THE SOCIAL AND CULTURAL CONTEXT OF MENTAL ILLNESS IN PRISON

By

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Table of Contents

List of Tables 2

List of Figures 3

Acknowledgements 4

Glossary of Prison Terms 6

Abstract 9

Chapter 1: Introduction 11

Chapter 2: Background, Literature Review, and Research Questions 14

Chapter 3: The Research Site: Oregon State Penitentiary 34

Chapter 4: Methods 50

Chapter 5: Mentally Ill Inmates' Relationships with Correctional Officers 94

Chapter 6: Mentally Ill Inmates' Relationships with Mental Health Staff 132

Chapter 7: Relations Between Staff: Security, Medical, and Mental Health Staff 165

Chapter 8: Mentally Ill Inmates and Their Relationships with Inmates 188

Chapter 9: The Cultural Construction of Mental Illness in Prison 219

Chapter 10: Conclusion and Discussion 261

Appendix A: Interview Questions 288

Appendix B: Codebook 294

References 297

List of Tables

Table 4.1 Recruitment Statistics 53

Table 4.2 OSP Inmate Sample Characteristics 54

Table 4.3 Days Housed in Disciplinary Segregation 55

Table 4.4 OSP Point Prevalence: Psychiatric Disorders 62

Table 4.5 Staff Sample Characteristics 81

Table 4.6 Inmate Interview Statistics 83

Table 4.7 Staff Interview Statistics 86

Table 4.8 Direct Observation Statistics: March 2009 – November 2009 90

Table 4.9 Interviews: Analysis Methods 92

List of Figures

Figure 3.1 Map of OSP 36

Figure 8.1 OSP Hierarchy: An Old School Convict's Emic Perspective 193

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Glossary of Prison Terms

BHS – Behavioral Health Services; the mental health treatment services within the Oregon Department of Corrections.

Usage: *Call BHS, this guy needs to be seen*; *I need to see my BHS worker*

Blocks – Cell blocks, primarily D and E

Usage: *I was housed in one of the big blocks*

CTS – Counseling and Treatment Services; previous name for mental health services in ODOC. Used interchangeably with BHS or in conjunction depending on inmate or staff.

Cellie – Cell-mate in two man cells

Usage: *My cellie's real cool, we play cards all the time.*

Correctional Officers – Professional term used for officers in penitentiary.

Usage: *We're not guards, we're correctional officers.*

Cops – Correctional Officers

Usage: *The cops don't bother me around here.*

Ding – Negative term to refer to an inmate with mental illness

Usage: *I got celled in with a real ding!*

Dirty UA – receiving a positive result for drug use from a urinalysis.

Usage: *He got a dirty UA and got sent to the hole*

DSU – Disciplinary Segregation Unit; “The Hole”, “Seg” – the jail within the prison that houses inmates who have committed rule infractions.

Usage: *I got 30 days in Seg this time.*

Ed Floor – Education floor where inmates attend education classes

House – A cell

Usage: *I don’t want the cops to come shake down my house.*

IMF Floor – Inmate Management Floor; offices for mental health providers, correctional counselors. Inmates are seen on this floor for scheduled appointments.

IMU – Intensive Management Unit; OSP’s supermax unit – a disciplinary segregation unit in which inmates are locked down 24.5 hours/day. The prison inside of the prison.

Meds – Generally refers to psychiatric medications.

Usage: *I need to get my meds adjusted.*

MHI – Mental Health Infirmary; current name for inpatient psychiatric unit.

ODOC – Oregon Department of Corrections

OSP – Oregon State Penitentiary

Pill Line – Area of control room floor where medications are distributed to inmates.

Spinnin' Out – term used to describe an inmate with psychotic symptoms or extreme emotional responses to prison stressors.

Usage: *This guy is spinnin' out, call BHS.*

Security: General term for uniformed corrections officers

Usage: *Don't do anything stupid to get security to come over here.*

SMU – Special Management Unit, former name for the inpatient psychiatric unit for Oregon State Penitentiary. (Pronounced "Smoo")

Usage: *We gotta get this guy upstairs to SMU.*

The Social and Cultural Context of Mental Illness in Prison

Abstract

by

JOSEPH D. GALANEK MA MPH

This dissertation investigates how social and cultural processes in a maximum security state penitentiary may mediate the course and outcome of severe psychiatric disorder for inmates. It identifies those processes which may contribute to recovery from severe psychiatric illness in prison. Participants included 20 inmates diagnosed with a severe mental illness and having high mental health treatment needs. Participants also included 23 prison staff. Through ethnographic interviews and direct observation of the prison environment, this research identifies how social processes such as relationships with staff and inmates, as well as cultural constructions of mental illness, may mediate positive outcomes for inmates with severe mental illness.

In terms of social processes, inmates and staff identified that relationships with penitentiary staff were crucial for inmates' functioning and well-being within the institution. These relationships were structured along institutional cultural ideals of respect and trust. Rather than the prison being a site of "total control", correctional officers in particular were able to exercise a high degree of flexibility in their interactions with mentally ill inmates to ensure that these inmates received appropriate treatment. Additionally, inmates' relationships with treatment staff were also identified as crucial to inmates' positive functioning

within the penitentiary. Participants also identified that positive relations with both mentally ill and non-mentally ill inmates contributed to psychiatric stability by offering social support and opportunities to engage in pro-social activities within the institution.

Cultural constructions of mental illness in the penitentiary also mediated course and outcome of psychiatric disorder. These constructions created an institutional space for these inmates that warranted a more flexible interactional style from staff. Staff reports of inmates' complex clinical histories confounded discrete constructions of personality disorder, substance abuse disorders, and major mental illness. Further, staff and inmates identified contextual factors such as employment, appropriate housing, and coping skills as critical as pharmacological interventions for psychiatric stability within the prison.

This dissertation contributes to anthropological theories of psychiatric disorder, social theory as it relates to prisons as total institutions, applied anthropological work with vulnerable populations, as well as correctional policies in the United States.

Chapter 1: Introduction

The United States has the highest rates of incarceration in the world with approximately two million individuals incarcerated in U.S. jails and prisons (Bureau of Justice 2011). The past 20 years has also seen increases in the numbers of individuals with psychiatric disorder enmeshed within the criminal justice system. The most recent conservative prevalence rates for major mental illness in prison are between 15-20%, with some states reporting at least 50% of inmates as having significant mental health needs (Ditton 1999; Lamb 1998; Torrey et al 2010). Little is known of these individuals' lives, and how they manage and cope within these intensely toxic institutions.

These statistics are the entry point for this dissertation. Within the following pages, I utilize current theory and research in medical anthropology which attempts to conceptualize how cultural and social processes may mediate the course and outcome of psychiatric disorder for a group of mentally ill inmates in a state prison. This formulation centers on the ethnographic record which demonstrates that subjective illness experiences, systems of healing, and societal and familial responses are inherently cultural processes (Gaines 1992; Good 1994; Kleinman 1988). Additionally, the social context in which individuals are enmeshed in may also intensely shape the course and outcome of illness (DesJarlais 1995). Thick ethnographic description, a contextualization of the lives of individuals with psychiatric disorder, may reveal how these social and cultural processes may "do their work" within local moral worlds.

Following from this research agenda, I conceptualize the prison context to be its own unique social and cultural environment, and attempt to apply medical anthropology's research paradigm to this setting. Through contextualization of the lives of incarcerated individuals diagnosed with psychiatric disorder, this research attempts to identify the social and cultural processes within a state penitentiary that may mediate serious psychiatric disorders. Further, this dissertation seeks to identify social and cultural processes within a prison environment which may contribute to positive outcomes for this unique psychiatric population. This dissertation challenges Foucault's (1977) construction of the prison as a site of "total control". This dissertation demonstrates that individuals do indeed have more agency within these social contexts than current research indicates (Rhodes 2004). Moreover, this dissertation also explores how informal rules structure social relations, and how cooperative efforts between staff and inmates contribute to keeping the social fabric of the institution intact and operating. Cultural values of respect and trust are revealed to structure social relationships within the institution, and this argues against Foucault's (1977) construction of inmates being passive recipients of "control".

This dissertation examines how interactions of social categories in the prison generate the social structure of the institution and individuals' place within this structure. In particular, I examine how social categories of the "mentally ill inmate" are constructed within the institutional setting and how staff and inmates' cultural responses to this social category may mediate the course and outcome

of psychiatric disorder for these individuals. The complexity of this construction is revealed through ethnographic description of the challenging clinical work that is enacted within this penitentiary.

In this sense, this dissertation is informed by applied anthropology's concerns with applying anthropological methods and theory to "real world" problems encountered within unique social, cultural, and historical contexts. In order to accomplish this goal, I apply medical anthropology's current formulations of culture and psychopathology in order to conceptualize and understand how mental illness is constructed and understood with a state penitentiary. Moreover, I attempt to frame these institutional cultural processes within the social processes of this unique institution.

In the following chapter I examine the literature that informs this dissertation, and at the conclusion of that review, I more clearly formulate the objectives and research questions of this dissertation.

Chapter 2: Background, Literature Review, and Research Questions

This foundation of this dissertation is the application of current medical anthropology approaches, theories, and findings regarding psychiatric disorder and applying them to a prison context. In the following sections I discuss the current epidemiologic findings on the incarcerated mentally ill and I briefly summarize the anthropological findings and perspectives on psychiatric disorder and the questions it raises for the incarcerated mentally ill. I then examine the prison literature relevant to this dissertation, including how the prison has been theorized and studied by primary anthropological and sociological research. Finally, I conclude with the research questions proposed.

The Context of the Mass Incarceration in the U.S.: The Incarcerated Mentally Ill

In 2009, the United States Bureau of Justice reported over 7.2 million people were under some form of correctional supervision with 1,613,740 individuals incarcerated at the end of 2009 (U.S. Bureau of Justice 2011). Although this was reported as a decreasing number of inmates within the U.S., "mass incarceration" is still the hallmark of the nation's penal policies, with no clear insight into how these criminal justice policies will affect the nation in the next decades (Tonry and Petersilia 1999). These large numbers of incarcerated individuals also include a large population of individuals who have been diagnosed with the presence of a psychiatric disorder. The most recent conservative prevalence statistics for major mental illnesses in prison are between 15-20%, within some states reporting at least 50% of inmates as having

significant mental health needs (Ditton 1999; Lamb 1998; Torrey et al 2010). This dissertation seeks to examine the lives of this hidden population of mentally ill by utilizing medical anthropology theory and methods to understand how the prison context may mediate the course and outcome of psychiatric disorder for these individuals. I turn now to anthropological approaches that focus on how cultural and social processes may enact this mediation.

Course and Outcome of Psychiatric Disorder: The Role of Social and Cultural Processes

Although psychiatric disorders have a presumed biological etiology and uniform course and outcome, it has been demonstrated that the course and outcome of these disorders vary, depending on the social and cultural context (Good 1993; Hopper et al 2007; Hopper 2004; Kleinman 1988; Murphy and Raman 1971; Jenkins 1988a, 1988b; Waxler 1974; Waxler 1979). Medical anthropology primarily frames the relationship between psychiatric disorder and social and cultural processes as "mediation" (Kleinman 1988). Kleinman (1995: 7) formulates the experience and mediation of psychiatric disorder as the "outcome of cultural categories and social structures' interaction with psychophysiological processes". In this construction of psychiatric illness, cultural and social processes profoundly affect the experience of illness, the response of the sufferer's social networks, larger societal responses, and how the sufferer engages with professional and folk systems of healing (Gaines 1992; Good 1994; Kleinman 1988).

This anthropological model of psychiatric disorder argues against a biological reductionism, and instead focuses on how cultural meanings are intrinsic to illness categories so that these categories structure illness experiences and elicit culturally prescribed responses from the individual sufferer's social networks, families, and the professional, or *ethnopsychiatric*, systems of healing they engage with (Kleinman 1977, 1988; Gaines 1992; Good 1993). For example, Jenkins (1988a, 1988b) has demonstrated that within the familial context, Mexican-American families' labeling schizophrenia as *nervios* (a less severe disorder) elicited culturally prescribed *emotional* responses to ill family members which were then correlated with decreased rates of psychiatric relapse and hospitalization.

Hopper (1991; 2004; 2008:207-208) has raised the issue, however, that the actual mediating work of culture has been difficult to establish or actually document given the processual, contested, and dynamic nature of culture (Lewis-Fernandez and Kleinman 1995). To this effect, Hopper states (2007: 279),

> We have not made substantial analytic headway in resolving the 'dilemma of context': devising appropriate means for assessing the influence of cultural variables that take into account the contexts within such variables acquire meaning and exert effect.

Hopper suggests that family is one "domain of everyday practice" that may offer some avenue of inquiry as to how cultural processes "do their work". A question this dissertation raises, however, is how cultural processes shape the course and outcome of disorder for individuals who have no connection to family,

or radically altered familial relationships in environments fundamentally dissimilar from “home life”, such as total institutional contexts which “assault the self” through “pains of imprisonment” (Goffman 1961; Sykes 1958). Moreover, individuals in total institutions are enmeshed in “forced relationships”, with fellow inmates and their custodial staff (Goffman 1961: 28). How would these compulsory relationships then mediate the course and outcome of psychiatric disorder?

Moreover, given that correctional institutions have been characterized as violent (Fleisher 1988), where individuals with severe mental illness are more likely to be victims of sexual assaults and violence (Blitz et al 2008; Wolf et al 2007), where social relations are hierarchical, and at times exploitative (Skyes 1958) and where institutional emotional climate can best be constructed as hyper-masculine and stoic, or restricted (Gaffin 1996), what role would social relationships have in the course and outcome of severe psychiatric disorder? How would these radically altered social relations affect course and outcome of severe psychiatric disorder? Presently, there has not been an examination of how social relationships might impact the course and outcome of psychiatric disorder for incarcerated individuals.

In terms of larger societal process, termed macro-social processes, how have these been construed as mediating the course and outcome of psychiatric disorder? DesJarlais et al (1995: 5-8) have theorized that there is a “clustering” of social pathologies, with social, mental, and behavioral problems as overlapping and interconnected. For example, the clustering of particular social

pathologies indicative of poverty, such as increased rates of substance abuse, violence, social isolation, and other toxic environmental conditions has been theorized to contribute to poorer outcomes for individuals with severe psychiatric disorders (Cohen 1993; Desjarlais et al 1995). These contexts of poverty have been associated with a host of adverse stressors that may affect outcomes for individuals diagnosed with schizophrenia, including disturbances in social relations, increased isolation, and exposure to crime and violence, and increased risk of victimization (Warner 2008: 168-169). Moreover, lack of employment opportunities have also been associated with increased risk of relapse of schizophrenia (Warner 1994). Given that prisons are also the sites of violence, and over-crowding (Gibbons and Katzenbach 2006), exposure to criminal behaviors, and substance abuse (Inciardi et al 1993), do these institutional social processes then mediate poor course and outcome for inmates with psychiatric disorder?

Anthropological perspectives demand experience-near thick ethnographic descriptions of these contexts. Rather than assume *apriori* that these contexts create poorer outcomes for the incarcerated mentally ill, ethnographic research may explore the possibility of resiliency and explore how agency is enacted in these toxic environments. This is also not to say that individuals will always "overcome". Rather, contextualizing the lives of individuals who are enmeshed in environments understood as profoundly antagonistic to resiliency, recovery, and psychiatric stability may offer some insight into how social and cultural processes

may mediate their illness experience, as well as indicate what processes may contribute to sustained recovery.

Social Theory and "The Prison"

I now turn to some of the core sociological and anthropological texts in conceptualizing the prison. This body of research provides insight into the context of the U.S. prison, and some of the social and cultural processes that have been identified within these total institutions. I begin with an examination of the writings of Foucault, who's Discipline and Punish has substantially informed the most current anthropological examination of the prison (Aretxaga 2001; Gaffin 1996; Rhodes 2000; 2004).

Foucault's Discipline and Punish

Foucault's writing on the prison, *Discipline and Punish* (1977) can be best characterized as a structural functionalist historical account of the birth of the modern prison. Additionally, he utilizes interpretivist or hermeneutic analytic methods to uncover the functions of the modern prison, and also takes a phenomenological approach in his examination of how bodies are disciplined and ordered with these institutions. Foucault focuses on "strategies" of social control, based in modern or Enlightenment methods of control and classification of individuals, and how these strategies are conceived and enacted within the modern penal institution.

Foucault's work is significant to theorizing the prison because he established that the "rationality" of the prison's orderliness was reflective of

broader political and historical trends. He also interpreted the professional discourse of the prison's "experts", such as psychologists, criminologists, psychiatrists, and prison administrators, as "making up" a state-sanctioned "self".

The prisoner's own affective and behavioral patterns are matched against the state's construction of "the self", and in doing so, the inmate's deviance is transformed, or corrected, through the construction of professional knowledge that uncovers the etiology of this deviance and employs corrective measures to "normalize" these deviant selves. These measures are intimately linked to systems of surveillance and work. This ties directly to Foucault's conception of Knowledge and Power; control of an object rests on the knowledge of that object, and understanding of its potential for change, its forces, reactions, strengths, and weaknesses (Garland 1990: 138).

Foucault identifies and interprets institutional processes as indicative of broader social processes of control and the state construction of the self. However, he does not take into account resistance to this social control and classification (Ignatieff 1981: 171; Rhodes 2000; Waldram 1997), nor does his work reference a *specific* prison, again placing his work in a context of an ahistorical, acultural institution. His analysis is at odds with modern accounts of prisons in which there is variance in contact and relationships between staff and inmates (Dvoskin and Spears 2004); how inmate social hierarchies divided along class lines fundamentally structure the working of the prison (Davidson 1975) and the dynamic nature of prison populations (Hunt et al 1993). Moreover, Foucault does not address prison staff's own disagreement over the methods

and aims of institutional processes (Rhodes 2000, 2004), or how the staff themselves are also subjected to the mechanisms and methods of control (Rhodes 2004). Rhodes has discussed Foucault's writings as "good to think with", meaning they are used an analytic entry into prison research. Given how Foucault's writing does not provide true ethnographic accounts of how a prison actually operates on the local level, this dissertation takes an interpretivist perspective suggested by Garland (1990) and informed by Geertz (1973). This approach attempts to identify culturally specific meanings in the prison that structure social relations (Goifman 2002; Fleisher 1989; Reed 1999, 2003). Within the prison context, then, it is assumed that individuals have agency within the social structures of the prison. Prisons are then construed as unique social and cultural contexts in which these cultural processes are created through social interaction, create the social structures of the institution, are dynamic and contested. The following section, reviewing the key anthropological and sociological prison texts reveals that social relations and cultural processes profoundly shape the institutional landscapes of these unique contexts.

The Key Sociological Texts

Sociological research provided insight into social relations and inmate "culture", demonstrating that particular social processes, such as assimilation and meaning-making do occur within these institutions, and allowed for an understanding of prison beyond sites of total control (Blomberg and Lucken 2010: 123-124).

Clemmer (1940) established the social relationships within the prison are influenced by the very social context of the institution itself, including the prison's administrative goals, which inadvertently create an organizational structure. This social ordering structures particular hierarchical relations among inmates and staff, and is a dynamic social system. He coined the term prisonization, in which inmates take on "in greater or less degree . . . the folkways, mores, customs, and general culture of the penitentiary" (Clemmer 1940: 299). Clemmer established that the prison community is a unique cultural and social context to which individuals differentially adapt to the unique behavioral norms of institution.

Sykes (1958) examined the pains of imprisonment, five areas of deprivation that shaped inmates' responses to the prison environment: liberty, goods/services, heterosexual relationships, autonomy, and security. Social roles are taken on by inmates, such as "the tough", or "the rat", which further structure the inmate hierarchy. This deprivation theory has been utilized to account for the cultural and behavioral patterns observed in U.S. prison environments.

Irwin (1970) furthered this understanding of inmate roles and status; the felon's life and position is related to his pre-prison life; strands of continuity remain while the individual is incarcerated, and community identities overlap with deviant identities acquired in the institution. Irwin identifies that the prison is composed by a shared value system among groups of inmates that is related to self-conception and behavior within the prison.

This permeability of the prison and its embeddedness within the larger society was also taken up by Jacobs (1977), as he demonstrated that the management of prisons is influenced by broader governmental processes, and are not isolated total institutions. Carroll (1974) demonstrated that prisons, not only permeable and connected to prevailing social conditions, are also sites of racial segregation reflective of then-current African-American political movements. The prison, then, is not only structured according to social status and hierarchy, but also along racial lines.

In summary, key sociological works on the prison established that it is a unique social context; individuals differentially assimilate to the norms and values of the prison, the inmate social structure and behavioral norms are a response to the deprivations characteristic of total institutions, but are also largely connected to community criminal identities, subcultures, and values. This interconnectedness and permeability of the prison and the community in which it is embedded in also relates to prison management. Racial divisions in social relations are also understood to profoundly affect the social structuring of relationships within these institutions.

Some limitations of these works, however, is a deficient construction of culture, inherent in past sociological and, to a degree, anthropological writing. These writers did not share a processual understanding of culture, for example, and could not have foreseen the changing dynamics of the U.S. prison that re-structured inmate relationships along racial line and gang affiliations, as well as advocacy of a bureaucratic, paramilitary organizational style of governing prisons

that did not take into account inmate culture or social relationships in managing institutional life (Blomberg and Lucken 2010: 138-139). This dissertation, then, acknowledges the importance of these sociological texts, in their explication of inmate social relations and some generalized narrative of inmate culture, but attempts to take into account the restructured relations of the post-millennial penal institution in the U.S. (Hunt et al 1993). Moreover, I argue against unproblematic accounts of the prison (DiIullo 1987) that re-assert these institutions as sites of "total control" (Blomberg and Lucken 2010: 135-137), and focus attention to how social relations in the prison may substantially mediate the experiences of inmates.

The Key Anthropological Texts

Rhodes states (2001: 66) that "Little work in anthropology concerns prisons", and her review of anthropological work in penal institutions reflects a paucity of research, and only Rhodes' (2000; 2004) work specifically addresses individuals diagnosed with psychiatric disorder. However, within the anthropological texts, key formulations of the prison environment are refined.

Davidson's (1974) ethnography of San Quentin prison revealed how Chicano inmates use informal means of social control to manage social relationships within the institution. Outside of the parameters of formal institutional disciplinary procedures, Chicano inmates' use of social control is guided along parameters of cultural categories of masculinity, or *machismo*, and as an extension of barrio ethics this population of inmates controls underground

activities and protect fellow inmates from violence. This provides a further refinement of inmate "culture", in that particular community cultural categories are seen as utilized within a prison setting.

Cardozo-Freeman (1984), in an examination of the language of the prison in Walla Walla, Washington, establishes how specific language use in the prison reflects the worldview of inmates, and that a system of values exists beneath particular patterns of prison behavior. For example, there are several terms for murder within the prison, reflecting the violence inherent in the prison as well as inmates' focus on survival (1984: 473). Her focus on meanings inherent in language focuses on how shared meanings are created through social interactions within the prison, following from Geertz's earlier formulations (1973).

Fleisher (1989), in his applied research in Lompoc Federal Prison, attempted to understand how informal mechanisms of social control worked to within the prison to create a "relatively peaceful, humane, and profit-making maximum security penitentiary" among some of society's most violent offenders (Fleisher 1989: 16). Fleisher, through thick ethnographic description, demonstrated that the prison keeps social order through an interplay of structural, organizational, personal, emotional, and cultural processes that keep violence in check (1989: 64-65). In particular, verbal interactions mediate the influence of risk of violence in the prison; discourse among staff and inmates was demonstrated to be intimately tied to their public social images and the mitigation of violence acts (1989: 174-196). His analysis of interactions between prison staff and inmates demonstrates how social relationships help foster cooperative

atmospheres and may fundamentally shape institutional life. He also demonstrated that there were context-specific meanings attached to social status (1989: 108); the structure of time (1989: 133); work (1989: 141); and sexual behavior (1989: 156-173), among others. All of these analyses establish that these domains of prison life differ significantly from “life on the streets”, and the prison is itself a unique cultural world with its own lifeways and meanings. In particular, homosexual relations may be radically different in prison, with the aggressor of the sexual relationship or assault perceived as an asserting masculinity rather than homosexuality. Fleisher established that rather than social structure and social relationships being the only avenue of analysis, culturally prescribed meanings are also inherent, created, and fundamentally altered within the institutional context.

Waldram (1997) utilizing an applied medical anthropology approach demonstrated that the biomedical psychiatric system in Canadian prisons is at odds with traditional Aboriginal healing systems. Aboriginal inmates diagnosed with psychiatric disorder experienced greater success in recovery and healing using traditional religious methods. This reveals how prison biomedical psychiatric systems establish etiologies and treatments that are in discordance with certain populations of inmates. The resistance of Aboriginal men to biomedical psychiatric methods of “healing” and their consequent negative self-reported psychological distress and poor institutional outcomes reveals that particular cultural symbols in traditional religious ritual have more powerful effect for certain inmate groups. This work also suggests that symbolic healing, be it

through traditional Aboriginal religious symbols, or biomedical psychiatric symbolic systems, may occur within these penal contexts. Systems of healing within prisons are not monolithic, uncontested enterprises, but are negotiated and contested within penal institutions, and constructions of sickness episodes may be interpreted and reinterpreted along culturally specific models of illness.

What these primary anthropological texts argue against is Foucault's deterministic model of social control he characterized as inherent to the penitentiary system. Rather, what is found in both the sociological and anthropological literature are the following: The "prison" is an unfinished cultural enterprise that is specific to its particular social and historical context; the prison can be theorized and constructed analytically as a unique social and cultural context, in terms of the structured social relationships among inmates and staff, the context-specific meanings ascribed to behavior, and the dynamic processes at work within the institution; the prison is not a site of "total control", rather, since it contains cultural processes, we may apply current theoretical constructions of culture to analyze the prison's social relations and processes.

I turn now to specific research that examines incarcerated individuals diagnosed with psychiatric disorder, and specifically the work of Rhodes (2001, 2004), one of the only ethnographic accounts of psychiatric disorder in prisons, and the systems of treatment that this inmate population engages with.

Rhodes utilizes a critical perspective that is informed by the work of Foucault to examine how psychiatric disorder is constructed within a specific

prison environment in Washington State (2000). Rather than answer specific questions posed by Foucault, she utilizes his theories to "think through prisons". For example, she attempts to show how there are disciplinary "chinks" or resistance to the total control allegedly characteristic of the penal environment; there are disciplinary spaces within the disciplinary apparatus that allow for negotiation. Moreover, she demonstrates that prison staff is caught up in conundrums posed by the "rationality" of the prison, i.e. how to respond to inmates that do not adhere to penality's structuring of the self as a utilitarian rational actor.

In particular, Rhodes demonstrates the culturally-constructed, contested, and negotiated nature of psychiatric disorder within prisons (2000). By describing how DSM-IV R psychiatric categories of Axis I and Axis II disorders are utilized in the prison psychiatric treatment context, she demonstrates how psychiatric disorder may be constructed as volitional behavior and thus "untreatable" or outside of the will of the inmate, and thus "treatable". That is, Axis II disorders are constructed as immutable personality traits of inmates that are not amenable to biomedical psychiatric treatments, and thus under the auspices of correctional disciplinary measures. Conversely, individuals diagnosed with Axis I disorders, and with a biomedical psychiatric cultural model that presumes biochemical etiology, behavior is then viewed as out of the inmate's control, and spaces are created to accommodate an individual's bizarre behavior. The construction of an Axis I disorder opens the process of biomedical

psychiatric treatment, as well as a diminished role in institutional disciplinary processes in the “control” of the inmate.

These dichotomies are also demonstrated to be indeterminate, and negotiated among correctional and treatment staff, as well as the inmates himself. Rhodes keenly access the cultural processes of illness construction as well as provides some insight into how inmates with severe psychiatric disorders, or Axis I illnesses, may be allowed some flexibility in the rigid behavioral proscriptions of prisons.

Rhodes focuses primarily on the construction and diagnosis of psychiatric disorder in prison. What is not demonstrated or described in her work, however, is how the meanings attached to these behaviors may play out within institutional contexts. For example, her ethnographic focuses specifically on inmates in highly controlled settings of the inpatient psychiatric unit, not inmates in a general prison population who must navigate non-mentally ill inmates, or “line staff”, the correctional officers who may not be aware or attuned to mental health issues while working in a larger institutional context of cell blocks and “regular”, non-mentally ill “criminals” who populate these housing units. How do these inmates negotiate the “chinks” in the disciplinary processes outside of these tightly controlled institutional contexts, such as inpatient psychiatric units? Moreover, Rhodes does not analyze the prison’s social relations among inmates, in contrast to sociological accounts (Irwin 1970), or describe the larger institutional context in which inmates live (Clemmer 1940; Fleisher 1989).

Additionally, Rhodes' construction of culture is weak, with no attention given to recent formulations of culture that inform how cultural processes may continue to work outside of an inpatient psychiatric unit. Is the biomedical psychiatric categories utilized by this specialized correctional and mental health staff utilized throughout the larger prison context? Do inmates themselves recognize these categories? These questions are not addressed.

Further Research On the Incarcerated Mentally Ill: Current Findings

Research on the mentally ill's lives in prison has been slight, although this population of inmates is estimated to make up 15-17% of the nearly 2 million incarcerated individuals in the U.S. Within disciplines outside of anthropology, the culture of prison has been broadly conceptualized as "staff attitudes" towards mental illness, or "climate" of the institution (Holton 2003: 104-107). This research assumes that unpacking and examining the "attitudes" of staff and inmates and the "climate" of the prison through ethnographic research will provide significant insight into how cultural processes within the institution mediate the experience of psychiatric disorder. Within the prison, the public health agenda is recent, following from the World Health Organization's Health in Prisons Project which seeks to identify and enhance social determinants of health in the context of a preventive approach (2000).

The research on mentally ill in prisons has been largely epidemiologic in nature to demonstrate the prevalence of mental illness among prison populations (Ditton 1999; Teplin 1990; Lamb and Weinberger 1998). It has been

demonstrated that adjustment to prison and subsequent institutional functioning for mentally ill inmates has been poor, with higher rates of disciplinary infractions documented for this population (Abramsky 2003; Adams 1992: 306; Toch and Adams 1986). Toch and Adams (2002) have demonstrated that mentally ill inmates' psychiatric symptoms seemingly decrease during prison adjustment, but this research does not take into account particular environmental factors of the institution that may have contributed to this decrease, which presumably include the mental health treatment systems in the institution, for example, or mentally ill inmates' social relations. Inpatient treatment of the incarcerated mentally ill has been determined to increase institutional functioning and lower symptoms, but what of inmates who do not enter into such units for their treatment (Lovell et al 2001)? Adams and Ferradino (2008) have suggested that limited socialization with the larger inmate population may contribute to better functioning due to mentally ill inmates' inability to cope with the larger prison environment. But what if this is not an option for housing this population of inmates and they must live among the cell blocks with non-mentally ill inmates?

In terms of the environment and its role in the mental health of inmates, De Viggiani (2007) has most clearly formulated a model of prison research that attempts to explore whether social and cultural factors of the prison limit the health of inmates. Specifically, De Viggiani demonstrated that the prison environment creates particular social contexts, such as opportunities for victimization and idle time, which impacts the mental health of inmates. Although this does not discount individual level factors of the inmates in determining their

health, this approach attempts to incorporate the social and cultural context of the prison within the broader analysis of prison health.

