not seem to be fully effective, the prisoners might benefit from one of the new so-called "atypical" antipsychotics that were not, however, available to SHU inmates. But continued symptoms in prisoners on medication might also reflect the impact of conditions of confinement. That is, living at the SHU may have caused more severe psychiatric symptomatology than it is possible to alleviate with medication while the prisoner continues to be subject to the effects of those conditions. We do not have sufficient data, however, to form any conclusions about this possibility.

IX. RELEASE FROM THE MCF AND THE SHU

Upon release from either facility, prisoners with additional time remaining on their sentences are sent to other prisons, usually the institutions from which they came. If an inmate's sentence terminates either prior to or at the same time as completion of his term at the MCF or SHU then he is released to society. Good correctional practice encourages transitional programs to prepare inmates for return to life in society.[162] At the MCF there is a "transition" program for Level 5 inmates, who spend ninety days in a lower-rated facility, but there is none for Level 4 (DSU) inmates. Authorities at the SHU have instituted a pre-release orientation program for inmates that consists of written materials, tapes, and cell-door visits by relevant staff. Regardless of the amount of time he has spent in disciplinary segregation, an inmate is not given opportunities to interact with other inmates or to live in less restrictive conditions prior to release.[163] He is taken from a life of stringent controls and isolation and released to the street.

Although the Indiana DOC asserts that very few prisoners are released from a secured housing facility directly to the street, prison records and interviews with prisoners suggest otherwise. Of the 153 inmates in disciplinary segregation at the MCF at the time of Human Rights Watch's visit in July 1997, thirty have projected release dates from the MCF that are the same as their prison release date. During our 1996 visit to the SHU, twelve of the thirty inmates we interviewed were due to be released directly to the street.

To our knowledge, no one in Indiana or elsewhere in the United States has studied what happens to inmates who have been confined for lengthy periods in super-maximum security conditions and then released directly into the community. Expert opinion and common sense suggest that absent programming and services, inmates who have endured solitary confinement in such settings will have great difficulty adjusting to freedom. Prisoners themselves

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[162]According to Article 60(2) of the Standard Minimum Rules, "Before the completion of the sentence, it is desirable that the necessary steps be taken to ensure for the prisoner a gradual return to life in society. This aim, depending on the case, by a pre-release regime organized in the same institution or in another appropriate institution, or by release on trial under some kind of supervision."

[163]The NIC/DOJ, *Disruptive Maximum Security Inmate Management Guide* recommends the "provision of special privileges, e.g., small group activities, to disruptive inmates who are nearing release from the unit." p. 87.

are concerned about the prospect. Dr. Stuart Grassian describes the problem as follows: "Imagine taking a dog that has bitten someone, and kicking and beating and abusing it in a cage for a year. Then you take that cage and you put it in the middle of a city, open it and hightail it out of there. That's what you're doing."[164]

X. ACKNOWLEDGMENTS

This report was undertaken with the cooperation of Physicians for Human Rights. It is based on research by Joanne Mariner, associate counsel of Human Rights Watch; Jamie Fellner, associate counsel of Human Rights Watch; Juan Méndez, former general counsel of Human Rights Watch and current executive director of the Inter-American Institute for Human Rights; Allyson Collins, senior researcher for Human Rights Watch; Joanna Weschler, U.N. representative for Human Rights Watch; Gil Chachkes, a private attorney; Professor Garth Meintjes, director of the Center for Civil and Human Rights of Notre Dame University; Terry Kupers, M.D., and Carl Fulwiler, M.D. Dr. Fulwiler joined the research team in July 1997 as a representative of Physicians for Human Rights. The report was written by Jamie Fellner and Joanne Mariner, with the assistance of Dr. Fulwiler and Dr. Kupers. Cynthia Brown, program director at Human Rights Watch, edited the report. Christina Portillo, associate at Human Rights Watch, provided production assistance.

Human Rights Watch wishes to thank the many prisoners at the MCF and the SHU who spoke with us freely and extensively. We also wish to acknowledge the generous cooperation of administrators and staff at these facilities, who went out of their way to make our repeated visits as informative and comfortable as possible. The openness of the Indiana Department of Corrections to public scrutiny testifies to its determination to fully satisfy its responsibilities to inmates and the public. We wish more correctional departments were as willing to receive and respond to outside perspectives on prison operations.

We also with to express our gratitude to the lawyers and activists, particularly the members of the Northwest Indiana Coalition to Abolish Control Unit Prisons, and Charles Carney of the Eighth Day Center for Justice, who have sought to improve conditions for Indiana's prisoners and who have shared insights and information with us. Working with Indiana inmates, they have done a remarkable job in bringing to light abuses within the MCF and the SHU and encouraging the Indiana DOC to correct them.

Human Rights Watch is grateful to the Edna McConnell Clark Foundation and to the Open Society Institute for their support of our work monitoring prison conditionsand the treatment of prisoners.

[164]Human Rights Watch interview, Newton, Massachusetts, June 19, 1997. Dr. Grassian and Dr. Haney know of at least a half-dozen cases of inmates released from the Pelican Bay SHU who promptly committed murder or other serious felonies. Spencer P.M. Harrington, "Caging the Crazy: 'Supermax' Confinement Under Attack," *The Humanist*, January/February 1997, pp. 14-19.

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