The research to date on the mentally ill in prison raises more questions than it answers. Beyond prevalence statistics, little is known of the institutional lives of individuals diagnosed with severe mental disorder. Are they perpetual victims of more predatory inmates (Blitz et al 2008; Wolf et al 2007) or do they form relations with other inmates? Are they able to integrate themselves in the larger institutional context, taking on prison roles, as do other inmates (Irwin 1970)? Since so little is known of the lived experiences of the incarcerated mentally ill, these questions have remained unanswered. This dissertation, then, seeks to answer the following research questions:

1. How do social processes within a state penitentiary mediate the course and outcome of psychiatric disorder for mentally ill inmates? What social processes are associated with positive illness outcomes? By social processes, I refer specifically to social relations this inmate population has with the larger inmate population, the prison staff, as well as domains such as employment and housing.

2. How do cultural processes mediate the course and outcome of psychiatric disorder for mentally ill inmates? What cultural processes are associated with positive illness outcomes? To describe these cultural processes, I attempt to identify how mental illness is constructed and understood by staff and inmates within a specific prison environment.

Within the next chapter, I provide the reader with a thumbnail sketch of the research site, Oregon State Penitentiary. I provide this context first, rather than a methods section, as the methods section itself is intertwined with descriptions and explanations of the penitentiary.

Chapter 3: The Research Site: Oregon State Penitentiary

History, Place, and Space

Oregon State Penitentiary (OSP), is the state's oldest men's prison, the only maximum security institution in the state, and is located in the state capital, Salem. The penitentiary has had three separate sites in its history, with the final site at Salem being constructed in 1866. The modern history of the penitentiary is notable for a large riot in 1969 in which large portions of the institution were destroyed by inmates. Oregon State Penitentiary is also notable for its housing of death row inmates, and that during my employment at OSP and during this research, this was the site of executions for individuals sentenced to death in the state of Oregon. The numbers of the inmate population have been around 1900-2100 inmates for the past several years. For at least the past 17 years, the inmate population has not dropped below 2000. In terms of staffing of the institution, there is one correctional officer for approximately every 130 inmates. The penitentiary is described by both staff and inmates as a "city within a city"; i.e. it is a self contained city within the city limits of Salem, and has 22 acres contained within the perimeter wall. The wall of the penitentiary is 35 ft high and extends 35 ft into the ground. Towers surround the institution wall and correctional officers armed with rifles observe the inmates as they recreate on the yard or walk "the avenue", a large paved street that leads to the prison industries area. The prison industries area houses the laundry, for example, which is a large warehouse in which the Oregon Department of Corrections

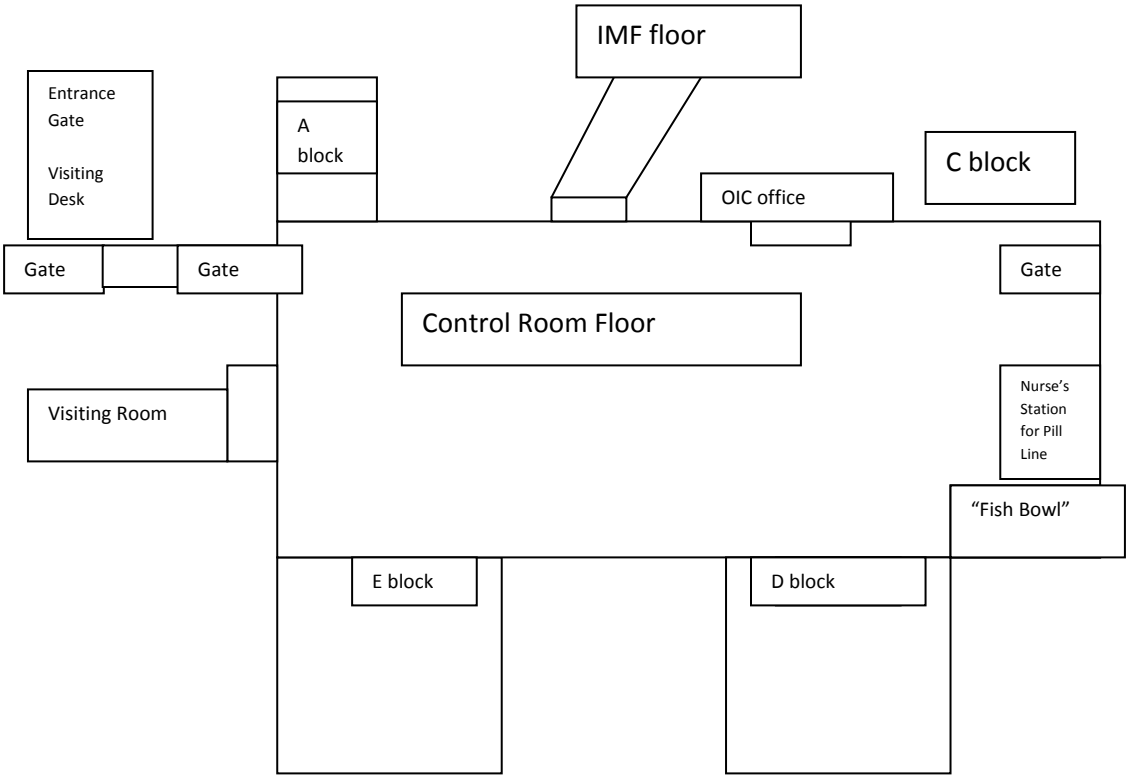
contracts with community agencies and institutions, such as the Salem hospital to perform laundry services.

OSP has four major housing units, which are designated A block, C block, D block, and E block. D and E block are termed “the big blocks”, and house approximately 500 inmates, primarily in double man, 5 x 8 cells. In the diagram below, I have mapped out the main areas of the penitentiary to allow the reader some insight into the physical lay out of the primary housing units of the institution.

Note that in this diagram I lay out the major living areas of the institution and where the primary sites of research occurred. I do not attempt to map out the 22 acres of OSP, including the yard, infirmary, industries, or segregation units. Past the gate from C block there is the canteen where inmates can purchase consumer goods. Down from the canteen is the chow hall, and across from the chow hall is the recreation yard. Parallel to the yard is The Avenue, which stretches to the industries as well as the disciplinary segregation units.

Additionally, I have provided a glossary of terms that are used throughout this dissertation to refer to staff, sectors of the prison, and some commonly used prison terms among staff and inmates to guide the reader.

Figure 3.1: Map of Oregon State Penitentiary



The Research Site: Issues of Site Selection

Oregon State Penitentiary was selected for the research site due to my own professional history within the institution. In 1996 I was hired by the Oregon Department of Corrections to implement the mental health case management program in the institution. In the chapter discussing inmate relationships with mental health staff I provide substantial detail on the history and operation of OSP's mental health program as well as more detailed descriptions of my work. I worked as a mental health specialist at OSP from 1996-2002, and concluded my service for the ODOC at the state's minimum custody institution from 2002-2003.

I chose to return to OSP to conduct this research due to my own experience at the penitentiary. Prisons are notoriously complex institutions, and attempting to grasp the workings of a prison foreign to me was assessed as too difficult a task given that this research was slated for 12 months. Additionally, I had long standing professional relationships with mental health, medical, and security staff at OSP. My initial assessment was that I could enter the prison with minimal questioning of my credibility, and I could readily re-establish myself in the social fabric of OSP as a "researcher". Waldram (1997) and Wacquant (2002) have discussed the inherent difficulties of entering the prison context in order to "do ethnography" behind the walls of a penitentiary and county jail. Wacquant (2002) and Rhodes (2001) have discussed the difficulties in ethnographic work in correctional institutions as related to the changes in management of the U.S. prisons, in which there is a closed system of management within the large state and federal bureaucracies. In the history of

the U.S. prison, sociologists were considered key resources in understanding the social context of these institutions. Since at least the 1980's, the U.S. prison has been a "closed" system, i.e. researchers and "experts" in fields other than corrections or criminal justice have had difficulties in entering the prison context to document the lives of inmates and staff. Waldram (1997) has discussed the challenges of entrance into the institutional environment within the Canadian prison system, and how ethnographic researchers' presence within prison may be contested by administrators and line staff.

The decrease in thick descriptive work in U.S. prisons has been largely discussed as paralleling the rise of "in house" prison experts, such as psychologists and correctional staff identified as "managers". Relationships with outside researchers, such as the University of Chicago's Sociology Department and the Illinois Department of Corrections, are discussed primarily as something that is a relic of the past (Rhodes 2001). Specifically, researchers coming into the prison to examine the complexities of the prison environment and the inmate and staff populations have been on the wane, at a time when the U.S. prison population has undergone unprecedented expansion (Wacquant 2002). Although researchers do access quantitative data from state and federal agencies, and inmates do participate in qualitative interviews with outside researchers, "hanging out" in prison to access the complexities of the social and cultural context is, in 2011, an unusual research agenda for most social scientists. Rhodes (2001) has specifically discussed how little of anthropological research concerns prison or jails, and from my own experiences, this may be a

matter of “selling” ethnographic methods to corrections’ administrators and research divisions, who may be oriented strictly toward quantitative methods. In the following section I provide a brief narrative on entering OSP.

Initiating Research at OSP

In the summer of 2007 I provided the Research and Evaluation division of the Oregon Department of Corrections a copy of the research proposal, and scheduled a visit to Oregon in order to meet with ODOC administrators at OSP to discuss the research. Additionally in 2007, I had the opportunity to tour OSP as a visitor, re-establish my plans and future presence in the prison with staff, meet with OSP’s superintendent, the director of Evaluation and Research, the mental health manager of OSP, and ODOC’s chief psychiatrist.

After arriving in Oregon in November of 2008 I contacted the current mental health manager at OSP to discuss the details of the research, and begin my entry into the prison. No longer an employee, I would have to come into the penitentiary as a “volunteer”, the official designation for all students who enter the prison to conduct research or do clinical internships. I then met with the mental health administration, including the director of Behavioral Health Services and the Clinical Supervisor to discuss details of the research, including days I was to be at OSP, the number of inmates to be referred and screened, as well as how best to recruit staff without disrupting the normal operations of the mental health program. This last issue in particular had to be addressed substantially due to

the challenges of providing mental health treatment in a prison setting, and ensuring that my research would not disrupt the work of the mental health team.

During these meetings with the administration of Behavioral Health Services it was agreed that letters would be sent to OSP mental health staff, interviews were to be conducted on scheduled lunch or dinner breaks, and any inmate concerns were to be reported immediately. This process speaks to the sensitive nature of conducting research in a prison among a vulnerable population as well as security concerns of the presence of a new volunteer in "the toughest" institution in the state of Oregon. Specifically, unrestricted access to the cell blocks and the larger institutional context for a student research is quite unusual for student interns in the Oregon Department of Corrections. Negotiating times of observation and explicitly discussing my goals in observation was crucial not only to ensure my own safety, but also reassure ODOC administration that my presence would not disrupt the work of the mental health team or cell block officers. The Behavioral Health Services administration authorized the final approvals for research in late January of 2009, with a more restricted timeline for data collection and observations. The final timeline for the research was authorized to be from March 2009 – November 2009. The length of time for submission of research proposal and meeting with all administrative staff to authorize the research speaks to the security concerns of the Oregon Department of Corrections as well as the scrutiny research proposals are given due to the vulnerability of research among prisoners.

Visitor Status Achieved : Orientation to Oregon State Penitentiary

In February of 2009 I was granted "volunteer" status, and attended a volunteer orientation at ODOC administrative offices. This training and orientation generally prepped volunteers, primarily Alcoholics and Narcotics Anonymous and religious volunteers, on how to appropriately interact with inmates as well as some of the broader rules of visiting the prison environment. This training included discussions of what not to bring into prison, such as pocket knives or cell phones, as well as what not to do for inmates, such as allow them phone calls from prison office phones. This two hour training was primarily a primer on behaviors expected from volunteer staff. The second orientation and training, Institutional Access Training, was scheduled at the end of February at Oregon State Penitentiary. This was a secondary layer of institutional orientation that was specific to OSP. In reviewing my notes from this training, the correctional sergeant discussed several issues of OSP's "culture" that ended up being substantial aspects of my own characterizations of the cultural context of the penitentiary.

Included in the orientation were discussions of how to interact appropriately specifically with OSP inmates. I include the details of this orientation as it foreshadows much of what I observed and what inmates and staff told me about the penitentiary's social structure and culture. First, volunteers at OSP were to be aware that inmates "manipulate" and play "con games". You were to "keep your eyes open" to potential manipulation or safety and security threats. The prison environment was characterized during the

orientation as one of “paranoia, negative vibes, and hostility”. Officers at OSP were characterized as focusing on “big issues” when it came to “managing” the inmate population, and the officers didn’t “sweat the small stuff”. Inmates were discussed as “mostly normal guys” who “made a bad choice” to come to prison.

Inmates have their “own rules of conduct with each other and staff”. These rules of conduct centered on “respect”. Respect, as discussed by the sergeant, determined the course of interaction with inmates and staff. It was characterized as “fragile”, i.e. that it could be easily lost in interactions with inmates, and inmates could also lose respect from other inmates quite easily. The sergeant discussed the penitentiary as a “stratified, hierarchical society”, in which “Darwin’s theories were applied 24 hours”. This last comment referenced a “survival of the fittest” popular conception of Charles Darwin’s theories of evolution; within an environment characterized as “predator and prey”, the sergeant was already hinting at what I would come to understand as an ethnographer. This environment was one in which the physically and psychologically strongest rule the inmate hierarchy. The amount of respect that an inmate receives corresponds to their niche in the hierarchy, and an inmate may achieve respect from other inmates from engaging in actions as lethal as murder. An Inmate’s niche is secure only due to the respect given to him, and respect is due to an individual primarily in how they carry themselves in the penitentiary.

In terms of interacting with inmates, it was suggested that you keep a friendly, firm, impersonal and distant stance. If you disrespected an inmate, such

as “calling him out in front of his buddies”, the inmate would lose face, and have to “earn his respect back”. You had to keep a physical distance from inmates, and watch your body language, or you would disrespect inmates. The sergeant stated, “You kinda learn all these rules as you go along”. These rules, as this dissertation discusses, are inherently cultural, and many staff and inmates discuss “inmate culture” and the “culture” of the penitentiary as something that has to be learned while doing time at the penitentiary or working there as a state employee. The radically different culture of the penitentiary was emphasized during these initial trainings to gain entry into the prison; what would be considered quite “normal” on the streets “may get you or another staff killed in here”. A staff, whom I quote later in this dissertation, bears repeating due to the power of the statement. This staff pointed to the state employee badge attached to his shirt one day, and stated, “This is a passport to a foreign country. When you come through the gates, you are entering a third world paramilitary country.”

Entry Into Oregon State Penitentiary: An Etic Perspective

I now provide a description of entrance into the prison. This description allows the reader some understanding of the security practices in place and the entrance into the “city within a city”. One does not simply walk into Oregon State Penitentiary. First, employees and volunteers park in the main parking lot of the institution, and walk approximately 60-80 yards up a sidewalk to the main entrance of the prison. The grounds are meticulously landscaped by inmates from minimum custody institutions, and one observes these inmates using hedge clippers and lawn mowers to groom the grounds. As one continues their walk,

they must pass next to a large tower in which an officer, armed with a rifle, observes all vehicles driving up to the main entrance of the penitentiary. The front of the penitentiary, on an given day, may have bus loads of inmates from county jail, deliveries from soft drink companies, state police vehicles transporting inmates, state DOC transports taking inmates to court and hospitals, or staff loitering in the designated smoking areas to the periphery of the main entrance. All of this is within the shadow of the 35 ft high concrete wall which surrounds the penitentiary. As one staff noted, “That wall is to keep people in there, and keep the community safe, it’s not for show”.

Steps lead up to the visiting area where one must check in with the officers at the visiting desk. Visitors to the penitentiary and other volunteers may also be in this area, waiting to be authorized to go through the mental detectors. Officers and plain-clothed staff are observed walking from the interior gates, leaving for lunch or ending their shifts, and one is immediately aware of their grey police uniforms and the militaristic atmosphere. Checking in with the officers at visiting could take up to 15-20 minutes, depending on the other issues they were addressing, which included answering the phone, or checking to see if civilians were on inmates’ visiting lists. Minimum custody inmates are also in this area, sweeping and mopping floors and bathrooms in this waiting room.

I would arrive at OSP around 8:15 a.m. on the days I was scheduled to see inmates. After checking in with the officers at the visiting desk, they would review my volunteer ID badge, confirm I was on the DOC’s computer system as an authorized visitor, and then allow my entrance to the metal detector. There, I

would have to remove my belt, shoes, watch, wallet, car keys, and eye glasses and walk through the metal detector. This can be a particularly unnerving experience, as staff are walking out of the penitentiary right next to the metal detector, and observing you as you seemingly disrobe to ensure you are not carrying metal into the prison – either a knife, gun, or other weapon, or anything that could be used as a weapon. This process is quite similar to post-911 security practices, in which one awkwardly attempts to put one's shoes back on, and re-loop one's belt after passing through the metal detector.

Once one is authorized past the metal detector, I walked down a ramp to a gate. This gate is then opened into a small area that is locked by three additional gates. At the control room window, one is to show their id badge, and then sign in to document that you are inside the penitentiary, in the event that there is a lockdown, i.e. that no one is to leave or enter the prison in case of an emergency or disturbance. The control room is behind bullet proof dark glass, reinforced by concrete and steel beams. It is difficult at times to hear the officers as they direct you or ask you questions. As you hand them your id badge, they scrutinize your face to ensure it is your face that is on the volunteer id badge, and then they open a gate that leads into the penitentiary. From there, one walks down a long corridor, and there is no longer natural light. The walls are painted an institutional yellow, and now one is bathed in artificial light. Down this 20-30 yard corridor, one can see the control room floor, and one final control room where officers will check your id badge one more time, and open the final gate into the

penitentiary. This entire process, from parking in the penitentiary's parking lot, to the opening of the final gate may take upward to 25 minutes or perhaps longer.

Once the final gate is open, one walks onto the control room floor. Inmates may be walking to and from cell blocks, officers linger and stand at various areas of the control room floor to observe inmate movement, and non-uniformed staff are seen walking to and from their offices. One can see the entrance gates to the large blocks, D and E, and across the control room floor, one can see a final gate that leads out to the "avenue" and the yard, and some hint of sunlight.

I provide this description of the physical space of the penitentiary in the same vein as how Wacquant (2002) provided a thick description of his tour through Los Angeles county jail, albeit without his suggestion of documenting the ethnographer's visceral responses. This provides some insight to the reader of how staff and inmates are enmeshed within the social and cultural context of the penitentiary. One indeed feels "within the belly of the beast" as one staff described it, due to the intense process of entering the prison. This experience of entering into the prison did indeed substantiate the previously quoted staff's observation that one is entering a "foreign country".

Some Comments on Reflexivity

Qualitative researchers should be aware of their own biases and perceptions within the context of their research (Ulin et al 2005: 168). In particular, for prison research, researchers must be aware of how their own

personal style and characteristics may influence the individuals that agree to speak to them (Fujisaka and Grayzel 1978). For example, Fleisher (1989), in the context of his ethnographic work in prison came to associate strongly with correctional officers, but during this research *he actually was an officer*, and was doing the work of security as an entry point into his research.

My own moment of reflexivity for this ethnography came after the first day of interviews with inmates and after the first day of "hanging out" in the penitentiary. My first concern was that as a former mental health staff member I did not want to bias myself into documenting the "successes" of mentally ill inmates and the mental health program due to my personal investment in its continued accomplishments. I was aware that this could bias me in favor of reporting that mentally ill inmates did well in this environment simply due to the foundations myself and other staff created between 1996-2002 in the penitentiary. I had the opportunity to speak with several former colleagues during the initial stages of the research, and attempted to process through these potential biases. What I discovered was that I was actually skeptical of the current operations of the mental health program, its relationship with security, and how it worked with inmates. This stemmed primarily from my knowledge of the high level of staff turnover and continued challenges in maintaining relationships with security staff. Further, peripheral discourse from staff indicated to me that the penitentiary was currently somewhat of a "problem" institution; high levels of acuity (i.e. high symptoms and marginal functioning) were reported for mentally ill inmates, and there were continued challenges in providing mental

health services in the institution. Given these reports, I came into the research apprehensive on what the findings would be, rather than eager to document how my own professional efforts nearly 15 years ago set the groundwork for inmate's recovery from mental illness.

What this experience did afford me was an almost instantaneous access to institutional life. Notes from the first day of my work at OSP reveal that I was surprised and *concerned* on how easy it was to "slip back into institutional habits". I was comfortable in the institution, I knew how to "speak the language" and "carry myself" within the prison, and due to that, it was easy to re-establish rapport with staff and inmates. There were several domains of the prison that I had to "re-remember" in order to interview inmates and staff. However, I was able to quite easily shift back into appropriate institutional behavior. I believe Inmates and staff perceived me as "knowledgeable" and "experienced" in correctional mental health, and that I knew how to speak their language, and did not need intensive clarification of many ideas (e.g. how the prison works). My own assessment was that this put participants at ease. Over 30 years ago Fujisaka and Grayzel (1978) entered Oregon State Penitentiary to conduct qualitative interviews with inmates. After initial challenges in getting inmates to speak with them, Fujisaka and Grayzel (1978) discussed how different "styles" of the ethnographers may have contributed to their success in getting inmates to speak with them. An inmate told me one day, "You dress like a cop"; another told me, "With you glasses and hair, people might think you're a sex offender if you were doing time here". Point well taken. Presenting myself as respectful to

inmates, understanding of their situation, and professional in my interactions I believe all contributed to inmates speaking with me. Further, inmates did discuss sporadically during the research that discussing what helps them function and cope in the institution was a positive experience; they could re-affirm in the interviews what they thought was helping them. Inmates also discussed how they hoped their reports could help other mentally ill inmates, and that their interviews might assist prison staff in working with mentally ill inmates. Finally, I can not discount that speaking to a researcher in a private office was not an "interesting" or "novel" experience that broke of the tedium of inmates' lives. I believe all of these issues converged and assisted in accessing inmates as well as explaining why they agreed to speak with me.

I turn now to the methods section for this dissertation. I discusses how inmates and staff were interviewed and recruited, how ethnographic observations were made within the prison, and how data were analyzed.

Chapter 4: Methods

Overview

The research design initially proposed was a mixed method study at Oregon State Penitentiary in Salem, Oregon and data collection occurred from March 2009 – November 2009. The sample included n=20 inmates diagnosed as having the highest mental health treatment needs within the penitentiary, and n=23 staff who self-identified as having experience working with mentally ill inmates. The goal of obtaining an inmate sample was to recruit inmates that had good objective institutional functioning and who also were diagnosed with a psychiatric disorder with psychosis as a primary symptom. The methods consisted of semi-structured qualitative interviews with staff and inmate participants. All interviews were recorded with a digital recorder at the time of the interview. Transcriptions and review of interviews were done by the interviewer. Quantitative data on all inmates in the sample were collected by the Oregon Department of Corrections Research and Evaluation. The data analysis strategy for the qualitative interviews was to transcribe the interviews or review them and take notes on the key questions asked during each interview. Codes were created during interview transcriptions and the interviews were coded using *Atlas.ti* software. For observations of the institution, fieldnotes were taken during or directly after observations of the institutional environment.

Research Design

The qualitative design of the research included ethnographic methods; open-ended qualitative interviews and direct observation of the prison environment were used to contextualize the experiences of mentally ill inmates within the penitentiary. Quantitative data was also utilized in the design; the Oregon Department of Corrections provided the following quantitative data on all inmates in the sample from the period of January 1, 2009 - December 31, 2009:

- Age
- Psychiatric Diagnosis
- Race/ethnicity/cultural orientation (identified by Department of Corrections and self-identified)
- Length of time within institution
- Length of sentence
- Institutional record – ongoing data collection based on inmates' functioning within the prison
  a. number of "write-ups" (or disciplinary infractions)
  b. length of time in disciplinary segregation units
  c. inpatient psychiatric unit on-site in prison
- Type of crime (e.g., drug offense, assault, burglary, sex offense)

The goal of obtaining quantitative data was to first create descriptive statistics of the inmate sample. Secondly, the goal of collecting quantitative data was to correlate any particular themes of inmate interviews with particular demographic or outcome data. Here, I define "outcome data" as defined by the Oregon Department of Corrections. Inmates are assessed as to their "functioning" in the penitentiary by basic outcomes data that is collected and assessed by the Oregon Department of Corrections. Here, outcomes data is not presented in the traditional sense, as in an outcome study in which at varying points in time outcomes are collected on each inmate and statistical analyses are conducted to

generalize to the effects of treatment programs or other interventions. Rather, outcome data here refers to specific data collected by the Oregon Department of Corrections for inmates within the system, and is utilized to provide a "thumbnail sketch" of the functioning of inmates within the system. This data includes the inmates' housing history, the number of disciplinary write-ups (DR's), and compliance with mandatory programming such as education, work, or mental health programming. Inmates, for example, who have a high number of days in the disciplinary segregation unit, the inpatient psychiatric unit, high number of disciplinary write-ups, or non-compliance with mandatory programming are assessed as having "poor functioning" within the institution.

This thumbnail sketch of an inmate's functioning in the institution is accepted within the penitentiary as a means to assess whether an inmate is "doing well" within the prison environment. Conversely, a low number or no days in disciplinary segregation or the inpatient psychiatric unit, a low number or no disciplinary write-ups, and compliance with mandatory programming within the institution indicates an acceptable level of functioning in the penitentiary. This quantitative data was also collected to ensure that inmates in the sample had an objectively high level of functioning in the institution. This data was collected from January 2009 – December 2009.

Recruitment Statistics and Inmate Sample Characteristics

The following table reports recruitment statistics. The designations MH3 and MH2 are discussed after these tables. Seven inmates were initially referred

that were of a lower treatment need (MH2) and did not meet the inclusion criteria. They were dropped from the study.

Table 4.1: Recruitment Statistics

Inmate Recruitment	**Values**
Inmates Referred/Screened	58
Declined Participation at Screening	7
No-Show for Screening	15
Consent	36
MH2 Inmates Consented -Dropped	7
Dropped - Work Conflict	4
Dropped - Increased Symptoms	2
Dropped –Transferred	1
Dropped - Declined to Participate After Consent	2
Dropped Total	17
Final Inmate Sample Recruited	20
Diagnoses for MH3 Dropped Inmates	**Values**
Schizophrenia	3
Bi-Polar Disorder	2
Schizo-Affective Disorder	0
Psychotic Disorder (nos)	3
Post Traumatic Stress Disorder with Psychotic Features	1
Total	16

Table 4.2: OSP Inmate Sample Characteristics

OSP Inmate Sample Characteristics		
Diagnosis of Participants	**Frequency**	**Percent**
Schizophrenia	9	45
Schizo-Affective D/O	4	20
Bi-Polar D/O	2	10
Psychotic D/O NOS	1	5
Major Depression	2	10
Mood D/O NOS	2	10
Total	20	100
Mean Age	45.59	
Minimum Age	25.2	
Maximum Age	57	
Mean Years at OSP	9.6	
Number of Years at OSP	**Frequency**	**Percent**
1 month - 2 years	4	20
3-5 years	4	20
6-10 years	4	20
11-15 years	3	15
More than 15 years	5	25
Total	20	100
Race/Ethnicity	**Frequency**	**Percent**
Anglo/Euro	12	60
African American	7	35
Native American	1	5
Total	20	100
Crime	**Frequency**	**Percent**
Murder	7	35
Attempted Murder	1	5
Rape	2	10
Robbery	4	20
Sex Abuse	1	5
Kidnapping	1	5
Burglary	1	5
Arson	1	5
Possession of Controlled Substance	1	5
Ex Con Weapon	1	5
Total	20	100

The following table presents the number of days inmates within the sample were housed in the disciplinary segregation unit during January 1, 2009 – December 31, 2009.

Table 4.3: Days Housed in Disciplinary Segregation

Disciplinary Segregation Days	**Values**	
N	20	
Mean	13.95	
Mode	0	
Std. Deviation	32.94	
Minimum	0	
Maximum	138	
Disciplinary Segregation Days For Inmate Sample		
Days	Frequency	Percent
0	14	70
6	1	5
13	1	5
27	1	5
44	1	5
51	1	5
138	1	5
Total	20	100

Five inmates were housed in disciplinary segregation during the 2009. Of these five, two inmates were admitted to disciplinary segregation during the course of the study and were re-admitted to the study after their release to the general prison population. The n=2 inmates who were sentenced to 51 and 138 days in disciplinary segregation were convicted of major offenses within the institution. The n=4 inmates who spent from 6 to 44 days in disciplinary segregation were convicted of minor offenses. Here, I make a comment

regarding the initial proposal for this research in which I sought to do statistical correlations with particular inmates' interview themes to determine if any particular themes were associated with these objective outcome measurements. Due to the lack of variability in these objective measures, e.g. number of days housed in disciplinary segregation and the inpatient psychiatric unit, compliance with work and programming, statistical tests were not performed.

Sampling Strategies and Sampling Size: Inmates

The technique used for sample selection was a purposeful sample that incorporated extreme sampling and typical cases (Ulin et al 2005: 56). I sought to recruit inmates that were functioning exceptionally well in the penitentiary, and were also typical of the inmates that mental health case managers worked with in the institution.

The goal of inmate recruitment was to obtain a sample of inmates who had a serious mental illness with psychosis as a primary symptom of their disorder and demonstrated good functioning in the penitentiary based on the previous discussed ODOC outcome measures. The aim of recruiting inmates with serious mental illness and positive institutional outcomes was to document the social and cultural processes they themselves identified as contributing to their success within the penitentiary.

Inclusion criteria for the inmate sample were as follows:

- Psychiatric diagnosis with psychosis as a primary symptom, which included schizophrenia, schizo-affective disorder, psychotic disorder (nos), or bi-polar disorder

- Currently assessed by their institutional mental health case manager as being psychiatrically stable enough to engage in a discussion of informed consent at time of approach to recruit
- Currently housed in general population
- Conduct clear of disciplinary reports for 6-12 months at time of approach to recruit
- Compliance with all mandated ODOC programming and work at time of approach to recruit
- Housed at Oregon State Penitentiary for at least 12 months

Exclusion criteria for the inmate sample were as follows:

- Diagnosis of Developmental Disorders or Mental Retardation
- Currently housed in the inpatient psychiatric unit or disciplinary segregation unit
- Currently assessed by their institutional case manager as not being psychiatrically stable and unable to engage in a discussion of informed consent
- Non-compliance with mandatory work and programming in the institution
- Incidences of disciplinary during a 6-12 month period

A comment should be made regarding the seemingly wide range of diagnostic inclusion criteria for the study. Psychosis as a primary symptom of mental illness is largely considered by corrections administrators, security officers, medical, and mental health staff as marker for an inmate to be classified as having the highest mental health treatment need. By utilizing this symptom as a primary entry point into recruitment, it was hoped to gather a sample of inmates that reflected a high level of treatment need in the institution as well as reflective of the types of inmates that mental health professionals spent most of their time interacting with and treating. Moreover, untreated psychotic symptoms within a prison setting tend to be the most disruptive and potentially hazardous to staff and other inmates. For example, an individual with paranoid delusions or command

hallucinations is a security threat to other inmates and staff if left untreated. So not only are these inmates of primary concern to mental health staff, they also are also regarded by security staff as needing substantial attention within the institution. To provide some context, an inmate with schizophrenia who was severely symptomatic, murdered a correctional officer at Oregon State Penitentiary in the 1970's, due to his paranoid delusions. Psychosis, regardless of the diagnosis form which it stems, is a considered a significant risk factor for safety and security within the penitentiary.

The MH Coding System

Inmates with psychiatric illness are classified under the "MH" code system utilized by Behavioral Health Services (BHS). This system of classification is used to determine the allocation of mental health resources provided to inmates. MH codes also provide information to other corrections staff about an inmate's needs for services and can be shared as they indicate treatment need level rather than details of diagnosis or symptoms, and thus are in compliance with HIPPA regulations. The codes include:

MH3: Assigned to an inmate who has been assessed by BHS treatment provider and, based on diagnosis as outlined, meets criteria for mental health services. The inmate will be restricted to institutions where mental health services are available.

Diagnoses within the MH3 category include: (DSM-IV-TR codes are also give)

- Psychotic Disorder NOS 289.9

- Schizophrenia 295.xx
- Bi-Polar Disorder 296.xx
- Major Depressive Disorder, Recurrent
- Schizo-Affective Disorder 295.70
- Dissociative Disorders 300.12
- Schizophreniform Disorder 295.40

MH2: Assigned to an inmate who has been assessed by a BHS treatment provider and, based on diagnosis, meets criteria for mental health services. These inmates are also restricted to institutions where mental health treatment is available.

Diagnoses within the MH2 category include: (DSM-IV-TR codes are also given)

- 307.1 Anorexia
- 307.51 Bulimia
- 307.50 Eating Disorder NOS
- 301.83 Borderline Personality Disorder
- 287.1 Delusional Disorder
- 294.xx Dementia
- 299.80 Pervasive Developmental Disorder
- 296.2x Major Depressive Disorder, Single Episode
- 301.22 Schizotypal Personality Disorder
- 307.23 Tourette's
- 301.13 Cyclothymia
- 300.22 Agoraphobia
- 300.01 Panic Disorder
- 300.3 Obsessive-Compulsive Disorder
- 311.0 Depression NOS
- 296.90 Mood Disorder NOS
- 300.4 Dysthymic Disorder
- 301.0 Paranoid Personality Disorder
- 309.81 Post Traumatic Stress Disorder
- 298.8 Brief Psychotic Disorder

Oregon Department of Corrections Diagnostic Procedures

Here, some comments should be made regarding the diagnostic procedures within the Oregon Department of Corrections to provide some context at to how diagnoses are arrived at. First, all inmates who are sentenced

to a state institution are processed at Coffee Creek Correctional Facility (CCCF), the intake center for all inmates. At this point, inmates may come into the state system already prescribed psychiatric medications from county jail, and mental health staff at CCCF are informed by medical staff, who review medication records, that an individual will need a mental health screening. Additionally, inmates may come from county jail to CCCF and come to the attention of security, medical, or mental health staff due to exhibiting signs of psychiatric disorder that would warrant a mental health screening. During my employment with the ODOC, I had the opportunity to provide screenings and observe first hand how these assessments are done. A master's level mental health staff or PhD are the staff designated to provide psychiatric evaluations at CCCF. Inmates who come into CCCF already prescribed psychiatric medications are then given a 30-45 minute psychiatric evaluation in which a biopsychosocial history is obtained. Within this evaluation a mental status exam is also performed, and a suicide evaluation.

After this process, the inmate is provided a provisional diagnosis, if warranted, or a concrete diagnosis if there is a clear mental health history. For example, an inmate prescribed anti-psychotic medication, who self reports a history of psychiatric hospitalizations is screened to determine the nature of the psychosis spectrum disorder. Additionally, inmates are also assessed as to whether mental health programming will be mandatory while incarcerated. Although all psychiatric treatment is voluntary, ODOC mental health staff will

assess whether mental health treatment is recommended and part of an inmate's mandatory program within the receiving institution.

After this process, the ODOC's mental health system reports to the receiving institution that the inmate will need a further screening once they arrive at that institution. From there, mental health case managers further assess an inmate's mental status, assess for suicidal and homicidal ideations, and begin the process of gathering a more complete biopsychosocial history on the inmate. Current ODOC policy states that mental health case managers must have a Master's degree, a PhD in Clinical Psychology, or PsyD to provide mental health treatment within the institutions. Clinicians may have a Master's degree in Counseling, Social Work, or Psychology. Provisional MH codes are provided at CCCF to alert mental health staff on how to prioritize incoming inmates. When at the receiving institution, mental health staff then refer to either a psychiatric nurse practitioner or psychiatrist for further assessment for continued need for psychiatric medications.

I previously included the table of diagnoses in the MH2 category to provide the reader with the context for the diagnostic categories that are the focus of mental health services within the Oregon Department of Corrections. It should be noted that other than Borderline Personality Disorder, individuals with primary diagnoses of personality disorder, or DSM-IV-R Axis II disorders, are not priorities for treatment within the prisons. This is not to imply that Axis II disorders are not understood and conceptualized by mental health staff as being present along with Axis I disorders, but that individuals with primary Axis II

diagnoses are not treated for these disorders. More discussion on these distinctions will be explored within the chapters pertaining to how mental illness is constructed within the prison environment.

To provide further perspective on the numbers of inmates with mental illness within the penitentiary, the following table is a point prevalence of the MH3 diagnoses in the penitentiary, as well as point prevalence for MH2 inmates. This point prevalence is based on the review of the ODOC's 400 system which documents the number of inmates with mental health needs within the system.

Table 4.4: OSP Point Prevalence – Psychiatric Disorders

OSP Point Prevalence May 2009	
MH2 + MH3 caseload	457
MH3 Caseload Only	214
Schizophrenia	44
Schizoaffective	22
Bi-Polar d/o	48
Psychotic d/o (NOS)	22
Major Depression (recurrent)	78
	214

As shown in this table, 457 inmates were receiving mental health treatment at the time of the study or 22% of the inmate population. OSP generally houses 2100 inmates with some flux in population. The point prevalence for MH3 inmates in May of 2009 was 10.19%.

I will unpack further the issue of diagnosing inmates within OSP in a later chapter of this work. However, it should be noted that diagnoses fundamentally hinge of the clinical judgment of ODOC providers, who also take into account inmate histories elicited in initial assessments and interviews, as well as processes of consultation among providers at the receiving institution. I quote here from the ODOC's Mental Health Codes and Level of Services Policy dated 7/22/08.

> *Initial Assessment*: When an inmate is evaluated by a BHS treatment provider, a diagnosis will be determined an MH-code with an Acuity level will be assigned. Diagnoses which determine and MH-code can be provisional but not rule-outs. Justification for the diagnosis should be noted. The MH-code is based on the most severe diagnosis. However, the most prevalent diagnosis will drive the treatment approach.
>
> *Discrepant Diagnoses*: If one treatment provider disagrees with another treatment provider about a diagnoses, such as a prescriber and a case manger, there will be a consultation between the providers to determine which diagnosis will be assigned. If a consensus cannot be reached regarding diagnosis, the BHS manager will make the determination.

Formulation of psychiatric diagnoses for inmates is founded primarily on clinical judgment of BHS staff, consultation among staff, gathering of past histories, as well as records or medications prescriptions from county jail. I draw out this distinction to emphasize, then, that the inmates within the sample were not diagnosed through a formal psychiatric schedule, such as the Structured Clinical Interview (SCID), or other such instrument. Inmate diagnoses can change once they are received at their parent institution, or may change over time based on mental health provider assessments. As the majority of this

sample of inmates had been in the penitentiary for at least 15 years, these were diagnoses that had been established for some time, and mental health staff had identified the presence of "true" mental illness in this sample.

Additionally, BHS also assessed acuity levels for inmates, which were designated as Mild, Moderate, or Severe, with frequency and intensity of mental health services based on the acuity levels. These acuity levels were assessed by their primary mental health provider and based on the individual's clinical presentation, current or past Global Assessment of Functioning Score (GAF), and the Behavioral Health Services treatment provider's clinical judgment. The inmates in the research sample were all in Mild (GAF 61-100) or Moderate (GAF 31-60) categories, which was congruent with inmates' self reports of functioning in the institution. If any individual was categorized as having severe acuity, obviously they were not considered as part of the potential inmates for recruitment; there was an assumption on the part of BHS providers that these individuals may not have been able to engage in a discussion of informed consent due to their current levels of distress or psychiatric symptoms.

Procedures for Recruitment

In March of 2009 the researcher met with the mental health staff at OSP at their weekly clinical meeting to discuss the scope and aims of the research project, as well as inclusion criteria. After a period of 1-2 weeks, referrals from case managers began to be sent to the researcher, and the week of March 30th,

2009 was the first full week of recruitment for inmates. No ODOC staff was part of the recruitment process, only I was engaged with recruiting inmates.

Recruitment took place in two areas of OSP which afforded the researcher varying levels of privacy. The first area was on what is termed the Behavioral Health Services Floor, or BHS floor. This area, on the 3rd floor of the Inmate Management Floor, contained 3 offices, one group classroom, and a large open meeting space that was used for chapel services. This area was staffed only by the BHS institution manager and administrative assistant, and all offices had large open windows so staff could observe each other while seeing inmates.

It was initially suggested by the Director of Research and Evaluation that letters be sent to inmates who were referred by mental health staff, and the content of the letter would describe the research. However, sending letters to inmates with mental illness could pose difficulties with confidentiality of inmate's diagnosis, as any security officer can "shake down" or search the inmate's property, and read any letters in the inmate's possession. The same risks were inherent with the inmate population. Inmates can and will demand to see communications from the outside from other inmates, and this could pose problems in the prison environment if the inmate is attempting to mask his mental illness from peers. Additionally, because of the wide variance in inmate's education levels and assumed poorer responses to written text, it was determined that a face to face meeting would yield a higher recruitment rate. Regarding this, a long term staff member commented, "People don't respond to text. You need to talk to staff and inmates face to face". CWRU IRB approved

an alternative method of engaging inmates in a discussion of informed consent that had the researcher inmates being called up to the offices on the BHS and Education floor.

All inmates had to be sent a call pass to authorize them coming to one of the floors for recruitment. The BHS secretary entered the inmate's name within the DOC 400 computer system, an online system utilized by all ODOC staff that tracks all inmate appointments, housing histories, as well as medical and psychiatric needs and diagnoses. Once the researcher was scheduled with the referred inmates from the mental health staff, yellow slips of paper are computer-printed, and then delivered to the cell blocks to be distributed by security officers to the inmates on the cell block. There is limited confidentiality within the prison environment, then, as the researcher's name had to be on the call pass, as well as the inmate's name and cell assignment. Any DOC staff can review any other staff's schedule on the DOC 400, and all inmates' movement and appointment must be tracked in the institution for safety and security of the institution. One pitfall of this recruitment method was that inmates received call passes for a staff member (the researcher) unknown to them, and were called to the BHS or Education floor. In many instances, inmates came to the floor mildly suspicious or apprehensive as to why they were being called out by a staff member that they did not know. This was navigated with substantial care; inmates were asked to come into the private office, and the researcher immediately stated he was a student researcher and was asking inmates if they wanted to discuss participation in the study. As part of this initial discussion, I explained that due to

the limited confidentiality of the prison environment, I did not want to send them written materials or engage them on the cell blocks, and most all inmates understood that this face-to-face process was slightly more private and confidential.

In response to the call pass from an anonymous staff member, a number of inmates accepted the call pass, and assumed that I was a new mental health provider or a student intern calling them out for an interview. With this recruitment method, there were several no-shows, which actually placed inmates in an unauthorized area, and at risk of receiving a DR. The inmates who no-showed were placed on one more scheduled call-out, and if they did not show for the second appointment, they were dropped from the list. Within the penitentiary, navigating and determining what is coercive in an inherently oppressive and coercive environment is challenging. However, given the nature of the inmates' status as a vulnerable population, the researcher attempted repeated call-outs conservatively as to not make the process intrusive or coercive; there was no continued attempts to meet with inmates if they no-showed after two missed appointments. After an inmate stated he did not want to hear more about the research study or continue to be in the office, there was no second attempt to provide more information or suggestion to stay in the office, which was done to minimize any agitation on the inmate's part. Only 2-3 inmates appeared frustrated with the process, and most inmates, even if they did not want to be in the study, respectfully declined and asked to leave the office. In this way, recruitment proceeded without incident.

All recruitment scripts, informed consent forms, and HIPPA waiver forms were reviewed and approved by Case Western Reserve University's Institutional Review Board. All forms and scripts were created at an 8th grade reading level as per CWRU's IRB. All recruitment procedures, including obtaining informed consent were done within the private offices provided by OSP. No recruitment or discussion of informed consent was done in public areas of the institution.

The researcher also made every attempt to review the referred inmates' schedules to ensure it did not conflict with work, school, programming or other scheduled appointments or activities, such as yard time or visits. Given that the researcher also had only three days a week for office space to recruit inmates between the hours of 8:30 a.m. – 2:30 pm, this posed substantial coordination challenges. During this 6 hours block of time, it should also be noted that one hour of it was "count time" in which all inmates were locked down in their cells to literally be counted to ensure no escapes had occurred, and generally from 11:30 – 1:00, inmates were eating lunch, and their availability was variable. Inmates could be scheduled two at a time in each half hour interval, however. This again posed substantial challenges to time coordination. If an inmate consented, then more time had to be taken to discuss the research. If both inmates declined in 5 minutes, the researcher then had 25 minutes of "down time". Generally I used this time to take notes, get coffee, make myself visible by taking a quick walk through the institution's cell blocks, or simply by waiting for the next appointment slots. I characterized several days as "wasted" days, as half the inmates did not show, and the ones that did declined to participate. Given this, I was able to

establish my presence in the penitentiary during these “wasted” days, and I discuss this further in the chapter on observations of the institutional environment.

Initially, the Education floor was an alternative place for recruitment and inmate interviews, as the offices on the BHS floor were available only intermittently during the initial stages of the study. The BHS floor did not have an officer posted, so the researcher had to engage inmates and monitor their arrival and departure on the floor. However, this floor proved to be the optimal setting for recruitment as it was quiet, had a high level of privacy, did not have other inmates present, and was in an environment that mentally ill inmates were used to engaging with staff outside of the normal prison environment. The office was spacious, had natural light (in contrast to the normal institutional lighting in most other areas of the prison), was well ventilated, and had a comfortable area for personal space. The Ed floor office, in contrast, was small and decreased the area of personal space between researcher and inmates. It was not well ventilated and had no windows. It led to a small broom closet with janitorial supplies. One inmate commented that he would not meet with the researcher in this office due to its physical discomfort of the space (i.e. hot, humid, poorly ventilated). This office’s door opened to an area of the Ed floor that was loud, and had high inmate presence, as it was the area for inmates to wait for education classes and appointments. When an inmate arrived at the Ed floor to engage in a discussion of informed consent, other inmates were frequently present, eyeing the inmate and the researcher, and making comments within

earshot. This physical space was significantly challenging for recruitment or interviews, and this space was abandoned after 6 weeks, when alternative office space was found.

The bulk of interviews were then completed either on the BHS floor in a private office or on the IMF floor in the conference room, which afforded an equally comfortable environment. After numerous requests for different office space, I was denied several times with the phrase, “There is no more space to use”. After several weeks of a challenging schedule for room and space in the institution, I pro-actively coordinated the conference room for interviews. This may have been more difficult for another researcher to accomplish, as I utilized personal contacts in the institution to ensure I could schedule this office space. This was another example of the how “outsiders” could be treated within the institution, in that full time ODOC employees direct and can potentially control the movements and actions of “volunteers” or visitors within the institution. I had to aggressively seek office space on my own, or I would have to accept the office space provided. The conference room was carpeted and air conditioned, had cushioned chairs, and afforded a wider range of personal space. These issues, although seemingly incongruous, are notable due to nature of the penitentiary’s physical space. Office space is quite limited, and what was available was primarily represented by the small, cramped, and poorly ventilated office on the Education floor; comfort for inmates, or staff is was not a consideration in the physical space of the institution. To be able to schedule the conference room on

the IMF floor was a boon to the research, as it was similar to a professional office space in the community, rather than a “prison office”.

Recruitment and Challenges to Accessing an Appropriate Inmate Sample

Recruitment was initially planned as a 1-2 month process, with an assumption that I would recruit all inmates needed for the sample within this time frame. Recruitment was eventually done in two phases, with a target number of around 30 inmates sought for the study. In the first phase, from March-June 2009, inmates were screened, and a sample of inmates meeting the diagnostic criteria was recruited. During the June of 2009, a second phase of inmate recruitment was done to gather a second sample of inmates for the latter part of the study.

Of the initial inmates referred by mental health staff, n=7 did not meet diagnostic criteria for the study. The difficulty in addressing this issue specifically pertained to HIPPA regulations in the institution. If an inmate consented to be in the study, it was *only then* that the researcher could present the HIPPA waiver form to receive the documented diagnosis from BHS. A process initially planned as seamless then became a two-part meeting as initial referrals from BHS staff did not meet inclusion criteria, with the second meeting have to be used to discuss with the inmate why he was not eligible for the study after he was referred and consented. Given the time constraints in recruitment, and office scheduling, two meetings to discuss IC and review diagnosis was not a prudent use of time.

After several inmates were recruited, and the HIPPA document signed, it was found that these inmates were actually in a lower treatment need category, MH2. Inmates were being referred to the researcher, but this was not the population that was targeted with this study's inclusion criteria. There was concern that the mental health case managers were referring individuals with low mental health need. My own assessment of this issue was that there was not complete stakeholder buy in to the research process, most likely due to the intensity of the job demands of providing mental health services in a state penitentiary. Due to the challenging nature of providing mental health services in OSP, regularly scheduled meetings between myself and the mental health case managers was not an option to scrutinize caseload lists, staff potential pitfalls of referrals, or for to provide feedback to case managers on the referrals. As the study unfolded, a comfortable rapport was established with 3 of the mental health case managers, but at the onset of the study, there was a substantial discordance between the goals of the study and the demands placed on the mental health staff during their normal working days at the institution. This also impacted the inclusion criteria of having psychosis as a primary symptom of illness for the inmate sample. For individuals with Bi-Polar disorder (n=2), psychiatric files could not be reviewed by mental health staff to ensure that these inmates' psychiatric symptoms were specifically Bi-Polar disorder with Manic Features. This further impacted the initial inclusion criteria. The inmates who were initially referred, who were later discovered as being MH2 inmates (or lower treatment need inmates), were engaged with discussions on the follow-up

interview. After the HIPPA form was signed the researcher further screened these n=7 inmates referred by the case managers.

To these MH2 inmates, I posed straightforward questions as, “Do you know what your diagnosis is?”; “Have you ever been psychiatrically hospitalized?”; “Do you know the names of the medications you take?”; “Do you know what your mental health symptoms are?”. Several consenting inmates, in response to these questions, indicated that they had minimal mental health treatment histories, could not discuss symptoms outside of “stress”, “depression”, did not take anti-psychotic or mood stabilizing medications, and did not see their mental health provider very often. One individual indicated he had not taken psychiatric medications for several months.

Moreover, based on my own professional experience in the penitentiary, and 10 years as a mental health professional, these inmates met a profile for individuals who came to the attention of mental health staff, and were still on the mental health caseloads for “monitoring” purposes. These inmates that are seen every 2-3 months by mental health staff had adjustment issues at the onset of their incarceration, had fleeting suicidal ideations while in county jail (prior to coming to OSP), were maintained on low doses of anti-depressants or antihistamines (for sleep), and were did not have a substantial mental health treatment history. They were model inmates, and met the functioning criteria, but were not severely mentally ill. This issue caused some difficulties in recruitment, as the inmates then had to be told (after they consented), that they did not meet criteria for the study, even though their mental health provider had referred them.

However, I discussed with these inmates that they were not “severe” enough for the study was easily accepted. I frequently discussed this with inmates in the context that I wanted to recruit “SMU type guys” – a reference to OSP’s inpatient psychiatric unit, and synonymous with inmates who were severely mentally ill. My primary concern was that the inmate sample would then be composed of individuals with what is termed “mild mental disorders”, or disorders that warrant psychiatric treatment, but are not severe enough to be designated within the MH3 category.

Given the time limits of the study, the difficulty in coordinating office time in the prison, my limited access to case managers, and the challenges in recruiting an incarcerated vulnerable population, I determined in June of 2009 that I should ask for a second wave of referrals from the mental health staff after discussing with OSP’s Behavioral Health Services Manager that individuals meeting diagnostic criteria in the MH3 category were the population that I was seeking to access.

Here, it should be noted that 4 of the recruited inmates did not meet the specified initial inclusion criteria for having psychosis as a primary symptom of their mental illness. This pertained to the time constraints of the study as well as the high acuity levels at OSP. At the onset of the research BHS administrators were doubtful that 30 MH3 inmates with moderate or mild acuity could actually be recruited, or that inmates, who were recruited, would remain at a lower acuity level during the course of the study. At the mid point of the summer of 2009, only half the sample of the study was recruited, so the researcher had to

accommodate inmates with alternative diagnoses. Given this, three of the four these inmates that were recruited did meet criteria for highest level of need for mental health services, and these brief biographical sketches of these inmates demonstrates this.

Inmate A, diagnosis Major Depression: had several serious suicide attempts during his incarceration, including wrist cutting and hanging that resulted in community hospitalizations for medical care and several admissions and substantial length of stays in OSP's inpatient psychiatric unit. He has a long history of mental health treatment in ODOC.

Inmate B, diagnosis Major Depression: had several serious suicide attempts, including drug overdoses and wrist cutting while incarcerated. He has a long history of mental health treatment in ODOC.

These two inmates with major depression as their primary diagnosis received treatment from the BHS due to their history of suicide attempts, which were assessed as serious, planned attempts, with no documentation of manipulation, or a co-occurring personality disorder, which would place them in a different category among mentally ill inmates, i.e. along a continuum of a "behavioral problem", rather than an DSM-R Axis I diagnosis of major depression. Given that, these inmates were included in the study, as they met the criteria for an Axis I diagnosis and had substantial mental health histories.

Inmate C, Mood Disorder (NOS); this inmate was prescribed a number of psychiatric medications during his incarceration for an extensive history of staff

and inmate assaults, and inability to function in any institutional setting. This assaultive behavior resulted in numerous and long stretches in the ODOC's Intensive Management Units (IMU), or supermax special housing units, in which the inmate is locked down 23 ½ hours a day, and the minimal stay is 6 months. At the time of his consent to be in the study, he had had clear conduct for a period of several months, had obtained employment, and was living in general population in a double man cell with no concerns. Mood Disorder (NOS) is characterized by the DSM-IV-TR as a

> *Category that includes mood symptoms that do not meet criteria for any specific Mood Disorder and in which it is difficult to choose between Depressive Disorder Not Otherwise Specified and Bi-Polar Disorder Not Otherwise Specified (e.g. acute agitation).*

This inmate himself characterized his diagnosis as "bi-polar or adhd [*attention deficit hyperactivity disorder*] and depression". Again, this inmate, although not presenting with psychosis as a primary symptom, received substantial mental health resources to address his assaultive behavior, which was understood as the result of an Axis I psychiatric disorder, rather than due to an Axis II personality disorder or simply criminal or manipulative behavior. This was a type of inmate that often came to the attention of mental health staff, and received medications and counseling appointments to address his behavior in the institution, once a primary diagnosis of Axis II was ruled out. He is a diagnostic quandary in that he clearly benefited from psychiatric treatments, including counseling and medications, but he did not meet criteria for a number of other affective disorders, including Bi-Polar disorder.

Inmate D, Mood Disorder NOS; This inmate had a long history of mental health treatment for mood instability which resulted in self-reported mood swings, anxiety, paranoia, and depression. This inmate has a long history of stability in the institution and represented a lower category of mental health need among the sample and this is the only inmate in the sample that realistically may not have been entirely appropriate. However, given the inmates meeting inclusion criteria that had to be dropped, and the time constraints of the study, this inmate did prove valuable to the scope of the project for a number of reasons. Although he did not have a serious mental illness, he had had substantial contact with mental health staff and mentally ill inmates over the years at OSP, having social contacts of both non-mentally ill and mentally ill inmates. He was also an older, long term inmate, entrenched in "old school convict" culture, was high in the prison hierarchy and thus was a valuable resource regarding the details of prison culture, the characteristics of inmates and staff, the prison social structure, as well as a periodic sounding board for discussing the cultural and social context of OSP.

In ethnographic accounts, he could be considered a "primary informant", not necessarily for his own illness narrative, but as an individual living within the social and cultural context, and with enough experience and insight into OSP to provide valuable insight from "an inmate's perspective".

This altering of the initial inclusion criteria was done due to concerns of not being able to recruit enough inmates for the study sample given the time constraints of the research. This does alter the initial plan, in which individuals

with psychosis as a major symptom of their psychiatric illness were initially sought for recruitment. This inmate sample, however, are "typical" cases within the ODOC MH3 category; these inmates have been assessed as having the highest treatment need in the institution, and their illnesses are considered severe by the mental health staff at OSP. Moreover, for individuals who did not meet the proposed inclusion criteria, two had histories of multiple suicide attempts, and one had a history of staff assaults due to mental health symptoms. From a mental health staff perspective, these individuals are considered "serious cases" that warrant intensive monitoring and treatment.

The previously reported tables not only demonstrate that the inmate sample was primarily older, that slightly more than half the sample had been at OSP for at least 6 years or longer, and that their crimes were primarily person to person crimes, including murder and attempted murder, sex abuse and rape, kidnapping, and robbery. This inmate sample were what can be considered a "typical" OSP inmate, given the security level of the institution, and traditionally the types of inmates sentenced to this prison. Oregon State Penitentiary has been primarily conceptualized by Department of Corrections employees and inmates as an institution for older inmates with longer sentences. Although this was understood to be changing and perhaps no longer true due to the influx of younger inmates with shorter sentences, characterized by many staff and inmates as having "nothing to lose" and thus not bound to the old school convict code.

Given this, the inmate sample was overwhelmingly an “old school” OSP sample of older inmates with serious crimes, with substantial sentences who had primarily been at the institution for longer than 5 years, and 18 of the 20 inmates had the highest mental health need level within the institution. Additionally, the inmate sample generally conformed to the ethnic/racial breakdown of OSP, with 60% being Euro-Americans or Anglos, 35% African-American or Black, and 5% (n=1) being Native American, which is slightly higher than the inmate population. I bring this to the reader’s attention to highlight that regardless of their psychiatric diagnosis, these inmates were “typical” OSP inmates in terms of their age, crime, and length of time at the institution.

This inmate sample also can be shown to be functioning well in the institution. For these 20 inmates, there were no admissions to OSP’s inpatient psychiatric unit during the study. There were, however admissions to the disciplinary segregation unit for six of the inmates, with two of those in the sample being admitted to DSU during their participation, and 4 inmates having DSU admissions either prior to or after their participation in the study during 2009.

For the majority of inmates that were admitted to the disciplinary segregation unit, these were minor infractions. For the inmate that received 138 days in Disciplinary Segregation, this was a major rule violation that was incurred after his participation in the study, so the circumstances of his admission were not available. The inmate who received 51 days in segregation did so because of receiving a urinalysis positive for heroin.

Recruitment of Staff

For OSP staff recruitment, the sampling method can be characterized as a convenience sample. Staff members volunteered for the research who "self-identified" as having experience working with mentally ill inmates. An inclusion criterion was this self-identification of experience as well as being a current employee of Oregon State Penitentiary. In this instance, my own personal history in the institution was of some benefit, as staff who did volunteer to participate were assessed by me as having substantial experience working with this inmate population. Recruitment of staff obviously did not have the same ethical considerations as recruitment with the inmates with mental illness. However, recruitment of staff did pose its own set of unique challenges.

I was given an opportunity to speak at a large administrative meeting in March to present the research and discuss with security and professional staff how to participate. This process largely worked, as well as using my own former professional contacts to generate referrals from staff. One of the only criteria presented to staff for participation was self-identified experience with working with inmates with mental illness. Due to my history at the institution, this did make identification of potential staff participants easier, and I can confirm that the staff that consented did indeed have substantial experience working with mentally ill inmates. Twenty-three staff members were recruited, and this table provides a break-down of their role in the institution.

Table 4.5: Staff Sample Characteristics

Staff	
Security	7
Administrative	3
Mental Health	6
Medical	2
Correctional Counselor	3
Education	1
Work Supervisor	1
Total	23

All of the staff recruited had more than 5 years working at OSP. Of note is that of the mental health staff recruited, 4 of the staff recruited had worked at OSP for less than 18 months, and in ODOC for no longer than 2 years (at other institutions). This reflected the high turn over rate for mental health staff at OSP, which was estimated to be 100% turnover rate nearly every 6 months for the past several years.

One of the challenges of interviewing staff related directly to time staff could allot to participation in the study. As there was no compensation for participation in the study for staff or inmates, staff essentially had to utilize their free time during their working day, i.e. during their mandatory 30 minute lunch break or before or after their scheduled 8 hour work day. No staff volunteered to be interviewed outside of the institution, and the research design prohibited

interviewing staff at their home, as the researcher felt it was too intrusive. One of the challenges in interviewing staff within the institutional context was that appointments were sometimes canceled due to crises in the penitentiary, and staff's schedules did not always coincide with scheduled times for the researcher to be at OSP. On several occasions, phone interviews were substituted for face to face interviews, but only after a face to face discussion of informed consent had taken place, and at least one face to face interview. A handful of staff (n=3), indicated that they were too busy at work, or did not want to cancel their break, and were not wanting to "talk about work" on the phone at home after logging in an 8-10 hour day at the penitentiary, or on the weekends. These individuals were not consented, and declined to speak about informed consent. This reluctance speaks to the potentially psychologically draining nature of the working at the penitentiary. Staff's disinclination to participate seems to have had less to do with buy-in to the research, and more to do with time constraints and willingness to sacrifice breaks and their own free time outside of work.

For security officers in the study, interviews were also done informally on the cell blocks during down time on their shift while working in the cell block. This improvisational approach to interviewing security officers speaks to the limited amount of time they had during the day (for breaks) and the challenges of interviewing staff who engaged in shift work, but also to the officers' level of comfort in being interviewed or discussing aspects of their work while they had free moments during their shift.

Inmate Interviews

All inmates were interviewed at least 4-5 times utilizing a semi-structured interview style. (See appendix for questions asked of inmates). Of note is the number of interviews done with each inmate; generally there were 4-5 interviews with each inmate, of 30-40 minute in length, over the course of 3-4 months.

Table 4.6: Inmate Interview Statistics

Inmate Interviews	**Value**
Number of Participants	20
Number of Interviews	99
Range	3
High Value	6
Low Value	3
Average Number of Inmate Interviews	4.9

This research technique was utilized for a number of reasons. First, it allowed a comfort level to be attained by the inmates; after 1-2 interviews, the inmates knew that information from the interviews was not being shared with staff or other inmates. In transcribing the interviews, it was noted there was a perceived difference in the tone and comfort level between interviewer and inmates from the first interview to the last. Although a common process in interviewing, it should also be noted that many qualitative studies may rely only on one interview, which could potentially restrict the amount shared in an interview due to comfort level. In an environment such as the penitentiary, trust,

particularly for a staff member, comes slowly and with difficulty. This general inmate cultural rule for interactions with staff was compounded by the fact that these inmates had serious mental illness, and many of them had paranoia as a prominent symptom of their disorder. Moreover, inmates did complain and vent at times in the interviews. Capturing these narrative strategies in only one interview only allows access into one aspect of inmates' lives, and would not have fully captured the inmates' perspectives on their lives or experiences in the institution. I also used multiple interviews as an opportunity to ask the same question in different formats or with different emphases in order to ensure I was understanding the inmates' narratives appropriately. This strategy also spoke to dependability of the qualitative data, i.e. did inmates consistently state, for example, that housing was a substantial positive factor in their psychiatric stability, or was a fluctuation elicited in their interviews, and if so, what was the self-reported cause (Ulin et al 2005: 26)? Additionally, it spoke to some criticisms of the study raised not only by some Department of Corrections administrators. Simply, how would I know that what the participants was telling me was accurate or grounded in "reality" given that they were severely mentally ill, in addition to being inmates. This research argues against this custodial paradigm, and instead assumes that individuals with severe mental illness can accurately describe and discuss their lives, and that the perspective of these individuals is profoundly important to understanding the world in which they live (Davidson 2003: 4-5).

Although this may appear to be an inordinate number of interviews, it did also allow for the researcher to monitor the functioning of the inmates as the study progressed, and this allowed for a fuller understanding of their lives within the institution. For example, several inmates discussed how "nothing changed" during the course of their participation, and this contributed substantially to an understanding of how these inmates remained psychiatrically stable in the penitentiary. Additionally, other inmates were sent to DSU or the infirmary, had minor conflicts with other inmates or staff, and all of these events unfolded during the course of the interviews. Rather than 1-2 interviews that relied solely on capturing narrative, repeated interviews allowed for a contextualization of the experiences of the inmates in the study.

It also allowed the researcher to confirm certain reports of staff and inmates in terms of the events in the institution. For example, an inmate on the mental health tier became symptomatic and smashed his TV on the cellblock and was sent to SMU. This story was substantiated and fleshed out for the researcher during inmate interviews. Another inmate reported that he felt threatened by another symptomatic mentally ill inmate who had smashed his mirror and used shard of glass as a threatening weapon, and this was also confirmed through other inmate interviews over time. Conducting 1-2 interviews with inmates to document narratives may not have allowed for a full understanding of mentally ill inmates' experiences in OSP. Inmates also reported that the interview experience was positive, as it allowed them to verbalize and identify factors that contributed to their stability in the institution.

Staff Interviews

Staff interviews were conducted along similar lines, with 3-4 interviews done for each staff member during the course of the study. Staff interviews also followed a semi-structured interview process. See appendix for a list of staff questions.

Table 4.7: Staff Interview Statistics

Staff Interviews	**Value**
Number of Participants	23
Number of Interviews	69
Range	2
High Value	5
Low Value	3
Average Number of Staff Interviews	3

Interviewing both staff and inmates was a strategy not only to address issues of credibility and dependability of data (Ulin 2005: 24-26), but also to understand the larger institutional context in which staff and inmates interact. Interviewing only one group of this unique institutional context would only access one perspective on the penitentiary, and not fully capture a range of responses and understandings of social and cultural processes at work in the institution. Additionally, I also was interested in whether there would be discrepant identification of contextual factors that contributed to psychiatric stability for inmates with severe mental illness. If inmates identified a host of factors, and

staff did not acknowledge or agree with these factors, I was interested in what this would then mean in terms of institutional culture. With the understanding that culture is contested, expressed and understood along gender, race and ethnicity, class, and age, I wanted to also grasp whether there was congruence or discordance among inmates' and staffs' narratives. Staff narratives were profoundly significant; no matter what an inmate identified as contributing to positive outcome, it would not matter if staff did not also agree that these factors, such as housing, for example, would contribute to inmates' stability. And if staff identified particular social factors such as employment as significant, and inmates themselves did not, then inmates would refuse to work, and this staff opinion would be rendered meaningless to inmates. In this sense, then, I attempted to blend both inmate and staff narratives to arrive at a consensus as to how inmates with severe mental illness successfully functioned in the penitentiary, coped and recovered from their illness, and lived within the institutional context.

Observations of the Prison Environment

Observations of the prison environment were crucial to further contextualizing the narratives of inmates and staff. Although reviewers of this initial research proposal called into question terming direct observation of the penitentiary "participant observation" I would challenge this. First, my status in the institution was that of student researcher, which came under the social category of "volunteer". As a volunteer, and one that walked freely through the institution interacting with staff and inmates, I was under the same formal and

informal behavioral regulations as paid staff. I was frequently approached by inmates, and asked questions as to who I was, my research, and where I worked in the penitentiary (e.g. medical, education, etc). Additionally, inmates also engaged me in questions as to who to contact in the institution for information, if I knew how to accomplish particular goals, or simply to talk to pass the time. All of these interactions are actually participating as a staff member within the prison, as was outlined in the volunteer training I participated in as a condition of entering the institution. I did not simply observe, but also interacted with staff and inmates as any other staff member would. I make mention of a point which may seem obvious, but I want to emphasize that being physically present in OSP as a volunteer and ethnographer was substantially different than student experiences or visitor experiences I witnessed over the years I worked at the institution.

For example, visitors to the penitentiary are not allowed to walk through the institution unaccompanied, and must be in the sight of full time staff at all times. Students doing clinical internships are also within "visitor" status, and must be observed by full time staff at all times, or they are in the "volunteer" category. In my experience, students would not walk through the penitentiary unaccompanied by supervising staff, and as part of their clinical internships, they may never observe the workings of a cell block, the dining room, the infirmary, or the industries (e.g. laundry). Being in the context of the penitentiary required that I engage with inmates and staff. Moreover, as a volunteer, I was obligated to follow the Oregon Accountability Model, which required staff and volunteers to

model pro-social behaviors, and be aware of their own behavior and its consequences. At the most basic level, it required that staff/volunteers engage with inmates in a productive, positive, and substantial manner on a day-to-day basis. From the ODOC website:

> Decades of correctional research support Social Learning and Cognitive Behavioral principles in staff/inmate interactions. While the concept of a correctional facility as a learning environment is unusual, it is based on sound principles related to behavioral modeling. People learn by watching the behaviors of others who they respect; therefore in a correctional environment, staff members have a responsibility to act in a respect-worthy manner at all times.
>
> It is well known that both staff and inmates contribute to the institutional environment in which they work and live. Focusing on employees' responsibilities for pro-social role modeling begins to establish the necessary conditions for a pro-social institutional environment. Staff members are encouraged to recognize that they serve as immediate pro-social role models. Consequently, their every behavior needs to be worthy of emulation and adoption by inmates.
>
> The nature of interactions and communications with inmates is a key to success. The Staff/Inmate Interaction Component takes advantage of the period of incarceration to clarify and shape pro-social behavior with the ultimate goal of establishing durable behaviors that will translate to the community when inmates leave incarceration and re-enter society. The Oregon Accountability Model summarizes the manner in which DOC employees contribute daily to the successful achievement of the agency's mission.

The goal of this intensive engagement of the prison environment was to understand, on the most visceral level, how inmates lived and how staff and inmates interacted, as well as get a "feel" for the environment after being away from the penitentiary for several years. Observations occurred immediately entering the institution, and frequently after entering the penitentiary, I would take time before my first appointment to make notes on staff/inmate interactions, or note some occurrence I had witnessed. Observations were done in between

appointments with participants, and during the course of each day I was at the penitentiary. I conducted research 3 days a week for 36 weeks. Each day at OSP was at least 7 hours in duration. Approximately 432 hours of observation time over 36 weeks was conducted during the research.

Table 4.8: Direct Observation Statistics: March 2009 – November 2009

Direct Observation Time - 36 Weeks	**Value**
Average Daily Hours	4
Average Monthly Hours	48
Total Hours	432

Observations occurred in the cellblock, primarily D block, where the mental health tier was located, but also on the main control room floor, the IMF floor, the Education Floor, the Infirmary, and Industries. After each period of observation, I took notes in the office provided for me, or simply went to a common area (the OIC's office) and sat and took notes while having coffee with the security officers.

Data Analysis: Interviews and Observation Notes

Interviews were either transcribed or reviewed and notes were taken during this review. Interviews were tape recorded for all inmates. For a correctional officer (n=1) that I interacted with on the cellblock, notes were taken during the interview. A list of the research questions is provided in the appendices.

All transcribed interviews and notes from interviews were uploaded into Atlas.ti software (version 5.5). Codes were created based on the research question and the theoretical model utilized in this research (Bernard and Ryan 2010: 55-56). Additionally, as the research interviews were conducted, I created codes for data that were not already accounted for with the first codes. In the appendix is the list of codes, broken down into *apriori* and codes that emerged during the interview processes. In this process, interviews already had large segments that answered particular questions, such as "tell me about your relationships with mental health staff".

As interviews were transcribed, I made notes as to the themes which emerged utilizing the *apriori* codes such as "relationships with security staff". Processes for understanding the interview transcripts, or immersion, included reading and re-reading the interviews at the very least three times each, which allowed for further comprehension and review of the interview data during the research (Ulin et al 2005: 144). Reduction of data interview data to manageable coded sorts occurred after interviews were concluded, and allowed for review of all themes coded for in interviews (Ulin at al 2005: 144-145). Due to the number of interviews conducted, the amount of observation time, and the sample consisting of both inmates and staff, this lent *credibility* to the interview data, as interview data was verifiable through multiple interviews with multiple participants (Ulin et al 2005: 166). As appropriate during the analysis, and subsequent chapters of this dissertation, I present divergent findings on particular themes, as elicited in the interviews.

Finally, after compiling coded sorts of all interview themes, the large blocks of coded interview data were then compiled into files generated by Atlas.ti software (version 5.5) that correspond to the codes listed in the appendix. The interview data, now compiled and coded, was then reviewed for discrepancies and generalizations. During this process, observational data was also used to validate interview data as well as review for discrepant data. The following table presents an overview of interview data collected, as well as how it was handled; the majority of interview data was transcribed, with a small subset of interview data reviewed and with notes taken.

Table 4.9: Interviews: Analysis Methods

Interviews: Analysis Methods	**Value**
Inmate Interviews Transcribed	91
Inmate Interviews Reviewed with Notes	8
Total Inmate Interviews	99
Staff Interviews Transcribed	54
Staff Interviews Reviewed with Notes	15
Total Staff Interviews	69

Observation notes were utilized within this research to validate inmate and staff descriptions, observations, and explanations of the prison environment. Additionally, as a majority of the direct observations took place in D Block, where

an entire tier was established to house mentally ill inmates, this afforded some opportunity to observe how security officers manage a cell block while also interacting with mentally ill inmates. No observations were used for specific inmates in the sample; i.e. I did not follow inmates in the sample during the course of their day to observe their interactions with other inmates and staff. Observation methods were used to expand on the data gathered from inmate and staff interviews, as well as to understand how the penitentiary "worked" on a daily basis, in terms of inmate-inmate interaction and staff-inmate interactions. In summary, primary data was gathered using qualitative interviews, observational data was utilized to verify credibility of the interview data (for both inmates and staff), and the quantitative data was utilized to characterize the inmate sample as well as monitor these inmates' functioning in the prison environment.

Some Comments of the Use of Quotes

In several instances in this dissertation, I attempt to provide inmate and staff perspective on several of the domains discussed within the context of the research. In some instances, I provide 2-3 quotes from medical, security, and mental health staff to reinforce the validity of the data; i.e. it was confirmed by not only inmates, but by all sectors of the prison staff. Additionally, it should be noted that not all inmates were highly descriptive in their interviews. Some inmates spoke more extensively about particular issues and only gave shortened answers to some topics. I attempt to provide not only these longer blocks of narrative, but also smaller portions to provide insight into the data gathering process.

Chapter 5: Mentally Ill Inmates' Relationships With Correctional Officers

Inmates with mental illness interact most frequently with security staff than any other staff within the institution. A mental health staff member stated:

> There's literally nothing that happens in the institution that does not revolve around security staff. They're the first contact, the first line of defense and observation for inmates.

When speaking with penitentiary staff, they frequently discuss this as a source of frustration, or as an example of their expertise in dealing with inmates with mental illness. Mental Health case managers may see inmates on their caseload once or twice a week, once a month, or even every two months, depending on the severity of illness or acuity of the illness. Correctional officers interact with mental health inmates daily, depending on their post position in the institution. Moreover, officers get to see mentally ill inmates' behavior within the prison environment, interacting with other inmates, and observe their day to day functioning, such as if they go to yard, the chow hall, how their cell is kept, if their clothes are clean, or if they are speaking and communicating.

This depends on the particular post an officer has. For officers in special housing, such as IMU, DSU, or SMU, their interaction with mentally ill inmates is daily, and thus intense. For an officer with a post on the education floor or in industries, he or she may not have as much contact with mentally ill inmates. For officers on D or E block, the interaction with this inmate population is increased. Just at the onset of this research, the mental health tier was moved from E block to D block. This housing of mentally ill inmates together, in a specialized and segregated tier had the effect of making mentally ill inmates identified to

correctional officers, and also served to expose officers to this population of inmates. Moreover, since the cell blocks rotate staff every 6 months, as does the SMU, then officers do get some exposure to inmates with mental illness. It would not be accurate to say that all correctional officers interact intensely with mentally ill inmates during their work at OSP. But for the officers that do, they are the staff that interact with this inmate population the most.

The question, then, is what are the interactions like between mentally ill inmates and block officers? Does this make a difference in their illness outcomes? Does this daily interaction with officers mediate or impact their psychiatric illness? There are several themes that emerged from the interviews which indicated how officers interacted with mentally ill inmates, as well as how mentally ill inmates responded to questions of whether having relationships with security made a difference in the outcomes of their psychiatric illness.

What Is A Relationship in Prison?

"Relationship" has a double meaning in the penitentiary. Many times I had to re-phrase my question regarding relationships with staff as "professional" relationships. "Relationship" between staff and inmates, within the language of the DOC, *refers only to inappropriate relations*, such as financial or sexual. This understanding is key to grasping what is meant by relationship in the prison. Relationships with security are highly structured within the penitentiary, and there is an explicit hierarchy, with correctional staff being the ones in control of the institution. Unpacking this relationship reveals that it is substantially more

complex than this model of control. The following sections of this chapter, as well as contextualized account of these relationships reveal that there is more to these interactions and relations than the control and authority of the officers over the inmates.

The Context of Relationships Between Inmates and Security Staff

The ratio of staff to inmates alone demonstrates to inmates that there can only be so much control and force utilized to keep the institution running smoothly. A long-term mentally ill inmate discussed how physical control of the inmate population was simply not an option due to the staff-inmate ratio.

> Here, the institution can turn ugly easily. You gotta come out of the cell block for somethin'. Because it is a rambling, old institution, you got 500 somewhat guys in a cell block. [*as compared to other prisons where the housing units are only 100 inmates and segregated from each other*] So when you run in there with the goon squad, how many goons you gonna need to clear a tier?

This quote reflects the physical structure of the penitentiary in which officers are "outnumbered" by the sheer amount of inmates housed within the cell blocks. Officers and inmates frequently joke, "The inmates let us run the prison", and although this sentiment can be used by staff as a joke, or used by inmates as a veiled threat, it is true. A mental health staff discussed how rather than the use of force or threat of force, he understood the prison's workings and dependent on the relationships inherent in the institution.

> In order for the prison to run smoothly, it depends on layered relationships. The captains then have to have relationships with the line staff, and from the line staff to the inmates. Each one of those has to work. It isn't a formal agreement, but there is an agreement. Inmates have to agree that the line staff is running the institution. Line staff have

> to agree that the inmates know they run the institution. It's all about relationships in between. For it to run well, the relationship between the staff and inmates has to exist. And the agreement has to be understood…*'You're in charge, you're in charge of me, and I let you do that*'. It's a symbiotic relationship.

An inmate living on the mental health tier also agreed that the penitentiary is run on the relationships between officers and inmates. The high level of staff-inmate interaction, or "relationships" is one component that both staff and inmates point to as the foundation for how smoothly the prison operates. An inmate living on the mental health tier discussed security staff on the cell blocks have to rely on these relationships in order for the cell block officer to do his job.

> A: You have to have a relationship with others. It's not all 'get in your cell!.' A lot of that goes on, but the sergeant working that block every day, he has to develop some type of relationship with the inmates.

A correctional officer discussed this high level of inmate-staff interaction in the context of the Oregon Accountability Model (OAM), a programming model that encourages this high level of staff-inmate interaction to reinforce pro-social behaviors in the inmate population.

> The Oregon accountability model stresses the relationship that we have with inmates, in a wide variety of areas, that working relationship. I think there's more staff inmate interaction here than in any other institution in the department. We don't rely so much on cameras and electronics systems as we do turning the key and going face to face with inmates and giving them respect that way.

This same security staff acknowledged that in the past, this was not always the case, and prior to the implementation of the OAM strategies of control centered less on communication and relationships and more on "total control" through physical means.

> In the 80's, we took care of things physically a lot more than we do now. The first reaction was ok, let's get physical. I found that the more we got physical, the more physical we needed to be to maintain order. Your best tool in this business is your ability to communicate.

Here, we see a current emphasis on establishing and maintaining relationships through intensive communication with inmates. Officers participating in the research acknowledged that communication was essential in dealing with inmates on a daily basis.

This high level of staff-inmate interaction is the first thing one observes when coming into OSP. Inmates, although they do tell you that there is "a lot of cell time", actually move about quite freely in the institution, and interact significantly with security officers. Many times during my observational periods in OSP on the cell block, I would be the only plain-clothed staff among a dozen or so inmates and one or two staff, and all of us would be talking and interacting. This is quite different from other correctional institutions where, for example, correctional officers do not interact with inmates, inmates do not talk to staff, or officers may be perched on tiers within the institution and armed with rifles. This high level of staff interaction stems primarily from the implementation of the Oregon Accountability Model, a program-oriented directive concerning how staff are to interact with inmates within the institution, which includes modeling pro-social behaviors, treating inmates with respect, and providing opportunities for changing behavior.

This ethos of the penitentiary, then, creates the opportunity for staff

and inmates to interact substantially within the boundaries of a professional relationship. Contextualizing these interactions reveals how the course and outcome of psychiatric disorder for mentally ill inmates may be mediated by these relationships with security staff.

Inmate Perspectives on Relationships with Officers: No Relationships

Some mentally ill inmates discussed that they did not seek out any relationships with officers. This appeared to stem from a convict code of conduct in which inmates are not to interact with staff. Within the sample, n=4, inmates expressed no desire to interact with correctional officers on the cellblock where they lived.

> Q: What is your relationship with officers on the cellblock?
> A: Very basic. "Can I get this, can I get that?" I been down 8 years, I don't have a conversations with 'em. They're here to do a job I don't agree with…because I'm locked up…because of the officers, and I'm gonna take responsibility for what I did, but they are the ones who put me in here. Am I gonna be buddy-buddy with someone who's guardin' over me 24-7, that's tellin' me what to do when I'm a man? Not happenin'.

This inmate reveals his own perspectives on security staff that are informed by a convict code: that security is there to "guard" over the inmates, their jobs or livelihood is dependent on inmates being locked up, and there is also resentment that officers have ultimately have control. Three other inmates, one with a history of long term incarceration two with a life sentence mirrored this sentiment, of how they did not feel a need to interact with officers.

Another inmate discussed his lack of interaction with security due to a clash of personalities, and his mistrust of security officers in general due to their attitudes towards inmates.

> Q: What is your relationship like with security staff?
> A: We've have a few on our unit that you don't talk to. You try everything in the world to not have them around. They've developed some type of hate thing. You can't trust what they say or do, they suspect everybody all the time.

This inmate later revealed during an interview that he chooses to have minimal contact with security officers due to his self-reported history of being abused by officers in other correctional systems (he denies that this had occurred in Oregon), which fostered a deep resentment towards security staff. He did however, not bear a grudge against officers, nor did he adhere to a convict code that pitted officers and inmates against each other in the daily struggles of the institution. Rather, he simply avoided contact with them as much as he could while still meeting his daily needs in the cell block, and in particular, attempted to avoid interactions with officers that were overly aggressive or disrespectful. Although this inmate reveals that he has minimal contact with correctional officers, he also reveals within the same comment that some staff seem decent, and other security officers you simply avoid because of the way they interact with inmates. Another inmate also revealed he had difficulty in establishing rapport with officers due to his mental health issues.

> I don't have close relationship with lot of the staff. I don't seek out relationships with security staff here. I don't do it because of my own comfort. I'm a loner. So I kind of have a stand offish…they probably perceive me as stand offish or not trusting.

Here, we find varying reasons as to why some mentally ill inmates do not seek out more substantial working or professional relationships with staff. Either inmates are following some variation of the convict code which demands minimal staff-inmate interaction, or they perceive the officers as merely custodial workers with no reason to establish relationships. The previous inmate's quote implies

his own symptoms, which he later revealed to be based in paranoid symptoms, mitigated any relationships specifically with correctional officers.

The understanding of officers' personalities, their work, and the way they approach inmates comes from the daily contact on the cell blocks. From this daily contact, then, how do relationships arise? The forging of these professional relationships hinges on more than proximity, as inmates in the sample did discuss that they were not compelled to establish relationships, and could utilize officers as a custodial resource to simply meet their needs, such as open doors, answer procedural questions, or receive call passes.

Establishing Relationships: Mentally Ill Inmates and Correctional Officers

For mentally ill inmates that did establish working relationships with security officers, this relationship hinged on shared cultural values of trust within the institution, which is intimately tied to consistency in officer behavior, understanding and recognizing mentally ill inmates as a unique category of inmate, and officers' flexibility in exercising their control over the inmate population through rule enforcement. Although the prison is theoretically conceived as a site of observation, staff observing inmates, the inmates also observe staff as intently, if not more intently, simply because they have more time and initiative to direct their observations towards not only other inmates, but staff as well. Inmates get to know the personalities of correctional officers as they work their 6 month bid in the cell block. An inmate discussed how he perceived differences in correctional officers' styles of working with inmates and how the differences in officers' personalities structured how he engaged with

them on the cellblock.

> All the officers have their different ways of doing things. It doesn't really matter to me, now there's different officers on the tier all the time, cause nobody bid for the tier. Some officers treat us like shit, some don't. I try to stay away from them, but some of the officers do like me…and those are the ones that I look to, and the others I leave alone, and have less communication as possible.

This inmate reveal that it is important to get to know the personalities of the officers that work on the cellblocks. Even for correctional officers that are overly aggressive, strict regarding rule infractions, or, as inmates and staff like to say, "an asshole", inmates discussed how it was still important to figure out the personalities of the officers they were interacting with. Since the cell block can change officers every 6 months, or bid to a different post, then at times it is a matter of adjusting to different staff personalities as well as how they run the cell block.

> Q: What's your relationship like with security on the cell block?
> A: That's a challenge. Cause we've had normal ones there lately, it hasn't been switching up. But when they change officers every 6 months, then you got to go through this whole new program, 'this is what I do, this is my work thing', and that adds some stress, adjusting to that.

To determine the personalities of the officers, or even to ascertain whether they were having a "bad day" was crucial in interacting with them. Due to inmates' intense observation of officers, they also know their responsibilities on the cell block, and inmates do acknowledge that officers can be busy, and their terse manner is not something to be taken personally.

Trust: What Does that Mean in Prison?

Relationships within the institution are forged on a shared cultural value of

trust. Trust is a complex construct in prison. In an environment characterized as inherently paranoid, where no one can be trusted, how can trust be established with inmates or staff? The most critical aspect of gaining inmates' trust, the cornerstone of the relationship, is consistency of behavior, as demonstrated in following through on your word. A correctional officer unpacked this crucial cultural model.

> If you prove yourself to them, being straightforward and true to your word, not lying to them, doing your job the inmates will come to respect you. And that's when it'll work well for you, if they respect you.

Initially, all new correctional officers have to get to know the inmates they work with, and the inmates also have to get to know the personalities and work styles of the officers. This is done is through officers establishing a consistency of behavior. The hallmark of this consistent behavior is following through on your word. "Your word" for an officer can be something as simple as following through on an inmate's request for new supplies on the block, or as crucial as contacting a staff member on the telephone. Regardless of the request, or task, following through on the request, be it either "yes" or "no" it is critical for inmates to establish trust with staff. In following chapters of this dissertation, I will demonstrate how this ethos of trust is enacted between staff, but for now I focus exclusively on how it is enacted between correctional officers and inmates. Giving your word is crucial to establish to inmates that you are trustworthy. A security officer described this ethic:

> A: Finding the time to teach the inmates the proper conduct, it's like lead by example. You watch what I do…I do what I'm supposed to do, I am where I'm supposed to be. If I say I'm going to do something, I do it. That's what I tell new inmates,

> that this place runs on respect. And part of that is…*your word*. *That's all you really have*. When I give my word as a staff member to another staff member or inmate, you better believe I'm going to do it, unless there's some extreme circumstances, and then I'm going to get back to that person as to why I couldn't do it. And I and a lot of officers have that relationship. I'm good on my word. If I say you're going to get something, you're going to get it.
> Q: So this respect gets tied into being a man, and if not, then you're a punk, not a man. This describes people who don't follow on their word, or can't be trusted?
> A: Yeah, 'man-up'. Yes, that's accurate. It's the inmates' code, and we've adopted that, for security. For the staff, that's the code we follow, too. Not the bad parts of the convict code, but the keeping your word part, that part of the code. If you're going to have respect, you're going to do those things.

In this environment, this is also intimately tied to "being a man", or "manning up". That is, *doing* what you say you're going to do, and *meaning* what you say is critically tied into constructions of masculinity in the prison that are also tied to a convict code of behavior in the institution. A mental health staff also discussed how staff can be "tested" by inmates to determine if their word can be trusted, and how each staff member is assessed by inmates of being trustworthy, and ultimately worthy of respect.

> I think trust works experientially. In other words, the inmate population has this saying, 'you have to earn your bones'. For staff, they have this same mandate on them. They have to earn their bones with the inmates. That's about the stand up, when the staff follows through with what they say they're going to do, it commands respect. Inmates respect that. They may not like it in the moment…and there's some staff who won't do it…and the inmates don't respect that. The trust that gets built…it's a trust of being *who you are*, I trust you're going to do what you're supposed to do, and I'm going to do what I'm supposed to do. People are watching, and they remember how you react, and how you behave, and what you do and what you follow through with. I think everybody in that whole prison…you, me, everyone…is tested. Whether or not you're consistent or whether you do what you say and say what you do. Or you don't.

This cultural model of trust is critically unpacked through these quotes.

Following through on your word, consistently, will most likely gain inmates' respect and, in many instances, inmates will test you to determine "where you stand", and how you react. If consistency of behavior is observed and recognized by inmates, then a level of trust can be established, that the staff will follow through on his word, or quite simply, do his job. Respect is earned, then, in the penitentiary by staff. Once a staff is respected, due to this consistency in behavior, then this may set the grounds for a relationship among correctional officers and inmates. A mental health staff member emphasized, that in his opinion, this consistency in behavior was critical for mentally ill inmates, being in an environment where they have little control over their lives, stating, "The worst thing for mentally ill folks is when you can't predict what's going to happen".

Finally, an inmate discussed how establishing relationships with security was enacted through the intense interaction between inmates and staff, as well as how he pragmatically perceived these relationships as a potential means to meet his needs within the institution.

> It's like the Stockholm effect. These are your keepers, these are the people who have control over you. So to have some type of rapport with them is actually a good thing. A lot of guys are like, "I won't even talk to a cop". Well, if I need something or a higher staff, and I need to get something done, and it's urgent, I can manipulate that. Not in a bad way. I hate to say this, but there's some cops here I like, they're pretty decent guys. If I needed something done, if I needed to check my account, or make a call, they'll call my counselor. He may be cool, but he's still a cop. Cause if he's in the tower, and you're putting it on a mutherfucker [*assaulting another inmate*], he can still shoot you legally, and not do a day in jail. You gotta know.

This issue of trust and respect his is a cultural ideal within the penitentiary. Staff will remark that some inmates, no matter what you tell them, will interpret it

as deceit. Officers would remark that if staff didn't say yes to a request, it was perceived as malicious, or if the request was put through, and in the higher ranks of security officers the request was denied, then some inmates would accuse staff of deceit. For corrections staff in general, this is interpreted as inmates being "anti-social" or "gaming", or "using aggression to meet their needs". And inmates will also remark that some staff can never be trusted, regardless of their actions. I present this cultural ethos as an ideal type that staff and inmates are aware of as a value in the institution. How it is enacted and constructed may vary, there may be frequent violations of the ethic, if not outright flouting of this ethos. But it is always present, either contested, ignored, or defended staunchly by staff or inmates. I turn now to another component of relationships between mentally ill inmates and correctional officers, the officers' understanding, knowledge of, and acceptance of these inmates' mental health issues.

Mentally Ill Inmates Relationships with Correctional Officers: Taking Into Account Mental Illness

Inmates living on the mental health tier in D block discussed how this knowledge of mental health, and an acknowledgement that inmates can have mental illness, and *that it is actually present in the inmate population*, structured the working relationships they had with the officers that work on the cell block. The following quotes are representative of mentally ill inmates discussing correctional officers' knowledge of mental illness and how this impacted their working relationships with security.

> ***Inmate A***
> Q: Tell me about relationships with security staff…

> A: There's certain security that work with you better. Sergeant _____ is one of the few, that know about mental health. When they work there, it makes a difference. They know about it, and they know some of the things that people go through. They'll just come down and talk to you at the cell.
>
> ***Inmate B***
> Q: So living on the mental health tier, these cops know how to talk to you?
>
> A: They do, and they know my prior situations, and the difficulties I've had with officers and they keep that in mind. The officers have to know this in order to interact with you. They want to know how to approach you.
>
> ***Inmate C***
> Q: Do the officers on that tier understand mental health?
>
> A: They're very understanding and they know things.

A correctional officer also discussed how acknowledgement or understanding that inmates may have mental illness structured interactions:

> In general population, if he's a known quantity, like having a mental illness, and you have that knowledge of his illness, you take that into account for what's going on. You may take the extra minute to say, '*Are you having a bad day? Did you miss you meds?*' Whatever it may be.

Mental Health staff also discussed how officers' knowledge of mental health opens up the possibility of working relationships with this inmate population

> What I've heard from inmates is that security staff, in general, have an understanding of mental illness and they don't use their symptoms against them.

Correctional officers generally acknowledged that rotating through various posts in the penitentiary, particularly the inpatient psychiatric unit (SMU or MHI), or the large cell block with the mental health tier allowed staff to get experience and training regarding how to work with mentally ill inmates. A security officer

discussed how officers gain experience in working with mentally ill inmates as well as how the actual increasing prevalence of psychiatric disorders in OSP made it impossible to ignore this large segment of the inmate population.

> I think in the past, maybe 4-5 years, it's been brought to a more broad enlightenment of staff in general. The numbers…it's kind of one of those things you have to adapt to, because the number of mentally ill inmates and emotionally disturbed inmates coming in every day are going through the roof. It's a natural progression of the system, that the DOC has to adapt and know they're here.

A mental health staff also acknowledged how rotating through housing units that had high numbers of mentally ill inmates also contributed to an awareness and acknowledgement that mental health concerns must also be considered in the management of the inmate population:

> About a year ago the MHI changed to be a biddable post for officers. We thought we were going to get a bunch of security guys up here that don't know how to work with the mentally ill…*'it's going to disrupt the unit*'. Every 6 months when they changed the bid we got staff that need to be trained, and some of them don't work out. It's a disruption every 6 months, but overall it's been a positive benefit of distributing the wealth…distributing the training of staff to know how to work with the mentally ill, and these other staff go out to general population on other posts and they leverage that training with their fellow staff. I think it's been helpful. They've learned that these guys have an illness…it's just one other facet to managing inmates.

Two security officers specifically addressed how his rotation in the inpatient psychiatric unit allowed him to better grasp the signs of mental illness.

> ***Officer A***
>
> Everyone should work in the inpatient psych unit. I wasn't so sure about people hearin' voices. I saw a lot of things there – people posing in one spot until their feet bled, talking to the walls, people in positions on their bunk so they could urinate in their mouths.
>
> ***Officer B***

> I worked in special housing [*segregation units*]. I've seen these guys improve. Guys used to be smeared with feces, fighting you. The were warehoused. Now they're in population, doing well, on meds.

This informal training between corrections officers are coupled with formal in-service trainings provided to correctional officers. This allows an understanding of mental illness and how best to interact and address the needs of this inmate population.

> I think that's a product of training, doing the trainings, and being more cognizant of the issues these guys are dealing with and how best to deal with them. We've got more training over the years, and I think it's good. I just think there are staff who listen to that, and staff who do not. Some staff are trained better than others.

This security officer also suggested that not all correctional officers have similar trainings or interest in working and interacting with mentally ill inmates, a point that was also reflected in mental health staff's discussion of inmate-officer relations, as well as some inmates' discussions that not all officers have an understanding of mental health issues. During discussion of staff's perception of mental health issues in the prison and among inmates, there was always discussion about alternative discourses on mental health among security staff. That is, there was always acknowledgement that some officers "never got it", or were not interested in working or dealing with inmates with mental illness, and there was also assumptions by some security officers that all inmates were gaming, and mental health was a "crock". Another officer emphasized the voluntary aspect of working closely with mentally ill inmates:

> Q If an officer is aware of someone's issues they can work with them?

A: Correct, but you have to want to work with them also. You are not obligated to, because you can treat them like all the other inmates in here. But you have to want to. I think people have come so far in that direction - security staff.

However, here we find participants discussing that an important piece of the relationships between officers and mentally ill inmates is quite simply the acknowledgement of the numbers of mentally ill inmates within the institution. Additionally, displaying some type of understanding of the challenges for mentally ill inmates, and a working knowledge of mental health issues, such as appropriate treatment provides the basis for an interaction that is perceived by the inmates as positive. Inmates discussed how this acknowledgement or understanding structured their relationships with the officers and created a positive working relationship on the cell block.

Inmate A
Q: You said the officers were easy to get along with?
A: Yeah, they respected me, I respected them.
Q: So it wasn't like they were hassling you all the time?
A: Yeah, they treated me like a human being. They're very understanding. They don't make fun of people

Inmate B
It's like a comfort zone, you know you can come to work…and say you're frustrated, and you're going off the deep end, and you go up to the sergeant and say, 'I need the day off', and he says, 'Oh, you're having one of those days, no problem'. Instead of going [sarcastically], "*What's wrong*?!?" They know exactly what you're going through.

Inmate C
The cops are treating us different on the CTS tier. Most of the cops are showing us concern, checking up on us, seeing if we're going to kill ourselves or not. They want to make sure we're not distraught or suicidal.

Inmate D
Q: Sounds like trusting them and knowing that they care about what's going on in your life makes that relationship good, is that

right?
A: That's it, that's it, exactly.

Staff and inmates acknowledged that the foundation for the penitentiary's workings hinged on social relationships between inmates and staff. I will further address how this operates between staff in a later chapter of this dissertation. The relationships between officers and inmates is founded on a substantial daily communication and interaction that is encouraged and expected not only through broader Department of Corrections' initiatives, such as the Oregon Accountability Model, but also the structure, culture, and physical space of OSP. Inmates and staff have *opportunities* to interact due to policies and the culture of the penitentiary, which requires a high degree of communication to foster and maintain these working relationships. For mentally ill inmates, they may choose not to engage with security officers, due to strong or soft adherence to a convict code, lack of desire to foster those relationships, or having mental health issues that make forging such relationships quite challenging. Relationships among staff and inmates are founded on and structured along trust, which hinges on mutual respect. This respect is earned by consistency in staff's behavior, primarily measured by following through on your word. For mentally ill inmates, there is another component that is not present in regular staff-inmate relations, and that is acknowledgement that inmates may be suffering from a mental illness, and that a level of understanding fosters relationships between this inmate population and security staff. The final component of this relationship, officers' flexibility in exercising their control over inmates, is perhaps the most crucial element of the relationship between correctional officers and mentally ill

inmates. It is within this context that we can observe how these cultural processes of staff-inmate relationships, trust, and knowledge of mental health unfold within the context of help seeking for inmates and "management" of inmates for security officers. It also demonstrates that these relationships are established and maintained by correctional officers through a knowledge of the particular mentally ill inmates' specific mental health issues. This knowledge is gained primarily through the intensive interaction characteristic of the penitentiary.

How Relationships with Correctional Officers May Mediate Course and Outcome of Psychiatric Disorder for Inmates With Mental Illness

Accessing Services and Help Seeking

As established earlier, correctional officers spend the most time with face to face contact with inmates. The question is how this interaction, or how relationships might mediate the course and outcome of psychiatric disorder. Interviews with staff and inmates characterized correctional officers as the "first line" responders to mental health crises on the cell blocks, or the "gatekeepers" between mentally ill inmates and mental health staff outside of their normally scheduled appointments. An inmate summarized the process for accessing mental health staff in times of crisis in between scheduled appointments:

> Q: You said the officer's the gatekeeper?
> A: Yes he is. You got to ask the officer. That's how it works on the cell block, too…you need a call pass to go places in the institution. The officer will call up to mental health, and write you pass if it's alright for you to come up [*to see mental health on an emergency basis*]. If they say no, then you got to write a kyte and wait. You have to rely on the officer, especially if you need

> to talk to a mental health prescriber…like if you need your medication changed, or you have a problem like you're hearing voices and you might actually feel like hurting yourself, and you're like, '*Please, let me talk to someone, I feel like hurting myself…I need some help*'. If they know you, they'll help you. If they really don't know you or think you're playing, then they'll tell you to go write a kyte. If the officer likes you, and you're for real with them, they'll do you a favor, they'll help you. There's trust there.

Here there are several issues surrounding the context of the penitentiary that may mediate or influence outcomes for mentally ill inmates. First, mentally ill inmates can not access mental health staff readily in between their scheduled appointments. Inmates are not allowed to walk around the institution, or go up to the floor where the mental health staff are located if the inmate *himself* assesses that he needs to speak to mental health. He must ask the officer on the cell block to call his mental health case manager and report that he is requesting to see mental health staff.

This is a process that must be negotiated and navigated by inmates and correctional officers in the context of the cell block. The cell blocks, as noted in a previous chapter, are sites of intense activity. Inmates move freely from their cells to jobs and meals, and officers are responsible for opening and closing cell doors. Officers also answer the phone by the sergeant's desk, responding to requests for inmates from the visiting room or staff, coordinate issues surrounding the physical plant's addressing upkeep of the cell blocks, calls from other officers to share information, or any other variable and numerous requests. A typical day for the cell block sergeant is to answer the phone, write inmate passes, respond to inmates' questions and requests, check in with inmates arriving on the cell block, open cell doors for the first tier (both high and low side

tiers), and also observe inmate behaviors when they can to ensure a safe and orderly operation of the cell block. Added to this responsibility is responding to requests from inmates wanting to see their mental health case managers.

The question is how do officers know how to respond to these requests? Here, the title of "professional observers" that is used by some correctional officers to describe their work, comes into play. Officers, who have received training, or understand some signs of psychiatric symptoms make assessments of the inmates' needs. Additionally, officers get to know particular inmates, their signs of decompensation, and note changes in behavior. It is not simply the training that they may receive, either formally or informally, it is also their knowledge of the inmate himself. This was discussed by several staff and inmates and I provide quotes from inmate participants that reveal the importance of getting to know the inmates they work with:

> ***Inmate A***
> Q: It's important to have a good relationship with security if you have a mental illness?
> A: Yes it is, cause they'll walk by your cell and check up on you and say, *'How ya doin*?'. They speak to you and see you everyday, and they know you take medication cause you're in pill line.
>
> ***Inmate B***
> Q: Some officers will respond? Listen to you, and that's what makes them good?
> A: Yeah
> Q: Cause they don't have to do that, do they?
> A: No….They'll help, it depends on who it is, and if it's within reason.
>
> ***Inmate C***
>
> I was having an issue, I was hearing voices at the time…I went to a guard I have a pretty good rapport with and I told him, I'm having some issues and I need to see my CTS counselor, and he said, '*OK, since you're on my tier, and everybody down here*

> *has some issues, I'll write you a pass so you can see them and get the help you need. Don't use this as an excuse to go to the yard. I'll call up and make sure you got up there.*' On the mental health tier the officers that work that tier are flexible with us, they know what we're going through. If I qas going to a guard on the mental health tier I know I would be alright.

All of these inmates above discuss how a personal knowledge of the inmate, i.e. that he is in mental health treatment as has legitimate mental health needs, structures the officers' responses to inmates' requests for assistance. Security officers acknowledged the importance of working with inmates to ensure they accessed appropriate services when in crisis.

> ***Officer A***
> The sergeant works on the block 5 days a week. He gets to know the inmates, to know their personalities, and if they're not taking their meds, and the behavior is changing, he picks up on that pretty fast. We check in with him a lot and it's not only mental health staff checking in with these inmates, it's real important to have a lot of security check in with them, because we're the ones that spend a lot of time with them. Security staff do a wonderful job of checking in with these inmates, seeing if they're doing ok, they really take an interest.

> ***Officer B***
> If I know a guys is a CTS inmate, I will spend a little more time with him, I will go the extra mile, and actually try to get him hooked with his meds, rather than deal with the individual when he's off his meds and acting out. It just makes for a smoother flow. If you give 5 minutes of your time, 10 minutes to individuals you know have problems, you can avoid it. So it's up to you. You have to go the extra mile with the mentally ill in here.

Mental health staff also discussed how officers' understanding of inmates' signs of psychiatric decompensation, as well as knowledge of the inmates' histories are critical in alerting mental health staff of changes in behavior.

> ***Mental Health Staff A***

> There are many inmates they keep on an even keel, simply by stopping by the cell and talking to them. And from the officers' standpoint, a lot of it is monitoring, and a lot of it is proactive contact with somebody who may be quite withdrawn or quite suspicious, and wants contact, but doesn't trust it enough to go out and find it. It's very helpful to have an officer check in with them on every shift.

Mental Health Staff B

> We're lucky to have a lot of security staff that's worked in MHI [*inpatient psych unit*] or worked with them over the years and they'll give us a heads up…*'He's doing this or that'*. The officer will call us and give us a heads up on what's going on. It's a good thing that security has known the inmates over the years, and knows what they're symptoms are, and what is baseline for them…and what is normal, and what is problematic for them.

In these quotes, several themes emerge. First, officers get to know the inmates that they work with on the cell blocks, and through these relationships, they get to understand warning signs of decompensation. Officers are then encouraged to contact and communicate to mental health staff what they are observing. One mental health staff noted that officers are getting better at using professional psychiatric language such as "appears delusional" or "can't concentrate" rather than the catch-all prison argot terms "spinnin' out" or "nuttin' up" for any unusual behavior deemed to be "mental". This allowed mental health staff to better assess the nature of the crisis.

Here, we find that officers voluntarily establish some rapport or working relationships with inmates that are known to them to have serious mental illness. I turn now to how officers actually perform their tasks as part of the security sector of the institution. It is within these narratives that it is revealed that officers

may take a flexible approach to managing or interacting with mentally ill inmates. It is this flexibility, or allowance of a "grey area" of behavior in a strictly black and white environment that may mediate the course and outcome for inmates' mental illness, as well as contribute to positive outcomes for their disorder.

Flexibility in Exercising Control and Rule Enforcement

This section begins with a narrative from an inmate living on the mental health tier who discussed how an officer "cut him a break", didn't issue a disciplinary report, or "write him up" for being aggressive with another inmate.

> A: Well…somebody left a note on my bunk…fire and brimstone…saying I was going to go to hell. So I jumped on that person that I thought it belonged to…threatened to beat him to a pulp…and he turned around and told the block sergeant that I threatened to kill him.
> Q: Why would someone leave a note like that?
> A: I was doing something in my cell and he didn't like it. I'd had run in with this guy earlier about it…
> Q: Why did you threaten him?
> A: I don't know, I just went into a rage when I read the note I assumed it was him, and I threw the note in his house and I screamed and threatened him.
> Q: Did you get in trouble?
> A: No, the sergeant just asked me if there was going to be a problem. And I told him no.
> Q: What about this guy [*that he threatened*]?
> A: He didn't react to me threatening him, other than to go to the block sergeant.
> Q: Is he a rat then?
> A: Yeah.
> Q: What's going to happen now? Is he going to leave you alone, or are you going to fight….how does that work?
> A: Well the whole deal came from him staring in my house when he walked by and he's been doing that for years. And I keep telling him not to do that.
> Q: That's rude in here, isn't it?
> A: You never know when somebody's scoping your house, seeing if you have anything to steal…or catch you doing something.
> Q: Did you get in trouble with the sergeant?
>
> A: No. He pulled me aside and said, is there going to be a problem? And I told him, no. And I told him what happened and I also told him I talked to my case manager and my psychologist, and he sent them both an email….saying that he talked to me

> Q: Could the sergeant have written you up?
> A: Yes [*for threatening another inmate*]
> Q: Did he cut you a break?
> A: Yeah
> Q: Cause he could've just put you in the hole, right?
> A: Yeah, he recognizes we're on the CTS tier. He kept the note I threw in the other inmate's cell.

This inmate later revealed that the block sergeant contacted this inmate's mental health case manager to let that staff know that this inmate was having problems with another inmate on the tier. Here we find that there is a clear rule violation; the inmate verbally threatened another inmate, disrupting the workings of the tier, and potentially initiated a fight with another inmate. The officer recognized that the inmate had mental health issues due to his placement on the mental health tier. Rather than write him up, the officer decided to allow mental health staff to intervene and work with the inmate. Sending this inmate to disciplinary segregation would have potentially decompensated the inmate; the noxious environment of "the hole", and the inmates in that housing unit are notorious triggers for increasing psychiatric symptoms among mentally ill inmates. What this narrative reveals is a pragmatic approach to addressing the occasional outbursts, negative, or aggressive behavior of mentally ill inmates. Security staff discussed how a strict enforcement of prison rules may not be the best approach in the management of this inmate population:

> I think writing them up is the wrong thing to do in most cases for mentally ill inmates. Writing them up and locking them up and punishing them, it doesn't work. A lot of these guys, in dealing with them over the years, they're not aware of the consequences, it doesn't mean the same thing to them. It's much easier in the long run to work with them. The word gets around and we see what happens when they go into disciplinary segregation, they go downhill. So most staff won't do that, most of the staff will go out of their way to help.

An officer's narrative on how he was able to get a psychotic inmate out of his cell, cuffed, and to the inpatient psychiatric unit reveals how not only is flexibility important in addressing mentally ill inmates' needs, but also, in his own opinion, may have made a difference in getting the inmate to comply with his orders to be cuffed up to go to the unit.

> This guy was off his meds for a month. He was spinnin' out at 6:00 A.M. I guess he was hearin' voices, acting like he was in marines. I told him, "man, can you wait another hour or two? [*until mental health staff got to work*]. I called his mental health counselor, and we had to get him to SMU [*inpatient psychiatric unit*]. He wouldn't back up to be cuffed. But I know they guy. I said to him, 'eyes on me!' Another sergeant and me, we talked him into backing up to be cuffed (*to go to the inpatient psychiatric unit*). Man, that was easier. Back in the day, we'd just ***get him*** [*do a cell extraction*]. You can take that home with you [doing a cell extraction]. You just can't hit the gate and forget that.

A cell extraction is a risky scenario on a cellblock. Officers have to come to the cell block, "suited up", i.e. with black body armor, and with hard plastic shields that utilize tazer technology to stun the inmate. It generally involves two or three officers rushing into the cell and subduing the inmate. There are security procedures in place to ensure safety, such as filming the episode on a hand held camera by another security staff for later review to make certain that no abuse of the inmate occurred. What the officer is stating, however, is his relief that he did not have to get physical with a psychotic inmate at 6:00 a.m., just when the officer started his shift. Utilizing his own personal relationship, as well as using "his head" rather than the full brunt of security's coercive force ensures that the inmate goes to the psychiatric unit rather than the disciplinary segregation unit for "disobedience of an order". Once in disciplinary segregation, decompensated and symptomatic, the inmate now runs the risk of being ensnared in the

penitentiary's disciplinary apparatus, rather than in a treatment setting where his symptoms can be addressed adequately. The officer took an alternative route to address the behavior because he knew the inmate was mentally ill (due to him being housed on the mental health tier), and he understands the signs of psychosis to realize this was not a "security" issue, but a "mental health issue". It was mental health, not "behavioral", and thus warranted an alternative strategy to manage the inmate and respond to his needs.

There are other instances of officers being flexible with mentally ill inmates that may also contribute to their outcomes within the penitentiary. Officers were seen on the mental health tier during my observation periods, walking down the tier, having conversations with inmates in their cells, to monitor how they were doing, i.e. whether they were "doing ok", or rather, if they were showing any signs of psychiatric illness. An officer discussed how this process may help these inmates navigate the structure of the institution.

> A lot of the sergeants that are really good with these guys, who work with them a lot, they'll walk down the tier, and the guys who haven't gotten out, because they're confused or they don't know what time it is, they'll talk to them. "Hey Fred, how come you haven't come out, aren't you going to chow?". 'Oh yeah, I forgot'. And they'll go back and open the door for them. That is the exception; that is not procedure. If you don't make it out, you don't get out. You don't get to eat.

For inmates that are not mentally ill, officers strictly enforce the rules of the penitentiary. Officers don't "babysit" non-mentally ill inmates, or regular general population inmates. During my observation periods on the cell block, officers would, in response to an inmate question or request tersely state, "You already know the answer to that", or "Ask your cellie". One day on the cell block an

officer was in the cell block's office, frustrated. I asked, him, "What are you doing?". The officer replied, "I'm writing a dr (*disciplinary report*). Somebody told me to fuck off. That won't stand". Officers, although providing some leeway at the penitentiary, do not allow flagrant rule violations from non-mentally ill inmates. Another cell block sergeant remarked, "I told my staff, you gotta take control of the block. If not, the inmates are gonna run the block". There is also an expectation that inmates will manage themselves in the institution. Of course, minor rule infractions may be overlooked from a strictly pragmatic perspective, i.e. a verbal warning rather than sending an inmate to disciplinary segregation may work just as well to deter behavior. And the penitentiary has a reputation of being somewhat lax as compared to other institutions in the system in terms of rule enforcement. Other institutions were characterized as "nit picky" by some correctional officers in terms of rule enforcement. I propose that this primarily has to do with the relationships between inmates and staff that allow this perceived "looseness" or general flexibility in enforcing rules. A cell block sergeant stated, "When I'm, dealing with lifers, I put it in auto-pilot, they know what to do", meaning he does not have to manage every aspect of the cell block with inmates that "know how to do the time". The inmates manage themselves. However, when it comes to issues that are serious security concerns, there is no flexibility for general population inmates. An officer remarked one day to me while on the cell block, "On my block, there's no fighting, fucking, or doing dope". Otherwise, there can be a certain amount of general flexibility in enforcing rules, such as knowing inmates are passing nuisance contraband to each other, such

as magazines or pens. Some older officers will even state they won't shake down a cell if they smell tobacco smoke (tobacco is contraband), they just tell the inmate to "flush it down the toilet" and "don't let me smell that again". In other institutions, that would warrant a cell shake down, a disciplinary report, and perhaps even an interrogation to determine where the tobacco was obtained.

For mentally ill inmates, however, taking the extra time to monitor their behavior, respond to their requests, or simply inquire on how they are doing is itself a flexibility of approach that is not expected to be done with regular general population inmates. Regarding this difference in approach, a security officers discussed their different approaches with inmates; inmates without mental illness were held accountable for their behaviors all of the time.

> ***Officer A***
> Out in pop, the average Joe doing his thing for a while, and he runs off the mouth disrespectful, and you know he doesn't have mental health issues, he's not going to get any leeway. "*Ya know, you screwed up, I'm writing you up, have a nice day*". He doesn't really have…he has more control over himself, and is expected to hold a higher standard than a guy who has issues that make him lose control.
>
> ***Officer B***
> A lot of times with mentally ill inmates, you talk to them calmly, tell them what to expect, ask them what's wrong, see what you can do. I've used more 'what can I do, what's going on?' with them. It's more about *them* when you talk to them. Whereas, with a normal inmates, it's all about *me* [laughs].

In conclusion, the officers interviewed for the study discussed how a flexibility of approach in their interactions with mentally ill inmates was the best approach. That is, they took into account a mentally ill inmate might have difficulty in navigating the structure of the institution due to their illness, and thus officers may take extra time to check up on them in the cell block, ensure they

left their cells for meals, or respond to their requests more carefully. So this flexibility is not necessarily part of the general flexibility characteristic of OSP's correctional officer culture. Rather it is a flexibility based on the perceived deficits of mentally ill inmates' functioning and presence of psychiatric symptoms. In particular, to reference an earlier narrative, an inmate who would not leave his cell would most likely be the recipient of a cell extraction. Of course, officers would also attempt to communicate with him, due to the cultural changes in OSP over the years. However, knowledge that the inmate was seriously mentally ill directs the officer's attention to alternative, less black and white options to the "management" of the inmates' behavior, and warrants alternative strategies to get the inmate the treatment he needs, rather than "sending the ding down to the hole". This "checking up" on mentally ill inmates ensures that these individuals are navigating the institution appropriately, and meeting their basic needs. One officer remarked, "As long as they go to get their meds, get them to their mental health meetings and groups, they're good". Officers' attention to ensuring that inmates make pill line, get their cell door opened to go to mental health appointments, or are simply functioning adequately is somewhat beyond the scope of correctional officers' obligations with regular general population inmates. Inmates are expected to learn the rules of the institution, comply with the orders of staff, and manage themselves appropriately within the prison.

I turn now to a final component of the working relationships between officers and mentally ill inmates that is tied directly to this flexibility. In the following section, I discuss how officers may go further in their interactions with

mentally ill inmates by acting as social supports within the institution, a role outside of the normal scope of correctional officers' duties within the penitentiary.

Correctional Officers As Social Supports to Inmate With Mental Illness

The following narrative was heard from both inmates and staff regarding a particular officer that worked on the mental health tier and attempted to assist a mentally ill inmate beyond the normal scope of monitoring or checking up on him. An inmate who lived on that cellblock, but not on the mental health tier discussed how this officer assisted the inmate.

> There's this one officer, and there was this one guy on the mental health tier, and he had some severe mental issues, he was paranoid all the time. This guy is really fucked up, I think he's paranoid schizophrenic, and this cop would take him out a couple of times a week on the yard and walk around the track with him for a half hour, just so he could get some air, and he did that all on his own. That was pretty fucking cool, and he knew he was real sick, and he told him he needed to get out. These guys might get in their cells and go to la-la land, and just sit there stagnate for 3-4 days.

In the scope of their work, officers are not obligated to work intensively with this intensively with mentally ill inmates. As an officer noted in an earlier section, the officer has a choice, and officers are known to take interest in the particulars of a mentally ill inmate and may offer such assistance. The inmate referenced in the above narrative was a well-known inmate with severe mental illness with a long sentence, and had a history of severe dysfunction in the institution. A correctional officer also discussed with me one afternoon how he obtained a television for a severely mentally ill inmate to keep him occupied in his cell. He discussed this in terms of the inmate being in a cell, "with nothing", no radio, no books". Televisions are sometimes left behind by inmates who are

released from the penitentiary, and during my time at OSP, it was known that there was a “stash of tv’s” kept by the property officer, and due to informal relationships in the prison, staff could acquire a television as a “loaner” for mentally ill inmates, who did not have the $250 to purchase one. The inmate did not own it, but it was loaned to him simply due to the flexibility in rule enforcement at OSP; an inmate could not have another’s property in their possession. This informal process had been discontinued by the time of this research, but this officer had found a way to obtain a television for this severely mentally ill inmate, as a “loaner”. This fact itself was surprising, as I had not heard of this being done by officers. However, we do find in this story an officer going outside of the boundaries of his role in the institution to initiate, in his opinion, a therapeutic process, with the resources available to him as an officer that had good relations with inmates and staff.

Another officer discussed how he allowed some flexibility in encouraging an inmate to interact with another inmate who had mental illness on his tier. He also discussed how he perceived individual coping strategies as helpful to inmates and would encourage mentally ill inmates to keep active on the tier.

> A: This one lifer was couple of cell down from my [mentally ill] inmate orderly, and when he was having problems, this lifer would ask me if he could go down the tier and talk to him, not manipulate him, but for a good reason. It was out of care and concern. . You still got to watch ‘em. You can’t trust these guys as far as you can throw them. If it was just me between them and an open door, we know where we stand.
> Q: Have you ever encouraged a mentally ill inmate to write or draw?
> A: Absolutely. They’ll complain about not getting a letter, and I say to them, when was the last time you sent one out? If they’re upset about something, I tell them, if you can articulate it, then write it on a kyte, and I’ll deliver it for you. I’ll make sure I’ll put it

> in the hand of the person who can help you with that. Yeah, give them the means and the ability. Here's the kyte, go fill it out.

This officer's strategies of encouraging socialization and utilization of coping strategies for mentally ill inmates are outside of the normal work of correctional officers, as well as the parameters of rule enforcement. Inmates are not allowed to walk around the tiers to socialize. Allowing these inmates to interact, albeit supervised, was understood by the officer as a positive factor in the mentally ill inmates' life. Officers can also act as "reality checks" to inmates.

One inmate in particular noted how he would speak to an officer to ask his perspective on his paranoid ideation.

> It does matter if you have a professional relationship with staff, security and mental health staff, cause sometimes you might be having some delusions about what reality is, and they know that, cause they don't have schizophrenia, and they know the processes. Sometimes I'm having delusions about what my situation is, so the officers may say, it's not that serious, maybe it was a mistake why he [*another inmate*] did this, look at it this way. They talk you out of doing something that is not correct. I can work with cops on D block if I have issues.

This inmate discusses how he can turn to officers and ask them if he is perceiving a situation on the cell block correctly or if he is paranoid. Here, the officers that work the mental health tier, according to the inmate, will take the time to "process" through the inmate's thoughts and allow him a few minutes to "check in" with them, to get a perspective he couldn't get from another inmate. This narrative has a flavor of when a mentally ill inmate sees a mental health staff, checking in about paranoid thoughts, symptoms, and attempting to find strategies to cope with these experiences. Another inmate commented, when he was experiencing severe psychiatric symptoms, that "even the officers were

reaching out to me when I said I was having these problems. This one cop told me to rely on God".

Officers going out the normal scope of their duties to assist mentally ill inmates may be an anomaly in penitentiary. I bring these stories to light as a way to demonstrate that the penitentiary is not a site of rigid control, but that officers do have the means to step outside of their custodial duties to take an interest in the lives of mentally ill inmates, and attempt to assist them in their coping and functioning in the institution.

I now turn to a case study that unpack the previously discussed themes elicited in the interviews with staff and inmates regarding how relationships with security officers may contribute to positive outcomes for inmates with mental illness. This inmate's story is one in which he received substantial assistance in functioning in the penitentiary through his relationships with correctional officers, which he attributed to his success in recovering from his mental illness, and obtaining substantial employment.

Inmate David (not his real name) has a diagnosis of paranoid schizophrenia and has been in the penitentiary for over 15 years. I keep his age and ethnicity confidential to protect his identity. He was worked in a job in industries for many years, which for many inmates is like a job on the streets – an inmate in the study characterized it as a link to the outside world, because OSP has contracts with local hospitals, for example, to provide services to the community. David's narrative reveals how his formed his relationships with staff,

that they recognized he has a serious mental illness, how officers have assisted him while he was recovering from his illness, and how he maintains these relationships based on trust and respect.

> A: Officers ask me how I'm doing. I know they're checking up on me. They check up on me. They can tell I take medication, cause I'm at pill line, they see me being by myself, they know about my mental illness cause they've seen me go to SMU.
> Q: How do you build that up with an officer?
> A: It's like doing time, you see them everyday, talk to them, joke with them, they get to know you. You play around with them, things like that. Like, I might see an officer and say, '*Hey, how you doing*?' Some officers will just tell you - write a kyte, give you the runaround…just for you to get away from them. If they like you, they'll bend over backwards to help you. When I was up in SMU [*inpatient psychiatric unit*], the officer in charge, she let me go from SMU to go back to work in industries, cause I didn't want to lose my job. I was doing good…working, going to school, programming. I had to go up to SMU to get my medications changed. I told her I didn't want to lose my job, please let me go back to work, get me a cell downstairs. She helped me out and got me out of SMU. She checks up on me, too and asks me how I'm doing. I tell her I'm doing fine. This other officer, she asks me how I'm doing, and I tell her I'm doing fine. I see her every couple of months. I tell her I'm taking my medication and I'm doing good, She says, 'That's good'. I have a lot of support here.
> If you go mouthing off to the guards, 'Oh fuck you!' and lie to them and get caught with cigarettes, all kinds of contraband, get written up, get smart with them…That cop's gonna harass you…search your house…fuck with you…you don't want that. You want good relationships with officers. I try to build relationships with them. You don't want to have a bad relationship with officers. You want to have more officers that trust you, like you. Yeah, I'm not a gang member…I take my medication and stay out of trouble…I don't get into fights…I'm not in and out of the hole…Once you do that, and you have a good relationship with officers, they look out for you…and you're alright. You don't get into problems…you've got a clean record…they see you going to work everyday… doing your time…they respect that…that's what they want. If officers here like you and respect you, they'll help you out. Some people they won't do that for…it's a matter of the officers liking you, trusting you…you being honest with them. The officers know if you're using drugs or alcohol and they know the ones that don't want to be around it. I've only had two UA's since I've been here, cause they know I don't use it…once you get caught with a dirty UA they're on you all the time. And I stay far away from it! If they know you, they'll help you. If they really don't know you or think you're playing, then they'll tell you to go write a kyte. If the officer likes you, and you're for real with them, they'll do you a favor, they'll help you. There's trust there…
> Q: How do you think these relationships have helped you cope in prison, or do you think you've could've made it on your own?
> A: I think when I have a good relationship I'm doing good. That's always a foundation I can lean back on when I'm falling off a building…I'll always have a mat under me, I can get back on my feet without hurting myself. I

> like that feeling, having a good relationship with officers, teachers, mental health workers. That way they know me, they'll help me, always encourage me. You need that in prison. If you don't have those relationships, you'll have a hard time coping and adjusting to prison, especially if you're doing a long time. It's gonna be hard.

This inmate related that prior to receiving appropriate treatment, he had a history of violent behavior as well as suicide attempts within the institution. Here we find that this inmate has forged relationships due to, as one inmate called it, a "Stockholm Syndrome" effect, i.e. he sees officers every day and within the boundaries of a professional relationship, he makes small talk, asks them how they're doing, and goes about his day. Officers know he has a mental illness, "because they see me going to pill line", and other officers know him through stories that are shared, or they have worked with him in the inpatient psychiatric unit. He is a "known quantity", as one officer stated. Since he is know to officers as an inmate with mental illness, officers are willing to help him if he asks for assistance. An officer was even willing to be flexible in work assignments to ensure he received his job back when he was discharged from the inpatient psychiatric unit, which is not strict penitentiary policy. Inmates lose their jobs when they go to special housing, regardless of whether it is for treatment or discipline. He is also consistent in his behavior. He follows his program, stays out of trouble, and attends to his work and treatment needs. In his perspective, officers respect that, and trust him if he needs their help. They know he is not attempting to manipulate them, as he is known to be mentally ill. Moreover, officers accept his mental illness as a "real" entity in the institution. This may be a matter of his frequent admissions to the inpatient psychiatric unit, or the

observed differences in his behavior since his recovery from his illness, or simply that officers who acknowledge that mentally illness is present in the prison are more likely to “check up on him”.

What is key here is that for an inmate that has had such substantial difficulties in his initial adjustment to OSP, and has a severe illness, he has been able to forge relationships with officers that he himself has identified as contributing to his positive functioning in the institution.

His narrative unpacks and relates several themes that were uncovered in the qualitative interviews with staff and inmates. These themes identified how relationships with officers mediate the course and outcome of psychiatric disorder, and how these relationships may contribute to positive outcomes for mentally ill inmates. Officers acknowledged that there are large numbers of mentally ill inmates in the penitentiary, officers are the gatekeepers for mental health services and utilize their personal knowledge of the inmate and observations to assist with help seeking, and officers can be flexible with penitentiary rules in order to assist these inmates. Officers can also act as ancillary support for inmates with mental illness, providing positive interactions, and encouragement for inmates to succeed, which is a by-product of the structure and culture of the penitentiary. The opportunity and encouragement for staff-inmate interaction, professionally constructed as the Oregon Accountability Model, provides the foundation for inmates to forge working relationships with security officers, and also provides officers a basis and rationale for their interactions with mentally ill inmates. I close with another inmate’s comments on

how an officer assisted him in placing him in a job, and reinforcing in the inmate's mind that he could succeed in this position.

> The officer said to me, how would you like to have that job on the cell block? I said I don't know if I can do it. He said, 'Put your mind to it and you can do anything'.

Chapter 6: Mentally Ill Inmates' Relationships with Mental Health Staff

Unpacking and contextualizing the relationships between mental health staff and mentally ill inmates was limited in scope due to the nature of the research methodology, and how mental health services are structured in the penitentiary. Unlike correctional officers, who work in a public sphere in the prison, and are readily observable in their interactions among themselves and inmates (both mentally ill and non-mentally ill), the work of mental health staff in done largely in the confines of their private offices. This is due to the policies surrounding confidentiality in the Department of Corrections. Officers are not present in the offices for inmates' appointments with mental health staff. Mental health staff see the inmates on the caseload in their offices in order to confidentially perform their clinical tasks. Additionally, I could not, nor did I wish to, ask permission to sit in on appointments with mental health staff and inmates in treatment. This would be too intrusive, and would have been, in my mind, an inappropriate request given the sensitive work these clinicians engage in with this inmate population.

Moreover, unlike security staff, mental health staff do not have a common, public area in which they congregate and discuss their work. Mental health staff's offices are located on the Inmate Management Floor, a floor of the professional offices in that penitentiary the also contain offices for correctional counselors and administrative staff. Mental health staff members were frequently

seen in each others' offices in discussion, but I was not privy to these confidential meetings, which presumably entailed dialogue regarding their clinical work or the day to day operations of the mental health program. There is no common area on the IMF floor for staff to linger, and the fact that non-mentally ill inmates also work in this area as clerks further draws attention to the importance of mental health clinicians to discuss matters privately in their offices. It is not within the "culture" of non-uniformed professional staff to congregate in common areas and discuss their work. Frequently, when I was waiting for appointments to see inmates in the study, I would see case managers come and go from the floor, responding to crisis calls that warranted their presence on the cell blocks, or the special housing units, such as the inpatient psychiatric unit or the segregation unit. The intensity of the work of the case managers also diminished my ability to recruit a majority of mental health staff for the study. Two mental health case managers who initially consented for the study did not complete interviews as their work became overwhelming during the course of the study, and taking time out of their day to participate in the study was not an option for them. So in this sense, the mental health case managers were as difficult to access as was the inmate population.

The other issue that surrounded interviewing mental health staff was that in the past 4-5 years at OSP, there had been substantial turn-over in mental health case managers, and the penitentiary had a system-wide poor reputation for mental health staff retention. My own position at the penitentiary was filled upon my leave in 2002, but after two years, the original case manager I had

worked with transferred to another institution, my replacement took a management position at OSP, and then began, according to inmates and staff, a high level of staff turn-around. A former colleague characterized it as “100% turnaround in mental health staff every 6 months”. Additionally, this staffing instability also coincided with an increase in identification of inmates needing mental health services, and a budgetary increase that funded five more case management positions at OSP. This instability in staffing was the context for the ethnography of the penitentiary, and there were a few staff who had just been hired within 6 months of the study’s initiation. Given that these staff were new to the institution, and the Department of Corrections, it is understandable why mental health staff participation was lower than expected. My initial expectation was, “Who wouldn’t want to talk about this fascinating clinical work?”.

The reality was that mental health staff were coping with new positions, and orienting themselves to the prison environment and its population, both staff and inmates. Even for staff I knew, and had former professional working relationships with, their decline to participate was, “I don’t want to talk about my job after work”. Further, the hour-mandated lunch breaks in their 8 hour shift was an opportunity to leave the penitentiary, and further discussion of their clinical work and their perspectives on the inmates they worked with was not perceived as an opportunity, but rather an hindrance on time they may have needed to simply take a break from providing mental health services in the “toughest institution in the system” to the “worst of the worst”.

Fortunately, I was able to secure a small sample of mental health staff (n=7) that allowed considerable insight into their work and their perspectives on the population they worked with. For the mental health staff that did participate, I was able to access staff that had significant experience working with this population, as four of the staff had worked at OSP for over 10 years. The other mental staff recruited had worked at OSP between 1-2 years. I make these comments to draw attention to how much more accessible security staff were for the study, how they readily shared their experiences, and how their work, being done in a public sphere of the cell blocks, was much more observable. Moreover, the security staff recruited, and their perspectives were based on work histories in the penitentiary that were quite substantial, anywhere from 5 to 20 years experience in the institution.

Inmates in the study were more ready to share in their experiences of working with mental health staff, and officers did discuss how they thought the relationships with mental health staff did impact the functioning and coping of mentally ill inmates. Given my own perceived limitations of recruiting mental health staff, I provide several themes that emerged from staff and inmates' narratives which centered on how relationships with mental health staff may mediate the course and outcome of inmates' psychiatric disorders, and in particular, how these relationships may contribute to positive outcomes for this inmate population.

The Mental Health Treatment System and Its Team

The mental health services in OSP are currently deemed Behavioral Health Services, or BHS, but older inmates and staff still refer to this system and its staff as CTS, Counseling and Treatment Services. As CTS, the mental health treatment system at OSP was implemented by me and a psychiatric social worker in 1996. Prior to this, the only psychiatric services available at OSP was from a psychologist who managed all inmates' behavioral concerns, and a nurse practitioner who prescribed psychiatric medications in the infirmary. A contract psychologist also worked at OSP, and had been there 20 years upon my hiring, providing intensive group and individual treatment to severe mentally ill inmates. The inpatient psychiatric unit, or Special Management Unit (SMU), was available as an intensive treatment option, and provided screenings for behavioral concerns, and longer, intensive inpatient treatment.

On my arrival at OSP in 1996, this system was characterized as uncoordinated, and many inmates had difficulty accessing care or did not receive the intensive supervision that their illness required, regardless of the then current staff's efforts and professional skills. Many inmates with severe illness were housed in SMU or the disciplinary segregation units, and many of those were psychotic, decompensated, and not receiving the intensive services their illnesses required. I provide this history to establish the profound changes that occurred from 1996 to the present time of the study, 2009.

In 1996, the mental health program was initially created by ODOC administration along the lines of an intensive "outreach" model, in which mental health case managers would maintain a strong presence in the institution by

being highly visible in the cell blocks, working with officers and inmates, and seeing inmates in the housing units. Additionally, the case managers served a screening function, to assess inmate mental health needs, respond to crisis in the institution, and monitor and manage inmates with mental illness. This entailed doing work outside of the offices, as noted above, but also seeing inmates for scheduled appointments for this monitoring mechanism. This monitoring parallels security's discussion of "management" of inmates, and followed from a brokerage model of case management that monitored and assessed inmate's functioning and recovery from psychiatric illness, coordinated other mental health services, and responded to inmates in crisis as well as their needs in the institution such as housing, work, or programming. Additionally, there was also a clinical case management component to the case management services that allowed opportunities for psycho-education, and limited and short range therapeutic interventions such as brief Cognitive-Behavioral therapy. The common statement among mental health staff was that there was "no therapy" provided by case managers during the research period at OSP, so it is unclear if these clinical components were still in place in the case management program.

Case managers could also act as advocates for mentally ill inmates on their caseload. This entailed coordinating with Group Living, the office in the penitentiary that did cell/housing assignments for inmates, advocating for inmates to receive particular work assignments based on their needs, or, a recent development in OSP, intervening if a mentally ill inmate on their caseload received a disciplinary report. This last advocacy piece allowed mental health

case managers to present a case to the disciplinary hearing staff to either drop the charge or lessen the charge of a disciplinary infraction if the inmate was not responsible for their behavior due to psychiatric symptoms.

Case managers typically worked 8 a.m. – 5 p.m., and carried beepers in the penitentiary for crisis calls. At the time of the study, some case managers worked flex schedules to provide weekend and evening coverage in the institution. This clinical staff had substantial and intense interaction with the inmate population, as well as the prison environment. They also worked closely with contracted clinical staff to make referrals for services provided by this contract staff, and monitor the treatment and functioning of inmates on their caseload.

In addition to the seven case managers, there are also “contractors” or ancillary clinical staff, still part of the mental health team, but only contracted to provide 15-20 hours of clinical work in OSP for inmates. The contractors were either master’s level counselors or psychologists or PhD psychologists. They provided one-on-one therapy sessions for inmates as well as ran treatment groups, which included problem solving groups, or groups for inmates with Post-Traumatic Stress disorder. They have less intensive interaction with the prison environment and general inmate population, and primarily saw inmates within the context of one on one therapy sessions, or in the context of group treatment. They generally have little or no interaction with security staff, as all collateral information obtained through other penitentiary staff is filtered through the case managers, and shared, when clinically appropriate, with contract staff. At the

time this study was initiated, a contractor who had been at OSP for several years had just ended his contract work at the penitentiary, and there were new contractors hired during the time of the research. This individual had an excellent reputation among staff and inmates, and many discussed this staff member's departure as difficult. This history is provided to demonstrate that contractors, although ancillary, are still thought among staff and inmates are important members of the mental health team. They typically see inmates on the "BHS Floor", a third floor to the professional offices that are secluded and private, and also contains the office of the BHS manager of OSP. This office environment acts as a means to preclude them from the intense interaction with the penitentiary's workings, and also physically separates them from the mental health case managers and the medical staff who prescribe medications for the inmates.

This final segment of the mental health team are the termed "the prescribers". The penitentiary's psychiatric services (i.e. prescribing psychiatric medications) are done by a board-certified psychiatrist and a board-certified psychiatric nurse practitioner (PNP). They typically work up to 3-4 days a week in offices located on the IMF floor where the other mental health staff are located, and their inmate appointments may be as far spaced as 3-4 months, depending on the functioning of the inmate and the severity of his illness. They do have greater interaction with mental health case managers out of necessity; if an inmate is doing poorly on a prescribed medication and needs and adjustment (due to increased symptoms or medication side effects), case managers can

access these staff easily in between appointments. Due to medications being the primary therapeutic strategy in OSP, this interaction is crucial, as case managers can share clinical information rapidly and provide emergency visits to either staff if there are concerns. Each prescriber has a caseload of inmates that they attend to, who are in turn, on caseloads of various case managers.

In summary, the mental health team and treatment system at OSP functions like an outpatient community mental health center within the confines of the penitentiary. Case managers see inmates in their offices, go to "home visits" or see inmates at their cells and in special housing units, interface with medical staff regarding medication issues, and make referrals to other mental health staff for specialized clinical services. There is also an inpatient psychiatric unit, the Special Management Unit (SMU) or Mental Health Infirmary (MHI), which functions as a small hospital within the penitentiary. Mental health is a visible and talked-about faction in the penitentiary staff. No longer confined to a handful of staff, as it was prior to 1996, the mental health treatment system was quite intact and functioning during the research in 2009, regardless of the numerous staff changes since my departure in 2003. It is within this context that I now consider responses of inmates and staff when questioned about whether or not relationships with mental health staff "mattered" to mentally ill inmates, in terms of their course and outcome of psychiatric illness.

Positive Relationships with Mental Health Staff

A mental health staff remarked when asked about the importance of the relationships between case managers and inmates with mental illness:

> For a minority of the mentally ill inmates, they have little or no ability to form an interpersonal relationship. They just don't relate. That's the gross minority. The vast majority of the chronically mentally ill…that relationship with their case manager or prescriber, it may be the most important relationship they have. The dearth of other relationships make one that is a non-threatening and nurturing all that more important. Innumerable times in my years working in corrections, the only thing that has kept a mentally ill inmate in treatment is their relationship with a particular person. Most times, it's with their case manager. If we did not need the staff inmate relationships to be able to really actively manage these guys with their illness, then we could just do it with prescribers.

Within this quote are some key elements of the relationships between mental health staff and the inmates the treat. First, the relationship, established within a clinical encounter is one of "nurturing", or at least empathetic understanding, as expected between mental health staff and their clients. Secondly, the case managers work with inmates, their advocacy, monitoring, problem-solving, and engagement, is observed by this staff member as crucial to these inmates' stability and functioning.

In the previous treatment system, prior to 1996, there was no mental health staff for mentally ill inmates to meet with on a regular basis. Mentally ill inmates, knowing that mental health staff is available is a boon to their treatment in the institution. Inmates discussed how case managers and contract staff, by virtue of them offering some empathy and caring in the context of the professional therapeutic relationship, assisted them in terms of social support.

> ***Inmate A***
> The mental health staff…it seems to be easy to get understanding,

medication…they seem to care about me, so that's good.

Inmate B
You look forward to meeting with your counselor every month, to get things off your mind. It's a stress reliever to get to talk to somebody. Yeah, the BHS [*mental health*] staff…they care. When you come in and talk to them, they seem concerned.

Inmate C
It gives me somebody to go to, and say I'm having these problems, can you help me out?

These quotes are reflective of the 15 inmates in the sample of 20 inmates who discussed how they had a positive relationship with their case manager or contract psychologist and this assisted them in managing their illness. For inmates who reported a good relationship, they had confidence that the individuals working on the mental health team were professional, had the appropriate training, and cared about the inmates on their caseload. These relationships, then, are characterized as professional relationships that allowed inmates to discuss problems they experienced either with their psychiatric illness, or the daily stressors of prison during their individual sessions or group treatment. This regard for mental health staff may not appear to be particularly profound; a majority of individuals receiving mental health case management appointments reported that it was of benefit. However, I would remind the reader of the context of these relationships. In a maximum security penitentiary that focused on self-reliance and "manning-up" to your chosen circumstances (of committing crime and being sentenced to prison), having a staff member that is willing to listen to an inmate's problems in the context of a therapeutic relationship was perceived as a great help. For other inmates serving their sentences at OSP, this is not available, nor is it expected that they would need such connection to staff.

There may also be differential establishment of relationships, where an inmate may feel more comfortable in their relationships with a contract mental health staff. One inmate in particular, who complained that mental health staff rarely responded to his concerns and requests for more intensive counseling, discussed his relationship with a contractor as being paramount to his mental health treatment in terms of trust and the staff's thrustworthiness.

> The case managers, a lot of them, they job is '*Oh yeah, I seen him, get him out of here*' [*out of the case manager's office*]. The one man that I had trusted was Mr. _____ (*a contractor*). Basically, he didn't lie to me. He told me the truth - what time it really was. He come out straight on me. Told me straight what it is. '*Hey, dat what it is, dat what is goin' to be. Hey, it's out of my hands, I can't do nothin*'. He come to me straight. I can't do nothin' but respect that because you come to me 'hey, what time it is' [*i.e. the truth of a given situation*]. I told him, the bottom line is I don't need to ask no questions because you already let me know. He would say, 'Ok, this is why they're gonna send you to this place'[*a transfer to another institution*]. Ok, I don't need to ask no questions - I understand now. If we don't understand somethin', the first thing we gonna put in our mind is distrust. And the case managers they think, '*ok, we talk to 'em for about 20-30 minutes - then let 'em go - we did our duty*'. They didn't do their job! How can you call a person up there [*to the case manager's office*] and understand this person when he got somethin' goin on in his mind, and stuff.

In his interviews, this inmate focused on how he felt he needed to talk more, rather than receive medications as a primary strategy to assist him. The relationship he formed with this counselor was based on the staff being receptive to this inmate's desire to process his thoughts and emotions in the context of mental health treatment. Additionally, he perceived this contractor as trustworthy, because the contractor explained things to him and was honest regarding the inmate's circumstances, even though the news was bad, i.e. he was to be transferred out of OSP. Because the staff was truthful, and was

respectful to the inmate's needs for disclosure of the situation, the inmate was able to establish a relationship of trust, and he felt that it assisted him with navigating his life within prison. Here, the primary relationship with a mental health staff member was with a contractor, rather than the mental health case manager.

When I asked a mental health staff about the establishment of relationships with different members of the mental health team, a mental health staff discussed that contractors may be perceived as not quite full state employees and thus these staff members may be seen as people with whom one can more easily share sensitive issues.

> I've heard the inmates say, I'd like to share that with my case manager, but I'm reluctant to do that, because the case managers are part of *the system*. They know contractors are part of the system too. Inmates then won't admit to something like a point blank violation of the policies. They will kind of allude to drug use, but they won't say for specific. Sometimes you can talk about an issue between the lines. I'm not sure they'll even say that much to the case manager. They may know that the case manager is on their side, but there are limitations of confidentiality. So, I think the contractors are perceived as most outside of the system, and that enables them to share things they wouldn't share even with the case manager, or a security person.

This unique status among contractors, then, may contribute to establishing these strong ties to these members of the mental health team. This distinction between certain staff among mentally ill inmates was also perceived by a security staff, and an officer alluded to the fact that inmates also may be aggrieved by their interactions with mental health staff for more reasons than simply an inability to "connect" or establish rapport with the clinicians.

Here we find that for inmates who were doing well in the institution, based

on objective measurements of good functioning, they were able to establish and maintain positive relationships with mental health staff and perceived some benefits in their contact with members of the mental health team. These relationships were not necessarily centered on the primary and most accessible mental health staff, the case managers, but were also formed with contractors who saw the inmates in a more limited way, e.g. once a week for group therapy or individual counseling.

Relationships with Mental Health Staff: Establishment of Trust

As discussed in the previous chapter examining relationships with security officers, inmates establish these relationships within the context of trust within the institution. Trust is the foundation of relationships in the penitentiary and is gained through consistent behavior, either negative or positive behavior. This consistency is related to "keeping your word" and an establishment of your credibility as a staff member or inmate. I propose here, that in the same way, mental health staff and mentally ill inmates must also navigate their relationships based on trust and consistency. However, for mental health staff, in attempting to establish a clinical therapeutic relationship, they must also establish trust with inmates, and inmates must negotiate the dual role of mental health providers as clinicians as well as employees of the Department of Corrections.

A mental health staff discussed this interdependent establishment of trust:

> Q: What about inmates' relationship with mental health staff?
> A: It definitely matters. You have to have that rapport, that connection with them, or you're not going to gain that insight and they won't feel comfortable talking to you.

> Q: There has to be some type of trust built up?
> A: Yes, when I meet with guys I tell them what my role is, and that I won't make any promises. Tomorrow could be a lockdown, and we have no idea what's going to happen in here - but I will do my best and trust you. But if you burn me it's going to take a long time to get back to where we were. If you come in here and blatantly lie and I catch you you're going to start from ground zero and work your way up. Most of that is successful….at least I haven't caught them in their lies. [laughs]

This quote reveals that the trust is established by both the inmate and the staff member. Also of note here is that this mental health staff member discusses how she clearly lays out her role and her duties, i.e. what her "word" actually means in the context of the clinical encounter. Moreover, she expects the inmate to also demonstrate that they can be trusted, and if not, the clinical relationship goes back to "ground zero", or a place of no trust.

This relationship, structured along institutional constructions of trust, was also discussed by an inmate as being key to his ability to work with mental health staff. This inmate discusses how engaging with mental health truthfully strengthens the relationship.

> I don't want to do anything wrong and get in trouble with them [mental health staff.] cause I have to take medication the rest of my life and I don't want them to say, '*We saw you selling your medication'*. I don't need that jacket on me no way. If that's the case, then they'll tell everyone else in mental health that he's selling his medication…*'he's lying to us*'…things like that…and you don't want that over your head. I tell them the truth, so they know I'm not playing. It's for real…I'm having symptoms. That's the foundation you build with mental health…is when you tell them the truth about your mental illness, whether you're going to hurt yourself or not, and they'll trust you and then they work with you.

Mental health providers' role, which incorporates custodial and treatment concerns, is due to the fact that all mental health staff must be as concerned with the safety and security of the institution as security staff. Information reported in

a clinical meeting, such as if the inmate is expressing concrete suicidal or homicidal ideations with plans and means, is one aspect of their responsibilities as penitentiary employees. For the inmates who reported ambivalent, or no firm relationships with mental health staff, this was a concern for them. That is because mental health staff are still penitentiary employees. Sharing of confidential information and opening up fully to mental health clinicians was problematic, and thus an establishment of trust proved challenging. Mental health clinicians in community settings may take for granted that trust is an inevitable outcome of engaging in a therapeutic relationship, and community clients may also enter the clinical relationship with an understanding that the clinician can be trusted (depending on the context of the clinical encounter, and the characteristics of the client and clinician). In the penitentiary, the trust is earned, negotiated, and may be diminished due to the actions of both the clinician, as well as the inmate. Mental health staff must navigate clinical relationships in the context of broader cultural models of establishment of relationships in the penitentiary. Moreover, clinicians are not isolated in the community. That is, there is a constant feedback loop, characteristic of total institutions, that also reflects back the behavior of the clinician, and circulates narratives of how clinicians respond and work with inmates (Goffman 1961). Of this, a mental health staff confirmed that her reputation was known among inmates, and this prompted an individual to request to see her because she was trustworthy and treated inmates with respect.

> Inmates will tell you, you've earned the respect of staff and inmates, so I'll come talk to you. One guy kyted [*wrote an inmate*

> *communication*] me after I was here for 13 months and he said OK, I put you through the waters, I've done my research. They hear it from other inmates. If they say I promised them this and that and I did nothing, she sucks, and she always cancels my appointments…there's no reason to see me.

Another mental health staff discussed this feedback loop and how it operates within the penitentiary. The rapid nature of communication in the institution allowed for inmates to know the actions of staff rather quickly. It also allowed staff to establish themselves as trustworthy.

> It helps the clinician establish that things are confidential, because nothing's [*confidential information*] floating around, unless they're too impaired to check it out. That gives them reason to believe confidentiality, because they're not hearing stories from other inmates. If I did that on purpose tomorrow [*break confidentiality*], I might be done on Monday, depending on the information. The closed nature of the environment can work to your advantage, too. You can establish your credibility quicker here. Therefore they can share.

In both of these examples, it is demonstrated that clinicians are as embedded within the institutional context as inmates; their reputations and behavior can come under as much scrutiny as inmates' behaviors. This feedback loop further strengthens the role of the clinician within the institution and allows for an establishment of trust and respect among inmates.

Staff Turn-Over: A Barrier to Establishing Relationships

Some inmates commented on how the high mental health staff turnover rate affected their ability to establish relationships with clinical staff. Not all inmates commented on this issue, but for some inmates, this was a paramount barrier to forming and maintaining relationships with mental health staff. Four inmates specifically brought up staff turnover as

a barrier to establishment of a trusting relationship. I quote two inmates within this context:

> **Inmate A**
>
> If you have a steady CTS worker, they get to know you, know what you're about. It works on both sides. Unfortunately, you don't get that all the time. Then it just got bad. I was getting a new mental health worker every 2 months. It lasted that way for a few years. Then I have to tell them my story again, and they'd leave, and then would come another one, and then another one, that one would leave. I was like gee whiz, it's like a merry go round. I was like, "*What happened to so and so*?" "*Oh she went somewhere else, she found another job*". You can't depend on the CTS workers, you never know if you're going to have a new one, or if they're going to be around. I'm bound to take care of myself, cause no one else is going to do it. I go get my pills, but now I don't depend on mental health too much.
>
> **Inmate B**
>
> We get a new case manager every time someone leaves, and then we have to say 'Have you looked at my file?' I'm scared in a way, cause you don't know how they're gonna react to you and how you're going to react to them, when they say something. So it's a challenge.

Another inmate who discussed staff turnover specifically linked it to some mental health case managers' inability to advocate for mentally ill inmates on their caseload:

> They more they funnel mental health staff in and out [*of the mh specialist position, i.e. the more staff turnover*], the less they know what they should be doing and the more they're just being puppets to *The Man*. They're not going to fight for you if the administration's not willing to let them have anything to help you. And the psych counselors - they've [*security*] taken away a lot of their power to help you. One guy, his radio broke, and it took an act of congress to get him a new radio - and that's what they're here for [*the mh counselors*] - to help you maintain. There supposed to do it in a productive way, but the administration won't let them give you what they used to. They've taken a lot of the hustle out of their game

This last narrative reveals that the inmate correlates a decreased ability

for case managers to navigate security's rules and procedures with the increased staff turnover. New staff come into the institution with no social ties to security or other staff, and in the context of the cultural values of the penitentiary, must "prove" themselves within the prison context. If these mental health staff do not understand these informal rules, nor hold the position long enough to establish credibility as a penitentiary employee, they may not have enough "juice" or personal bargaining power to assist or advocate for mentally ill inmates on their caseload. Frequently, I heard throughout the institution, "Oh, did you know that mental health staff finally are able to intervene on disciplinary reports and hearings". This was a recent development according to most recent institutional narratives. However, when I left OSP in 2002, this intervention was a common practice among myself and other mental health staff in order to lessen culpability and disciplinary measures for mentally ill inmates whose rule violations were the direct result of psychiatric symptoms. In the following chapter on staff-staff relationships, I unpack this further, but for now, I include this inmate's narrative to illustrate that at least one individual perceived this staff turnover as a detriment to mental health staff's credibility, or "juice" within the penitentiary. I would also comment that any staff turnover in a mental health system may be a detriment to the individuals served in that system, and therapeutic alliances must be established again, trust must be re-established, and mental health consumers must navigate these new relationships, which can cause distress. However, for mental health case managers working in a penitentiary, the nature of their work is profoundly different, due to their engagement with inmates in the context of a

total institution. All aspects of the inmates' lives, not just their treatment, come under the purview of the mental health case manager. In this regard, and understanding of the prison setting is critical. Of this, a mental health staff remarked:

> You have to take into account the prison setting in everything you do, but then again, so does the inmate. So many things in the community, they may be able to get their needs met without ever having to contact you. In the prison community, since they have so many fewer options, and those options have very strong gate-keepers over them…it's going to funnel to the correctional counselor and the mental health case manager. So you're going to deal with a lot of things, say, a case manager in the community you wouldn't necessarily come into contact with.

The work of a penitentiary mental health staff must take into account the prison setting, as inmates may come to mental health staff for a variety of requests, both tangible, or simply advocacy to achieve personal goals, such as "putting in a good word" to get a job with another staff member. If the mental health staff has no significant relationships with other staff in the institution, then these requests, either appropriate or not, may go unfulfilled or disregarded.

Relationships with Mental Health Staff: Ambivalent or No Establishment of Relationship

In order to establish this therapeutic relationship, trust must be established. But how is that done in the penitentiary? How is this navigated? And how do inmates perceive the role of case managers in their dual functions in the institution, as both employees of the system and clinicians? An inmate related this story of how this unfolded in the context of an initial appointment with a case manager.

> I was talking to one of the mental health people when I first got here and she asked me to sign a piece of paper to let the guards know aspects of my mental health, and I refused. I told her, absolutely not. I can't even imagine you'd even be willing to ask me something like that. Tellin' a guard something like that! It's like giving them bullets or something. And of course I don't talk to that person anymore. And she lied to me directly. And, it's like, '*Why do you do that*?'. And the last departing words from her were, '*Have you always been paranoid?*'. [laughs]. It's the ultimate in frustration…what do you do, you know? And that's how they do it…that's how they use it against you. I think that I have the right not to tell Joe Blow out here whatever aspects of anything are!

Here we find that a mental health case manager was attempting to get the inmate to sign a release of information in order for her to speak to security about certain aspects of the inmate's mental health issues. It is unclear what the nature of this information was that the staff wanted to share, but the policy is that mental health case managers can share with security warning signs and symptoms of an inmate's psychiatric illness. This is done to inform officers of the warning signs of decompensation so officers can contact mental health staff to head off a potential psychiatric crisis on the cell block. In this narrative, the inmate felt that sharing information would be a detriment to his life on the cell block. This same inmate further expanded his concerns:

> Q: When you tell a mental health case worker or doctor, when you tell people things in the office, do you think they tell security?
> A: I think they would, yeah. There's always that overriding fear that you're going to react badly. I can partially understand it, and they run with it and take it way beyond the goal line [laughs]. I made a comment about the showers and how I would get really angry, cause when you take 576 guys and line 'em up for showers, there's a lot of unnecessary contact. And I've had trouble when I was a child, and it makes me just furious for someone to bother me, or come up on me…that closeness…and I made that comment, and he [mh staff] said, '*Now you're telling me something conflicting. When I asked you if you had any violent thoughts or anything, you said no*'. Sounds like I was saying I was going to go hurt someone, that was the spin he was putting on it. And I said no I'm not. You can't just

> say what you want to say, because they'll say, 'Oh, we think he's gonna hurt himself or somebody…' what they do is take you to a small room and strip you down, put you in a smock or something, and watch you.
> Q: You're concerned that they misunderstand you?
> A: Yes, either accidentally or deliberately. Given a different BHS [mental health] person, they could've spun that around. And you're saying, 'No, no no!'….bottom line is you're an inmate! You're not a mental patient, you're an inmate. So being a mental patient versus being an inmate, being an inmate always wins out, so [being a mental patient] it doesn't matter. Of course, when you throw on there, 'he must be crazy', you lose the argument.

This quote reflects that this inmate is concerned that the mental health staff may misinterpret his reports of anger, frustration, or aggressiveness, which would warrant increased and more intensive and constraining treatment, i.e. isolating the inmate in a cell with a no self-harm smock, being observed through a camera. The inmate is discussing how the actual context of the penitentiary was driving his symptoms and concerns, but that the mental health "doctor" did not correctly understand him. In this narrative, there appears to also be an underlying concern that within the clinical encounter, mental health staff may act unpredictably, i.e. rather than discuss the inmate's concerns about showering with other inmates, it's interpreted as homicidal ideations. Here, the overriding concern of the clinician, as perceived by the inmate, was security concerns, not the inmate's mental health symptoms, due to the fact that he, the "client" is in fact a prison inmate. To take this example further, an inmate reported that he was actually written up and put in the hole for "threatening behavior". The inmate stated that his case manager "misinterpreted" his behavior as threatening.

> Q: What is your relationship like with mental health staff?
> A: Overall, it's been pretty good. They had this one gal working here…I didn't have a problem with her, she had a problem with me, the way I was coming across…threatening towards her. I got thrown

> in the hole. I actually was expressing myself as stressed out…scared about whom I was celled in with in the future. I was very paranoid. She may have been an ex-cop, cause the way she wrote her report, it read like a police report…got the facts twisted. She really made up a lot of stuff. [If I did it] I'll totally admit it.

This final narrative relates how the mental health staff was perceived as no different from officers or other security staff, and the staff's unpredictable reaction to the inmate's behavior resulted in a write-up and being sent to the disciplinary segregation unit. This quote reflects some inmates' concerns of the blurred distinction between mental health staffs' role as treatment providers *and* penitentiary employees.

I quote an inmate who had minimal contact at OSP with mental health staff discussed how he limited his sharing with mental health staff due to his perception of their dual role within the institution.

> Q: But if you share too much with mental health, it gets into security issues?
> A: Yeah, like anything I say to them about hurtin' another inmate, or myself, they got to report it.
> Q: Do you wish that relationship was different or are you ok with that?
> A: It's two different things, yeah, I accept it, and it's all right…so I know medication is there for me and any counseling that I need I can go and get it from med management [*a treatment group*]. On the other hand, they are gettin' kind of personal, and you got to set down the ground rules and say, '*Naw, I ain't answerin' those questions, cause it could be…ah…detrimental to my life in prison or out on the streets*'.

Here the inmate discusses how particular statements he makes may be reported to security and it may be detrimental to his life in prison, i.e. security will then intervene in his life in the institution in a negative way, for example, writing him up or facilitating an admission to the inpatient psychiatric unit. Again, we find that an unspoken theme of trust runs through these narratives. Inmates who

reported minimal contact with mental health staff, or an ambivalent relationship with clinical staff discussed this in terms of how the dual custodial and clinical role of the mental health providers could result in unpredictable consequences if too much personal information was shared. Although not explicitly related to a convict code that creates substantial social distance between inmates and all penitentiary staff, there is still and underlying premise that staff are to be trusted minimally.

For another inmate who reported no significant relationships with mental health staff, he also commented on the importance of the clinician to know the environment in which the inmates lived. The inmate, perceiving the doctor did not fully grasp the prison environment, also felt that his reports were being misinterpreted.

> The doctor doesn't know the dynamics of what's going on in here. Like I told him you could even get into a fight by getting caught going through a door and he wrote in my file that I'm paranoid to go through a door. I'm trying to tell him what the [inmate] population is like, and all he does is belittle you….When I came back in to see him the next time he said, '*Last time I seen you, you were paranoid about walking through doorways*'. I told him, no…that you could get into a fight with a guy just next to you, who's going to go through the door first. If they don't want to understand how the prison works, then they're not being an effective doctor for what your problem is.

In this story the inmate stated that bumping into someone while going through a doorway warrants paranoia. If he bumps into the wrong inmate, there could be a fight, with more consequences than an injury. The inmate would lose his housing, his job, and be fined a substantial sum of money for fighting during a line movement. In the inmate's mind, this warranted a level of vigilance. Although this is the only inmate who reported a clinician's lack of authoritative

knowledge of the prison environment as a barrier to establishing a therapeutic relationship, it still hinges on the inmate's concerns of clinicians' misinterpretation during the clinical encounter.

Here, these narratives reveal, that for inmates who did not report a strong relationship with their mental health case manager, there was risk of being misinterpreted in their behavior, and in doing so, these inmates may then become ensnared in the disciplinary apparatus of the institution. These inmates perceived mental health staffs' roles as blurring the distinctions between their clinical roles and their custodial duties in the penitentiary, and potentially leaning toward the custodial duties of their work as penitentiary employees. Additionally, the final inmate discussed how his vigilance in the institution, a normal reaction to the stressors of the environment, was perceived as "paranoia", rather than legitimate fears of a potential conflict with another inmate. In both circumstances, there is a concern that mental health staff will misinterpret the reports of inmates, either because of a focus on security concerns, or quite simply a lack of knowledge regarding the penitentiary. In both instances, inmates kept a greater social distance from mental health staff, and although they confirmed they attended appointments and engaged in treatment, their interactions with staff were kept to a minimum, unlike other inmates who viewed their ability to talk freely with mental health staff as a positive aspect of their treatment.

I know return to the primary concern of this chapter, how relationships with mental health staff may mediate the course and outcomes of psychiatric disorder

for mentally ill inmates. Here, in the narratives of inmates that did not establish strong therapeutic bonds with mental health staff, these individuals were still considered as functioning at high levels in the institution, with no admissions to the psychiatric inpatient unit, and maintaining low symptoms and good institutional conduct. These inmates were able to maintain this level of functioning in the prison due to their ability to attend to their own needs. Although they mistrusted mental health staff, they continued to remain in treatment, and saw benefits to remaining on their regimen of psychiatric medications and partaking in the minimal appointments mandated by the mental health staff to ensure "compliance" with treatment. Of this, two of these inmates commented:

> ***Inmate A***
> Q: What is your interaction like with mental health staff?
> A: That's very brief. They schedule you for a visit, you come in, they ask you about your appetite, 'Are you gonna kill somebody? Are you gonna kill yourself?' Do you sleep well at night, and how's the medication? See you later! But if I really need to talk to someone, I can go in and talk to someone.
>
> ***Inmate B***
> A: Sometimes just talking can help. Sometimes it don't, and sometimes you can't cause you don't know the type of person you're dealing with

Here is the key to understanding the minimal relationships between the inmates in this section and how to explain their functioning. Even within the context of minimal relationships or interactions, there is still a recognition that mental health staff can intervene, if absolutely necessary, in the case of a crisis, either through adjustments in medication, or responding to an inmate's increased symptoms.

This sharing of confidential and sensitive information, i.e. symptoms, cognitions, and emotional states is necessary for mental health clinicians to do their work within the penitentiary. Even for inmates who engaged minimally, they understood that if it was absolutely necessary, and they perceived some benefit to sharing, they could do so in the context of the clinical relationship. An inmate who reported positive relationships with mental health staff discussed how keeping an even affective "shield" was paramount for survival in the institution, but that in his meetings with mental health staff, he had to lessen this stoic affective presentation in order to work effectively with mental health staff.

> If you're talking to mental health, that's different, I have to let that shield down to work with them, and for them to work with me. I have a lot of issues in my head that I go through, (like) voices, paranoia, anxiety attacks. I go through all of those. Like right now, we're talking, so I've let my shield down. I get to go talk with my case manager, I let my shield down, but when I come out of that office, my shield goes back up, cause I don't want to be attacked. I don't want to be used, abused, taken advantage of. It was a challenge, because I had to learn to be strong about my shoes, my clothing, my possessions. When it comes to talking to mental health or a staff member, you let that shield drop a bit, but you still have it, in case you need to fire it back up…

In this narrative this inmate discusses how he must allow some vulnerability within the context of his clinical encounters with staff; he also has to put up this emotional shield in order to appear strong within the general prison population. What this means is that he cannot appear weak, or look like a victim, hence his comments about his shoes and clothing. If other inmates believe they can victimize you, they will, and part of that process is stealing shoes, or other items purchased with your own money through canteen (inmates can purchase expensive leather sneakers if they wish). This inmate discusses how he can not

entirely let go of this affective strategy utilized in the prison to avoid victimization, but does so when engaging with mental health staff in order to share.

In regards to expressing vulnerability, an inmate discussed this in terms of masculinity, which ties directly to the previous inmate's narrative on the necessity for a stoic affect in dealing with other inmates. That is, being masculine in the prison entails putting up this affective "shield", or stoic front, which communicates to other inmates you are not vulnerable, and will not be victimized. This is tied into a masculine identity in the prison, i.e. this stoic approach to prison life, and limited range of affect means you are "tough", and are "manning-up". This inmate stated:

> Q: How do you work with mental health if you have to be macho all the time?
> A: You don't just go and give yourself up to a therapist. With my CTS counselor [*case manager*], she's a woman, so you don't have to be macho. With my CTS case manager, it's easier, cause I don't have to be this tough guy. I can tell her my fears, or about the voices. With a male, you can't just admit you're crazy and hearing voices.

Not all inmates framed their relationships in this manner, but I draw out these last two inmates' narratives to provide insight into inmates' perspectives on this "good" relationship, while still enmeshed within the broader social and cultural context of the penitentiary. These inmates' strategies, of presenting a stoic affective front within the context of the general prison population, had to be negotiated in order to engage successfully with mental health staff. These inmates recognized this dichotomy, these dual cultural proscriptions of affective display, and attempted to negotiate these for the benefit of their treatment.

Another potential obstacle an inmate reported to fully sharing in his mental

health concerns with mental health staff was his perception that clinicians would doubt the credibility of his self-disclosure. The two quotes reflect this concern among some inmates.

> I don't want my case manager to think, '*Aw, he's just gamin*"' or whatever. Yeah, I want to share…but…I don't want to be seen as, '*Oh, he just fakin' it*'.

Another inmate discussed why clinicians may be dubious of inmates' reports due to this potential for malingering and manipulation.

> Everyone in here has broken the law. Because of that, the staff can't say, '*OK, this person here, I'm dealing with them exclusively as just a patient*'. You can't make that judgment call…he may be a patient, but he's also an inmate…he may try to con me out of this, get this from me…that's always in the back of mental health staff's minds…cause they may have known inmates to do that will staff. Let's face it, we're dealing with convicts in an institution always trying to get over on somebody. They're looking for the next drug to get high on…It's usually the short timers that are ruining the treatment for people doing a long time and suffering from mental illness. They go to see the mental health workers and basically lie about their symptoms…to get a drug to get high or sell it to someone. I'm aware of that…Every time I go see mental health, I have to be as honest as possible, cause I don't want them to assume or even think that I'm one of those individuals. In the back of their mind, no matter how much they want to help you, they're always going to be thinking, '*Maybe he's one of those guys trying to get something out of me…maybe he's really not going through anything*'.

This clinical relationship must be established and negotiated in the context of the penitentiary, where malingering must be taken into account during all clinical encounters. This inmate was acutely aware of the malingering that occurs in the prison, and was concerned that mental health staff may misinterpret his real distress as "gaming" for secondary gain. This perspective ties into disparaging remarks heard among corrections professionals, and one that I

heard frequently when an employee, “If an inmate’s mouth is open, he’s lying to you”. This theme is strongly connected to a previous inmate’s comments that no matter what he says to mental health staff, he is still an inmate, and their clinical relationship will always be structured along these lines. Even for these individuals who reported positive relationships with mental health staff, they were still concerned with the perception that they may be manipulating or malingering, simply due to their inmate status.

In regards to clinical staff responding to manipulation, a mental health staff discussed how this could be an inherent part of a clinical relationship within a penitentiary. The following quote also reveals that the relationship must be engaged in, regardless of the potential for manipulation or malingering. Moreover, the actual inter-personal relationship forged in the clinical encounter allows for setting of boundaries and the ability to accurately assess whether there is a real need behind requests and reports of psychiatric distress.

> The real board game in working with an inmate is knowing what’s going on with him and knowing how to relate to people in a functional manner to establish a therapeutic relationship within that context. In order to be able to do that in a non-personal fashion….a professional one, in which you recognize that these are the options for this guy and some of the options he chooses will be appropriate and some of them will not be appropriate. Don’t take offense…he’s just trying to get what he wants. But to be able to direct that appropriately, that requires that interpersonal ability to establish that relationship and that gives you the ability to say, ‘*No’*, and allows you to see behind the games to see whether there’s something that really needs to be done there, in terms of addressing illness, and what’s appropriate…for a housing change…for a med change…You can’t do that just from a piece of paper, otherwise you’d have these guys fill out a form and do it from a desk.

Summary

The primary question this dissertation chapter seeks to answer is how do relationships with mental health staff mediate the course and outcomes of illness for mentally ill inmates, and specifically, do these relationships contribute to positive outcomes for their psychiatric disorder and functioning in the penitentiary? From inmate narratives, several themes emerge that provide insight into how this relationship mediates their illness experience. First, a majority of inmates did express that their relationship with mental health staff was positive, and they felt it did contribute to positive outcomes for them, particularly in terms of the ability to talk to a mental health professional about stressors in the prison or specifics about their mental health symptoms.

For inmates who described a minimal relationship with mental health, this lack of substantive relationships was due to their perception of mental health staff as being closely aligned with security in the institution, and thus these security concerns overrode any clinical concerns for the practitioners. Moreover, a lack of understanding of the prison environment was also cited as problematic in interpreting inmates' concerns and symptom reporting. For these inmates, there was some concern that they would be isolated either through security measures or intensive psychiatric treatment measures, i.e. taken out of general population and housed in disciplinary segregation or the inpatient psychiatric unit, and thus lose hard-earned and established routines, housing, jobs, or other comforts that made life manageable in the prison. However, these inmates did still discuss that they would pursue appointments with mental health if they truly needed an

intervention, such as a medication change, for example. Even these concerns of inmates are linked substantially to penitentiary cultural models of trust, i.e. there was a concern that mental health staff would act unpredictability, outside of their proscribed role as treatment providers, and act solely within a custodial domain. For inmates that did report good relationships with mental health staff, there was still significant concern that the recent history of staff turnover was difficult to overcome, and also lessened some ability to trust mental health staff. But for the inmates that discussed this, it was more of a "work in progress" rather than a "giving up" of establishing trust. Mental health case managers were also not the primary staff inmates established relationships with. Contract mental health staff, for some inmates, was their primary relationship, and they perceived benefit from engaging in treatment with this staff.

Some inmates also discussed how they had to both navigate concerns regarding perceived manipulation and malingering in their interactions with mental health staff. Inmates also had to navigate appropriate affective presentations for clinical encounters, which opposed prevailing institutional cultural proscriptions for emotional disclosure. In the general prison population, to reveal a vulnerability is also to risk one's personal safety, autonomy, and agency among more predatory inmates. Additionally, the stoicism necessary to ward off potential victimization is contra-indicated for therapeutic encounters which require at least some degree, or sharing, of generally private affect and cognitions. Inmates themselves recognized this tension and attempted to navigate it. In summary, it appears that inmates did rely on mental health staff to

assist with their psychiatric disorder, and recognized that mental health staff could assist them when and if necessary. For this sample of inmates, relationships with mental health staff did mediate the course and outcome of illness, according to both staff and inmates interviewed. In terms of whether this affected positive outcomes, I propose here that not only the relationship, but the perceived availability of support was significant for these inmates. Finally, structuring these relationships along the cultural constructions of trust in the institution was identified by some inmates as paramount to establishing and maintaining these relationships.

Chapter 7: Relations Between Staff: Security, Medical, and Mental Health

As this research unfolded in the penitentiary, I focused on discussing with inmates their relationships with security and mental health, and attempted to gain insight into those staff members' perspectives on how those relationships may mediate illness experience, and potentially contribute to positive outcomes of this inmate population. In contextualizing the work of mental health security staff and their interactions with mentally ill inmates, it became apparent that the relationships I was exploring were not strictly dyadic, i.e. between mentally ill inmates and officers, or between mentally ill inmates and mental health staff. Integrated into this relationship between inmates and staff were also relations between the three sectors of the prison who are primarily responsible for the management of inmates, and specifically, the treatment of mentally ill inmates.

I had the opportunity to explore these relationships with mental health, security staff, and medical staff and how the relationships between these three sectors of the penitentiary worked together to ensure appropriate care of mentally ill inmates. In this regard, I explored both formal and informal means in which this relationship is established and enacted. Of course, due to the culture of the Department of Corrections and the paramilitary orientation of the institution, officers are obligated to "work" with mental health staff. This could be something as simple as letting a mental health staff walk down the tier to see and inmate cell-side. However, there were various informal relations uncovered in discussing these working relationships, and I include these findings as I believe they are the final key in understanding not only how the prison operates and

maintains order, but also how mentally ill inmates may also receive appropriate access to treatment. It is within the network of staff relations that mentally ill inmates may receive immediate attention for their psychiatric illness, and thus these relationships between security, mental health, and medical may facilitate positive outcomes for mentally ill inmates' illnesses.

These narratives are strictly from a staff perspective, and do not necessarily relate to the inmates in the study sample. So I do not propose a direct correlation between inmates' outcomes and the relationships that staff participants have with other sectors of the prison. Nor do I propose that the staff participants enacted working relationships with each other, and I was able to access the nature of these relationship. Rather, I asked staff how they work with other sectors of the institution, and if this may impact the institutional functioning and illness outcomes for inmates they work with. In accessing these narratives, what is revealed is that the prison functions and operates due to the cooperation and inter-staff relationships between security, medical, and mental health. Rather than conceptualizing the prison as a site of total control, directed solely by security, medical and mental health staff negotiate relationships with security to provide treatment and alternative means of managing and addressing inmates needs.

Mental Health Staff: Perspectives on Relationships in the Prison

A Multi-Disciplinary Approach

When asked about how to appropriately "do mental health" in prison, a mental health staff member discussed how it was crucial to build relationships

with other institution staff in order to appropriately work with inmates in the penitentiary.

> Anybody in this kind of environment, if you try to fly solo, you're going to crash. If you don't rely on your own network, if you don't build relationships with your co-workers, security, health services, administration…you're not going to have access to a lot of data you need to make clinical decisions. Every little piece of the puzzle has a direct bearing on not just the safety and security and well being of the mentally ill inmates, but also the safety and security of the entire institution.

Mental health staff framed their comments regarding intra-staff relations in terms of relying on officers' and medical staffs' observation to assist them in making clinical assessments, as well as utilizing these observations as a means of monitoring inmates' functioning in the prison environment. Although security may be the primary staff that is understood as the "professional observer", medical staff, specifically nurses, interact with mentally ill inmates to deliver medications to the inmates. In general population, this is done during pill line, and in the special housing units, where inmates are locked down nearly 23 hours a day, nurses go to the cell front to deliver medications and mark in the MARs (medications administration record) books if the inmate received and took his medication.

Frequently staff discuss the penitentiary as solely run by security, due to the prevailing directive that all staff attention and ultimate goals should be directed toward the "safety and security of the institution", a phrase which is utilized continuously by staff to frame their activity in the penitentiary. However, mental health staff did discuss how they utilized a multi-disciplinary team model to address the needs of mentally ill inmates. The following quote from a mental

health staff provides insight into how this multidisciplinary team approach is conceptualized and how a flow of communication between different sectors of staff is critical in providing treatment for mentally ill inmates.

> I'd hold back in saying it's security's show around here. It really is a multi-disciplinary team. That's the model of an effectively run prison, that's safe for staff and inmates…that there are those team connections, we all understand the importance of each other, and we all have a piece to the puzzle. The key is to build those processes and networks where we're exchanging information with each other. Security, mental health, medical, correctional counselors, the physical plant workers, education and religious services, job supervisors in prison industries, all of them play an important part. In mental health, we rely on officers, medical and correctional counselors. For that model to be effective, there has to be that flow of communication between groups. It's really about that multi-disciplinary approach that affects outcomes for inmates. You can't do it in isolation. You can't be a lone ranger, because your decisions will impact people down stream. Decisions about inmates can impact other areas of the institution.

Here there is an emphasis and an institutional cultural ideal that focuses on the inter-staff relations as paramount to addressing the needs of mentally ill inmates. Moreover, this staff emphasizes how knowledge of other penitentiary staff's concerns and foci are essential; making decisions and working within formal systems in the institution must be approached with a knowledge of how one's actions may affect other staff and other areas of the prison.

I asked a mental health staff about the importance of these relationships in the day-to-day duties of her work. She discussed how these relationships can expedite and facilitate elements of psychiatric evaluation, as well as how these relationships are maintained through informal means.

> Q: Is it important to have relationships with medical and security to do your job?
> A: It's crucial…For some of my guys who come here that I don't know, and I get a random kyte [*written inmate*

> *communication*]…and it's not sitting right…they're reporting problems with memory or something, I'll talk to medical and say I need some help…*Can you pull him up and rule out medical before I go down this mental health path*? And they'll do the same, rule out mental health [*as the origin of the problem*]. It's definitely important to have that relationship, because they will help, and if you're not on their good list, they'll tell you to tell the inmate to kyte them [medical]…Security…I feed the group living officer M&M's [laughs]…he can never get enough… I find out who likes coffee….I shmooze, and they know it…but you have to build that relationship with them.

A medical staff also discussed how informal channels can be crucial to smoothly funnel inmates through the treatment systems in the penitentiary.

> If I have someone who I think needs mental health services, and I think they need them right now, I'm not going to fill out the mental health referral form and mark urgent and put it in the basket. I'm going to call somebody, and even if it's not their patient, the mental health staff will come see them. That's not how it's supposed to work but there's times when I think I don't have time to let the mechanisms of the system do their work.

Another medical staff discussed how personal relationships may also facilitate treatment for inmates; a staff's relations with other staff members may be a link to an institutional resource that may facilitate appropriate care for individuals.

> If you're working with an inmate, or with a particular situation, and you know that a captain or sergeant, or an officer on a particular shift, or staff in an outlying area like the kitchen or industries, you'd call the person you're most likely to believe you're going to get along with first. I may not call the boss of an area first, I may call you because you've got a great relationship with your boss and your boss may not know me, or think about me.

The previous narratives present an ideal working relationship within the prison. I turn now to concrete examples elicited from mental health staff on how these relations with other staff are enacted, along more informal means. The previous quotes discuss these relations in the abstract, and I turn now to some

examples provided by mental health staff on how relations are established, what these relations mean, and how they may impact the outcomes for mentally ill inmates in the penitentiary.

Responsiveness Between Staff

Mental health staff discussed relying on security officers' observations with mentally ill inmates, and this was discussed in a previous chapter. However, I unpack this relationship further, as mental health staff discussed how their interactions with officer provided a means of educating security on mental health issues, and establishing rapport and trust through responsiveness and working on credibility in the institution. A security officer, in discussing how working relationships between correctional officers and mental health staff developed with frameworks of responsiveness stated:

> Q: How does the relationship between security and mental health develop?
> A: It's the responsiveness. Staff need responsiveness. It may be just the two of you [*correctional officers*] working in a housing unit of 560, and you have an inmate acting out or acting bizarrely, you need to have this inmate responded to, to maintain the safety and security of that unit. You let someone be disruptive, and then after a while, the whole unit is disruptive. And so how responsive are they to the needs of the staff? If you say, '*I'll get around to it*', or '*My regular office hours are…*', it's that kind of stuff that does not endear mental health staff to security staff, cause we're running this housing unit 24/7 and we need help 24/7.

Mental health staff commented that responding to officers' needs on the cellblocks, as well as understanding their work on the cellblock also facilitated a responsiveness. Officers looked to mental health to be responsive when they called for assistance on an inmate on the housing unit.

Observation

In regards to establishing relationships with security officers, mental health staff have to rely substantially on the observations and cooperation of security and medical staff.

> Q: Sounds like there has to be a level of trust and understanding with security?
> A: They are on the front line. I spend 75% of my work week in special housing…a high risk area for mental health inmates. Staff notes, and comments and observations become absolutely critical for us in determining in how a guy is really doing down in special housing.

A security officer also discussed how, as previously noted, since security officers are the "first responders" to mental health issues within the penitentiary, reporting their observations to a responsive mental health staff is crucial for inmates to receive appropriate care.

> Q: What do you think helps inmates with psychiatric problems succeed in this environment?
> A: Supervision, observation. Once we've identified someone with a mental health problem, and they get their treatment, then the mental health staff work with security staff, and let us know the needs of the inmate, while maintaining the integrity of their confidentiality. They tell us some things to look for, and how to take care of their needs.

Here, the treatment of mentally ill inmates does not solely occur within the confines of the clinical relationship or therapeutic encounter in the officer and in group treatment. Officers and mental health staff establish relationships based on a shared understanding that mentally ill inmates need monitoring and observation to ensure their appropriate treatment and functioning within the prison environment. The cultural ideal within the prison, then, is a feedback loop of the inmate's behavior, structured through working relationships with security

officers and mental health staff. Officers are not divorced from interacting and working with mental health staff. Rather, as part of this multidisciplinary team, they must observe and communicate with mental health staff to alert them of any changes in behavior or functioning in the inmates they supervise in the housing units.

A security officer provided some concrete examples of the importance of this observation, coupled with officers' acknowledgement of the importance of psychiatric treatment and relationships with mental health staff.

> That's why a lot of times, we call mental health. Cause there could be times when we're wrong [*about an assessment*]. I'm not a doctor. I'm not a mental health specialist. And we rely on mental health, '*Am I seeing what I'm seeing*?'. So we need that, '*yes, this person meets the parameters of being mentally ill, a special needs individual*'. The better relationship we have with CTS, the better it works for us. You can't do it on your own; you have to rely on mental health. It has to do with the amount of inmates we have…and the better relationships we have with the CTS people, we can bring inmates up and talk about them. They'll believe what we see and what we're dealing with day in and out, and have that input…

These quotes reflect reliance between these three different sectors of penitentiary staff. Observations of the mentally ill inmate population are crucial to alerting mental health staff of potential psychiatric crisis. This rapport between staff, then may facilitate appropriate treatment within the institution for mentally ill inmates.

Establishment of Trust and Credibility

A medical staff offered an example of why trust between staff, or specifically, trust in the other staff's observations, could be critical to getting inmates the treatment they need:

> In dealing with staff, I think what it means, if you tell me something, first of all, I believe it, because you've never given

> me a reason not to believe it. So if you tell me something's important, if it's important to you, it's important to me.

Staff's establishment of trust and credibility with security also centered on the perception that mental health staff was not "coddling" inmates or being "gamed" by their clients. Mental health staff are expected to establish relationships with security based on a respect of institutional security policies and an acknowledgement of security's concerns. For example, if an inmate is successfully "gaming" and manipulating mental health staff, the consequences could range from a lack of accountability for the inmate, or to actually jeopardizing safety and security in the institution.

> ***Mental Health Staff A***
> You have to establish your credibility with security staff, in particular….so show you know what you're talking about…you're not going to baby the inmate.

> ***Mental health Staff B***
> When you walk into the prison, they think that you're going to give the inmate a teddy bear, and coddle them, and be a chocolate heart, and to not hold them accountable. I write DR's [*disciplinary reports*]. I go down to the OIC's [*officer in charge*] office. I report security threats and concerns. You have to prove to them you're not just here to baby the inmates. Because unfortunately you do have staff here….they want to help the inmate but they don't think about the institution as whole. Your goal is for everyone to go home at the end of the day. You have to think like an officer sometimes, and be aware of your surroundings. You just have to show security the utmost respect.

These two quotes reflect the necessity of mental health staff accessing and utilizing security's perspective in their work; they must provide care for the inmates while still be alert to security issues and guarded against manipulation. Moreover, "coddling" the inmates, or being a "chocolate heart" (i.e. a "melting"

heart) would alert security that the staff is not “on board” with the culture of the penitentiary that dictates a detached firmness in response to inmates’ needs.

Regarding this issue of manipulation, another mental health staff discussed how this was negotiated and contested with security staff in advocating for housing for an inmate:

> If it’s a guy who’s been here a long time, you’re going against security and medical staff and other people who know this inmate, ‘*No, he’s just gaming you…don’t worry, he’s fine’*. We just had a guy move down to the CTS tier, and I have Captains and other officers pissed off at me. I said, ‘*If he’s gaming me, I will own up to it, and I will apologize to you guys*’. But if he’s decompensating, I want him on that tier so I can keep an eye on him. It’s an uphill battle, but I’ve done my damndest to bridge the gap between security and medical.

The inmate was moved to the mental health tier, and the mental health staff continued to work with security in monitoring and addressing this inmate’s needs. In another interview with a security officer, this same inmate and his housing needs were also spontaneously brought up in discussion. The officer stated that he had been at OSP for 19 years, that he had know the inmate, and that housing him on the mental health tier was not appropriate. Here, the relationships are negotiated along lines of trust. Is the mental health staff trustworthy? That is, does the mental health staff understand security’s perspective and value its opinions on behavior in the institution? A mental health staff member also related how these professional relationships are negotiated through responsiveness to officers’ requests that inmates been seen to determine if there are any mental health concerns.

> But you get the guys in D block that want to pull the mental health card when they don’t have a diagnosis. I got a call

> yesterday and this guy [inmate] is saying he's freaking out and needs to see his case manager, and I look him up and he's an MH0…[*no mental health diagnosis*]…but I told him I'd screen him, but not to let him pull that, because he's not mental health. The staff is getting to know the inmates. They know what's normal, and what's not.

This particular scenario can be quite common in the penitentiary. An officer will call mental health and state that an inmate is requesting to see mental health on an emergency basis, or is "freaking out", but the inmate may not have any current identified mental health needs. The mental health staff agrees to see the inmate to allay the concerns of the officer, and be responsive to the officers' requests for mental health assistance. In some instances, these relationships are also established and maintained through personal knowledge of the staff member. An officer that worked the mental health tier commented one day that he knew one of the mental health staff, had worked with her, and knew to call her personally about individuals on her caseload if he needed assistance.

Training

Engaging with security officers also allows mental health staff to educate and establish a rapport with officers. A mental health staff discussed how responding to officers on the cell blocks provided opportunities for informal trainings, which facilitated appropriate responses and referrals from officers.

> We've made significant strides in building credibility and establishing relationships with security folks. Those of us who've worked at it, and there are those of us who've worked very hard at it for the past two years - we're committed to sharing information two ways. The unit staff doesn't come to us and say, inmates Smith is 'freaking out'. OK, we're like, 'What are you seeing? What are you hearing? Is this a change in how he normally behaves?'. Except in the cases for our known frequent flyers [*chronically mentally ill who are known to all staff*]…I tell them, '*I trust you'*. If you feel the inmate needs to be seen, I'll

> see them. We also get back to the staff, not to share diagnoses, but say, '*When you have somebody who has the same disorder as this inmate has, this is the kind of behavior you might expect to see and it may be a sign that he's decompensating and you need to call us'*.

In responding to officers' concerns regarding inmates, mental health case managers may use it as an opportunity to establish relationships, as well as provide brief training and education on particular inmates or general training on mental health treatment and particular warning signs of inmates on their caseload.

The previous sections discuss how relationships are established and maintained in the institution, as well as how these relationships (primarily between security and mental health staff) may be crucial to maintain mentally ill inmates' psychiatric stability. Officers and mental health interact in a larger cultural model in the prison that emphasizes a multi-disciplinary approach to the management of this inmate population. But within this cultural ideal of "teamwork", we find that mental health staff must establish their credibility among security staff, and demonstrate their own acknowledgement of the importance of security officers' mission and professional observations in the context of these relationships. Additionally, mental health staff are able to use their interactions with security officers to reinforce their responsiveness and presence in the prison, while also providing short-term training to officers regarding particular mentally ill inmates and general issues surrounding mental health treatment.

I now turn to some institutional history to unpack this complex relationship among security, medical, and mental health staff to further contextualize these relationships.

Mental Health Staff: The "Red-Headed Stepchild" of Penitentiary Staff

A mental health staff discussed the broader relationships between medical, security, and mental health staff which took into account a historical narrative of the penitentiary in which mental health staff are the most recent addition to the penitentiary's institutional fabric.

> We're the redheaded step child here. The manager at medical told me, for many, many years it was only us and now you've come along, and it's you guys! So you have to work with them. I need their help with inmates…if I need an inmate to MHI, I can't escort them. I can't do all the roles myself.

A security officer also discussed how prior to mental health staff being at OSP, security "did it all", that the relationship between these two sectors of staff are still being negotiated, and that the high mental health staff turnover referenced earlier may impede this team building.

> By and large, I think the officers appreciate the efforts, some still harbor some resentment, because prior to CTS coming here, we did it all. The relationship between security and mental health is getting better. Security sees that there is a benefit to having mental health staff due to the large numbers of mentally ill inmates. Because of the high turnover in mental health staff, we can't develop the relationships with them, like when you and the original staff were here at OSP.

An officer also commented on how mental health was not initially perceived as being part of "the team" prior to the implementation of OSP's mental health program,

> In the old days, it didn't seem like teamwork. It was like, we're mental health, we're up here, leave us alone, we know what we're doing.

The discussion here references a time when mental health staff were primarily stationed in the inpatient psychiatric unit, and the general prison population relied primarily on the efforts of the psychologist and nurse practitioner to manage any mental health issues among inmates in the housing units. Officers will still discuss frustration on how mental health staff at that time were not visible or responsive to the needs of the institution, nor willing to accept the observations of security staff as legitimate. Medical also assisted in the management of this inmate population prior to mental health "coming on board", and older staff can still recount how they themselves dealt with mentally ill inmates with little training, knowledge, or mental health resources to provide assistance to the inmates.

I also draw this history out because of the high turnover in staff in recent years at OSP, and how these relationships must be established and re-established each time new mental health staff are hired. In regards to mental health staff being the "redheaded stepchild" in OSP, this is framed primarily in terms of visible and present mental health staff being a somewhat new aspect of institutional culture, and that in older historical accounts of the penitentiary, mental health staff were not perceived as helpful or responsive. I conclude this

section with a historical narrative from a security officer who remembers what it was like to work with mental health staff prior to the full implementation of the mental health program:

> I've been with the department for 25 years. When I started, it was not like it is now. Everyone is much more aware of the right things to do, there's proper treatment. I think we're moving in the right direction. Another inmate came in around 20 years ago. He came in young, so he went to a prison other than OSP. He had all these cuts on his arms. I remember staff talking about it. And they were deep cuts all on his arms and legs, down to the bone. And you couldn't sew him up, because he was tearing at them all the time. You had medical sewing and taping him up and he'd take it off and open it up. Back then we didn't have any training on how to deal with this, and there were no mental health specialists at this prison. There were some at OSP, but their attitude wasn't the same as it is now. And we locked him up, for disrespect or the wrong area or something. Well, he was in segregation for a few months, cutting himself. Nothing life threatening, but it was messy, and concerning. Well one night he tried to castrate himself to the point he had taken a razor blade and cut open his scrotum and removed one testicle. The other one, he told me he couldn't cut it off because it was too painful, he was ready to pass out. It was a bloody mess. So we called SMU [*inpatient psychiatric unit*] and they told me he was just acting out, he's not mentally ill. And it was astonishing to me that anybody that was normal could do something like that to themselves. He got sent over to the county hospital and then got sent over to OSP anyway. I don't think that something like that would happen now. He would have been seen way earlier, and not put into a cell like that where he wasn't able to cope.
> Q: You're making distinctions as security between superficial cutting and this extreme behavior?
> A: Yeah, over the years you see a lot of that and there just little scratches, but when it's to the bone, and we got pieces of meat lying around, that's a problem. You observe. You're no expert, but you know when someone's having problems, because of experience over the years. You see where it goes if something doesn't happen, like treatment. The next thing you'll see is them hanging in their cell

This officer's narrative reveals how non-existent or poor relationships were characteristic of the interface between security and mental health, and this profoundly impacted the treatment an inmate received. The officer also reveals how his own observations and concerns regarding the safety and security of the

cell block were not taken into consideration in his discussion of the case with mental health staff at the inpatient psychiatric unit. He also discusses that because of poor working relations with the mental health staff at that time, he had no options other than disciplinary procedures to keep the inmate secure and safe, i.e. write him up and place him in disciplinary segregation to get him out of general population. The officer also acknowledges that without appropriate treatment, mentally ill inmates are at risk for death, i.e. suicide in their cell.

I provide this historical background to the relationships between security and mental health staff to allow readers insight into some of the peripheral narratives obtained during the course of the study. The institutional memories of staff relate stories such as these, when only medical and security were at OSP to manage mentally ill inmates, and mental health staff were inconsistently responsive to the observations and concerns of these two sectors of prison staff. With the amount of staff turnover, these relationships were framed within these historical contexts as well as how establishing trust and credibility for mental health staff was a process, rather than viewed as a specific endpoint.

The Relationship in Action: Mental Health, Medical and Security Staff and the Management of Mentally Ill Inmates

I now turn to some specific examples of how the relationships between staff are established, enacted, and maintained and how these relationships may impact the psychiatric treatment and illness outcomes for mentally ill inmates. These narratives reveal how these three sectors of prison staff do work within a

multi-disciplinary framework to provide treatment for mentally ill inmates, while negotiating these relationships among themselves, and maintaining a broader concern for the safety and security of the institution for both inmates and staff.

> I worked with an inmate that was in IMU, the Intensive Management Unit [*a super-max disciplinary segregation unit*] - long, long history, well know to all the staff…had every diagnosis under the sun, every medication there is. The only thing that seems to work was Prolixin, because he has no impulse control. And he's been assaultive towards staff, and does self harm. We created a behavior plan. And we have security staff in the IMU saying, '*That's so and so - he's always been that way, why do you think this piece of paper is going to make a difference*?'. So you sit down with staff and explain, '*He does this because it gets him something he wants*'. We all do…we're no different. How do we figure out what he wants and teach him more prosocial ways to get his needs met? And in an environment that punishes….even thought we know that positive reinforcement is a much more effective motivator.
>
> We talked to security staff about it, saying '*Ok, if he goes through your shift, and doesn't break a sprinkler head, doesn't flood the cell, doesn't cut himself, give him a tea bag - he loves tea*'. They're like, '*Why should we give him tea? No other inmates get tea*'. Because what are we after? We probably aren't going to have significant long-term change with this inmate, we don't have the resources to do it. What we're trying to do is trying to make the managing of that inmate in this environment safer, and easier for everyone. Giving him tea after he's behaved for 8 hours gives you another 8 hours of peace and quiet. Doesn't that feel like it's worth it? And security is like, '*Oh, if you put it that way*!'….This is the kind of training we do with staff.

This mental health staff's narrative reveals that the treatment plan had to be coordinated with security staff, and could only be implemented if security complied with mental health's request to provide positive reinforcement. Mental health staff could not simply direct officers to engage in the plan. Rather, this staff's story reveals that this had to be negotiated with correctional officers, and in the process of negotiating this special treatment for this inmate, the mental health staff also engaged in some education, on the underlying premises of the

treatment plan, the underlying logic of the mental health staff's directives, all the while acknowledging the role security has to play in the management of the inmate. If officers did not agree to engage with the plan of providing the inmate tea, then it would simply not happen.

The following section demonstrates how this relationship may work within a housing unit. A mental health staff member discussed how an inmate, in mental health treatment and diagnosed with a severe mental illness, verbally "went off" on a nurse on the tier, and was at risk of being written up further for his actions and having more time added to his sentence in segregation. The mental health staff relied on the observations of the nurse, as well as her ability to intervene and negotiate with security that this inmate's behavior was the result of the symptoms of his psychiatric disorder.

> Q: How do you arrive at some clinical reality in here, then? You come in here 1-2 days later after a behavior and there's disagreement?
> A: I don't think we've fixed it yet! [laughs]. I think how it works well is…The last time I dealt with it, was the nurse was able to tell me objectively what she saw. This guy has psychosis…he's in his early 20's…his most recent conduct, I intervened on him…the nurse said she had no idea what was going on with him…and we're going to be diverting him out of here. The nurse was able to say, '*I've never had a negative interaction with him, never a negative word with him…I wasn't by his cell yet when he said it…I said [to the inmate], you were doing really well, and he was out of it*'. So it's easier for her, because she has some sense that this guy wasn't right. And security will also objectively describe behaviors they see, and then you just get all that information, get information from client…and if you've know him over time…then you're able to see behaviors in the past, it helps, too. But I don't think that part of the process is close to being effective. I feel like it's getting better…I don't know what the staff were like before I got here, but we have security staff who are real good about following the parameters of a plan…the corporal down here…has taken the DBT book home and learned it…[a woman]…we make here the point person for guys down here for guys that are more difficult to manage.

In this story, the nurse was able to provide information to the mental health staff that this inmate seemed "out of it" when he was verbally aggressive with her, and provided this information to mental health staff who then intervened on the disciplinary report with security. Security officers on the housing unit accepted that this inmate had severe mental health issues which caused the behavior, and no disciplinary report was issued.

In contrast, I provide another narrative from a mental health staff on how negotiating credibility, relationships, and observations may be more challenging. This mental health staff related a story on how she attempted to intervene with an inmate's work supervisor, but that it was unsuccessful.

> Q: So people have told you that mental illness doesn't exist here?
> A: Yes. I think it's horrible. There is somebody that works upstairs, work coordination, and one of my guys who's severely mentally ill and doing fine in general population, he's paranoid schizophrenic…I see him every 3 weeks, he's stable on his meds…now he's on Cogentin [*for side effects of the anti-psychotic medication*], and he gets it in his cell, and he was counted out at work, and he needed his side effect medication and went back to his cell to get it, and he got counted twice…which is a huge institutional problem. For that he could be in DSU [*disciplinary segregation unit*] for 120 days. So I intervened on his dr [*disciplinary report*], saying he's really mentally ill, and he'd decompensate if sent to DSU, I'd appreciate it if he got a fine or something like that…so I had lots of people pissed off at me that I intervened on the DR but then not only that, I went and talked to the work coordinator…I said, 'he really wasn't trying to screw up count…he's mentally ill and got confused'. The work coordinator said, '*he's not mentally ill, he's gaming you*'….This guys' been to MHI, been to the state hospital…he's had the best looking at him and saying he's mentally ill….but on this floor, he's treated as such, but in gp [*general prison population*] he's gaming, and he lost his job.

In this narrative, the negotiation was unsuccessful. The work coordinator, a security officer, was unreceptive to the intervention of the mental health staff,

denying that the inmate had a severe mental illness. The informal relationship with the inmate's work supervisor was not able to be negotiated successfully, and the one with security was. Communicating to the mental health staff that the inmate was "gaming" the system implies that the mental health staff's credibility is in question, and thus the trust between staff. The mental health staff could not leverage the work coordinator to be flexible in the rules, and the inmate lost his job, a serious detriment to any inmate's life in the penitentiary.

Within both of these narratives, we find that mental health staff must negotiate their relationships with security staff, and medical staff must also be leveraged into the relationships, as they also hold a key position in managing the inmate population through their observations and coordination primarily with mental health, but also with security.

Summary

This research uncovered a layer in the relationships between staff that may mediate the course and outcome of psychiatric disorder for inmates, and possibly contribute to positive outcomes for this inmate population. There is a prevailing culture in OSP that encourages and enables a multi-disciplinary approach to managing the mentally ill inmate population. For inmates who have extremely poor functioning in the institution due to mental illness, this is a critical component of their management and treatment. For the day to day operations of the penitentiary, medical, mental health, and security staff must interact and cooperatively manage the mentally ill inmate population. For mental health staff,

relationships with security were established through responsiveness to officers' reports and observations, this responsiveness allowed for building of credibility between mental health and security, and mental health staff also utilized these relationships as a means to educate officers and include them in treatment plans for inmates. These relationships had to be cultivated by mental health staff. Mental health staff, due to the high level of staff turnover, had to negotiate their relationships with security staff, and demonstrate that inmates were not "gaming" them, a reality that would diminish the mental health staff's credibility.

Some of the tensions in the relationships between penitentiary staff were related to institutional history, in which older staff recounted times when mental health staff were not responsive, and this diminished trust and credibility between staff. The three sectors of prison staff had to maintain and enact relationships for mentally ill inmates to not only receive appropriate psychiatric treatment, but also to open up the possibility of rule flexibility, such as dismissing a disciplinary report, or allowing an inmate to continue to work at their job after being fired. Mental health staff have to negotiate these relationships along lines of trust, cooperation, credibility, and responsiveness, possibly due to their "newness" in the institution's history, and the high staff turnover over the past several years. A security staff stated, "You have to remember, mental health staff changes here quite often. So we don't always agree, and it's a give and take".

As discussed in the final narratives of this chapter, one inmate was spared an enmeshment in the penitentiary's disciplinary apparatus due to intervention of mental health staff with security, based on the observations and relationship with

the medical staff. This further entanglement in the disciplinary measures of the prison, and subsequent continued housing in a disciplinary segregation unit is uniformly identified by mental health and security staff as contributing to negative outcomes for inmates with psychiatric disorder. The other inmate lost his job and was penalized for his behavior because the mental health staff could not negotiate flexibility in the reaction to the inmate's behavior. Loss of employment in the penitentiary is associated with a host of problems, including decreased ability to keep busy, increased cell time, lack of funds to purchase basic personal items (such as hygiene items), and being placed in another job that may incur more stress and difficulty for the mentally ill inmate. All of which may place him at risk for increased symptoms.

It is revealed within these narratives how these relationships may mediate the course and outcome of psychiatric disorders for inmates, and possibly contribute to positive outcomes for their illness. One morning, a high ranking security officer discussed how this relationship is continually unfolding in the penitentiary. Here, the officers emphasizes that mental health must understand and respect the work of security officers on the cell block, and also that security officers are attempting to establish their own credibility with mental health by utilizing appropriate terminology in their reporting. There is a goal to "understanding each others' jobs".

> Mental health has gotten to know the work of cell block officers. They know they're not just dealing with one inmate, so when they call down there, if there's frustration, they understand. Our security staff are able to use the mental health terminology. 'He's experiencing delusions, or he's suicidal'. They're able to

> communicate to mental health what they are observing. Mental health and security are coming together to a middle ground. They understand each other's jobs. That's important. For example, no one person's safety is more important than a nurse's. We had a guy 'nut up' on D block this a.m. And his mental health counselor wanted us to send him up to her. I said no way. I know this guy would smack her [*smacked fist to hand*]. If he didn't get the answer he wanted [*he wanted to go to SMU, the inpatient psychiatric unit*]. So I told her to come down here to see the inmate on the cell block. They understand what our job is.

It is this understanding between these two sectors of staff, security and mental health, that falls the outcomes for treatment for mentally ill inmates, and a critical component to understand how mentally ill inmates receive appropriate care and treatment within the context of this penitentiary.

Chapter 8: Mentally Ill Inmates And Their Relationships With Inmates

This chapter seeks to contextualize the relationships inmates in the sample have with other inmates serving sentences at OSP. The questions asked within this chapter are how do social relationships with other inmates mediate the course and outcome of mentally ill inmates' psychiatric disorder? Are these relationships in any way positive? Recent research on inmates with psychiatric disorder have demonstrated that they are at higher risk for victimization and violence within the prison context (Blitz et al 2008), suggesting that this inmate population's relations with other inmates may be one in which they are exploited or the victims of more predatory inmates. Another question that is raised within this chapter is what is the nature of social relations in a context characterized as "prey-predator"? Is there an opportunity to establish supportive relationships with other inmates within the prison setting? If an individual is identified as a "friend", what implications does that have for the nature of that relationship in prison, in which there are substantial alterations of community cultural norms surrounding masculinity, appropriate communication, body language, and sharing of personal information?

This section of the dissertation examines responses of mentally ill inmates to questions regarding their relationships with other inmates, both mentally ill and non-mentally ill, and how their perception as to how this may benefit the course and outcome of their illness. I hypothesize that for inmates functioning well in the penitentiary, they have established and maintain social relationships with other inmates, and attempt to avoid inmates more ensconced in convict culture, i.e.

individuals more likely to be involved in gang activity, the black market drug and tobacco trade, more prone to time in segregation, and more invested in a criminal lifestyle. Within this chapter, I also attempt to characterize the prison hierarchy and major social groups in order to establish where mentally ill inmates lie within these social structures. It is through this understanding of the inmate population that allows for a more contextualized understanding of the lives of mentally ill inmates within the penitentiary. I also provide comments and observations from staff participants, not about specific inmates in the sample, but their general observations in the prison environment on how relationships may assist mentally ill inmates in their institutional lives.

The Inmate Population: The Old School Convict, The Stand Up Inmate, the Young Bangers, Rapos, and Dings

A security administrator remarked to me at the onset of this research,

> The two inmate populations we are concerned with right now in OSP are the young gang members and the mentally ill. These are our two biggest management concerns.

This statement reflects the growing awareness in Oregon State Penitentiary of two large groups of inmates that provide substantial challenges to the effective running of the institution. In reference to "young gang members", many staff and inmates refer to these inmates as "young bangers". These are inmates referred to by Hunt et al (1993) as the "Pepsi generation"; these inmates are mostly young, between 18-30, have community gang affiliations, or have formed their own gangs within the penitentiary. These newly formed gangs are observed by staff and older inmates as "made up gangs", not traditional gangs such as Bloods

and Crips, or the Mexican Mafia, but created out of fear. This fear is largely discussed as fear of victimization; staff and inmates in the penitentiary discuss these “made up gangs” as formed among young inmates to ensure their own survival and protection within the institution. Older inmates also discuss how this is unnecessary, as OSP is “easy time”, “not a real prison” like institutions in California, characterized by low staff-inmate interactions, high levels of homicide, and over-crowding. One inmate in the sample discussed these “young bangers” as “the crack generation”, in reference to their upbringing. He stated that it is not a poor upbringing that creates these young offenders, but a complete lack of any guidance, either parental or criminal guidance from the streets, that has created this new inmate population, which shows little regard for “Old School Convict” cultural norms. This convict code dictates “do your own time”. Some of these broader cultural values include:

- Do not show weakness
- Do not tolerate disrespect
- Meet disrespect with threat of violence or violence
- Do not involve yourself unnecessarily in other inmates’ business
- Do not “rat out” other inmates
- Keep a social distance from staff
- Pay our debts

Similar to Hunt et al’s (1993) analysis, these young bangers are characterized as not adhering to these older convict rules, or not being aware of how these rules effectively structure and maintain hierarchical structures within the prison.

For example, these young inmates are often described as hyper-violent, or more prone to violence, because they feel as if they “have something to prove”. For an older inmate, engaging in assaultive behavior simply for the sake of engagement may entail loss of elite housing, a good job, receipt of fines, or entangling peers within an unnecessary conflict between other inmates’ social groups. Moreover, as one inmate discussed with me, all inmates have a “hustle”, from low end and relatively benign practices such as selling stolen office supplies or candy, to higher end and more perilous occupations such as trading in tobacco and drugs. Engaging in high risk behavior, such as assaulting other inmates to prove one’s worth would also disrupt one’s “hustle”. For these older inmates, who characterize themselves as “old school convicts”, these younger inmates are conceived of as an annoyance within the inmate population.

An older inmate in the study indicated to me how he was assaulted by another inmate on the yard, from behind, without warning. The inmate assaulted was black, the inmate who assaulted him much younger and white. The inmate who was assaulted was much older, an established “heavy” in the prison who was doing life without parole, and an inmate known to most inmates and staff throughout the institution. Due to the assault, this inmate lost his job, his housing, and was fined. For the younger inmate, it was alleged he increased his status among his peers, for the older inmate, he lost several institutional comforts that took a period of time to build up (e.g. single cell housing, cell block of his choice, job, programming, etc). This inmate later told me, “It was some young guy, I didn’t see him. He came up and hit me in the back of the head. I had to

fight him". Another inmate discussed this issue, framing it as a concern he has doing his time, now that he is back at OSP, and the dynamics of the prison have changed. He has to be more alert to the potential for sudden and unexpected violence from gang members.

> Q: So it's changed since you've been here…you have to watch your back now? Can you explain what it means to watch your back here?
> A: Say…one of these skinheads or white groups want to make a name for themselves or dude want to be up in his click or be with them they tell 'em, '*That dude right there…go get 'em!*'. So, he have to come fight me to make a name for himself and I have to protect myself even though…even though I'm not aggressive or nothin' like that…I still have to protect myself.
> Q: Right, they call that *torpedoing*?
> A: Yeah

Another inmate commented on these changes he has seen in the prison system in which younger inmates do not appear to be socialized into the "Old School Convict" value system.

> Well, it is…the trouble is they've brought a lot of children in…kids 18,19, 20 years old that have a lot of energy…and no direction, and they're not schooled like they used to be. Used to be they were taught how to behave…When I first got locked up, some of these kids do…you wouldn't even think of doin' it cause of the environment, it was a lot different. Bank robbers, and inmates like that…

These young bangers are also associated with increased levels of extortion in the institution, although older convicts are also associated with the practice. This includes having other inmates "pay rent" on the cell they are housed in, or it could be based on "protection" services for the inmate who is being extorted. This generally entails providing a certain amount of canteen items each month to the extorter, or possibly establishing a scheme where

money is actually put “on the books”, or the account of the extorter. Other strategies of extortion and victimization include “torpedoing”, in which a new member of the gang is sent to assault another inmate, under the direction of individuals in the gang with higher status. Some older inmates disparage this extortion or other forms of victimization, but it is a known practice and done throughout the prison, according to both key staff and inmate informants. And it is associated with the young bangers.

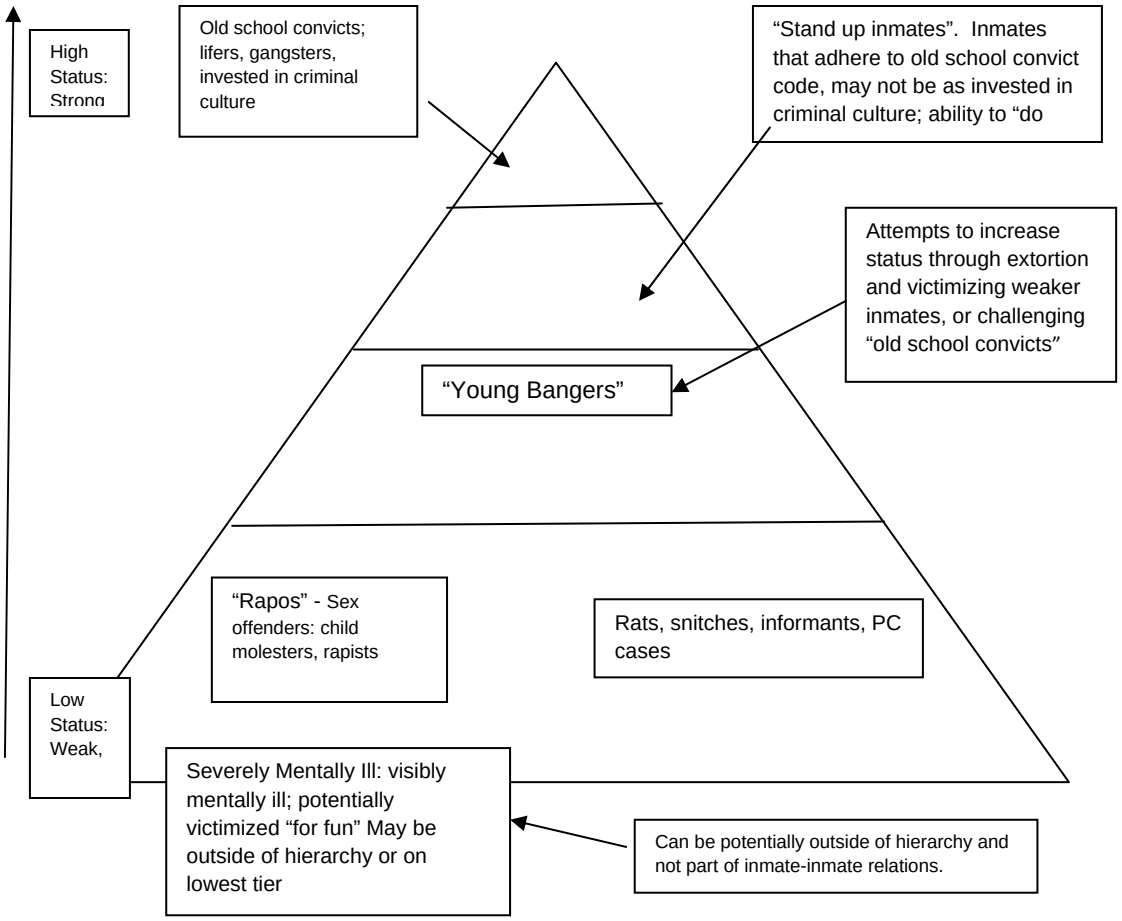
In terms of assaults, security staff and inmates characterized these acts as “PC moves” or protective custody moves, since they were done in highly visible areas where staff were already present and could intervene swiftly. True fighting, or “boxing” between inmates occurs in more secluded and less observable areas such as stairwells, showers, or utility closets. There, inmates can settle their differences, without staff intervention. As these more visible assaults were associated with Young Bangers attempting to “make a name for themselves”, this can be perceived as being “weak”, due to the swiftness of staff intervention.

Inmate Hierarchy

The following section contains a proposed hierarchy of the penitentiary, in terms of inmate relations, and which is based on informants discussions as well as my own observations. I provide this hierarchy, because it is only through knowledge of the penitentiary’s social groups that the reader can fully appreciate

the role mentally ill inmates take on in the prison, and how they may integrate themselves into the structure of the institution.

Figure 8.1: OSP Hierarchy: An "Old School Convict's" Emic Perspective



In the previous table, I present a diagram of OSP's inmate hierarchy that is informed by an "Old School Convict" emic perspective. I do not attempt to take into account age or ethnicity within this hierarchy, but I would suggest that adherence and allegiance to an "old school convict" code is one thing that distinguishes inmates at the top of the hierarchy, as well as type of crime committed. If an individual has lived a criminal lifestyle on the streets, or as one

participant characterized it, “carrying guns, shooting dope, selling drugs, ya know…gangster shit…a straight up thug”, then the likelihood of them having higher status in the penitentiary is greater. These individuals may also be older than the “young bangers”.

The second tier, are inmates that I characterized as the “Stand Up Inmate”. These are individuals who may have minimal or soft ties to a criminal underworld, such as the individuals described above, but they have still committed crimes that warrant incarceration. They may also be individuals, as one correctional officer described them, “they aren’t bad people, they made bad choices”. These are individuals who adhere to the “old school convict” code in order to successfully live in the penitentiary, and may also be physically capable enough to ward off any threats of extortion or violence from more predatory inmates. These are inmates who “quietly do their time”, attempt to avoid trouble, work and program, may maintain community ties, and have a forward looking orientation (if they indeed have a release date). This is the 75% of inmates that a former Oregon Department of Corrections administrator discussed with me as “ones who can benefit from programming, and do not want to come back to prison”. He discussed that a prisonization (Clemmer 1944) may potentially jeopardize this inmate population’s ability to make changes and not return to prison.

Given that this is an old school convict’s emic perspective, I place the young bangers below the “Stand Up Inmate”, as many old school convicts referred to them as “kids”, or quite simply “punks”, i.e. not a true man, with the

implication of coerced homosexuality. Old School Convicts would discuss this group in disparaging terms, as would prison staff, indicating that this group contributed to most of the management concerns in the penitentiary. These are inmates that are not the weakest of the inmate population, they follow some modified or improvised manner of the old school convict code, but their status is perceived as lower than Old School Convicts or Straight Up Inmates due to the problems and tensions they create, which goes against the convict code of "do your own time", or simply stated, stay out of other inmates' business.

At the bottom of the hierarchy are two concrete inmate categories: sex offenders and rats. In prison argot, sex offenders are termed "rapos" (rapists), or "cho-mo's" (child molesters), and are considered the "lowest of the low", and also called "freaks" due to their sexual deviancy. Approximately 33% of the OSP population are incarcerated for sex offenses. Inmates and staff discuss this as being a higher number, however, as both discuss that many inmates are currently incarcerated for one crime, but they "have a sex beef on their jacket", meaning that they may not be in on a sex crime for their current sentence, but in their record there is a sex offense. If this is true or isn't true, what it does indicate is that inmates are hyper-conscious to their potential victimization if they are a sex offender, particularly if their victim was a minor. In prison culture, sex offenders are the lowest of the low; "celling in" or being housed with a sex offender pollutes inmates and calls into question their own integrity. To associate with a sex offender likewise calls into question an inmate's adherence to a convict code. These are "bad" crimes, with "good crimes" being structured along

criminal lifestyle crimes such as robbery, drug sales, or homicide. Individuals labeled as a “rat” or “snitch”, who inform on other inmates, share this lower status, and these two categories are assumed by inmates to frequently overlap. Extorting, or victimizing sex offenders is “acceptable” to many inmates due to their place in the hierarchy. PC inmates are those that have gotten themselves into trouble with the inmate population and must go to the prison administration for protective custody, or “PC”. These inmates are also considered weak, as they are characterized as not being able to handle themselves within the prison environment and needed “The Man” to help them do their time.

I would also point out here that individuals in higher rungs of the hierarchy may also have a sex offense on their records. However, due to their “old school convict” status, or their ability to physically deter any attempts at extortion or victimization, they are left alone, being seen as “too much trouble” by inmates who extort sex offenders, or they may have had previous incarcerations which entrenched their status, and their sex offenses do not interfere with their re-integration into the prison community.

Additionally, this dissertation did not explicitly examine how gangs within the institution operated, recruited, or structured this inmate hierarchy, as for example, in the work of Davidson (1973). This further examination of the inmate hierarchy is outside of the scope of this dissertation. However, I present these ideal types as a means to further contextualize the experience of inmates in the study, and of the varying social groups inmates identify with, or are identified by other inmates as belonging to.

“Dings”: Risk of Victimization, Extortion, and Exploitation

I turn now to mentally ill inmates, who may also be low on the prison hierarchy, or due to the severity of their impairment, may be outside of the normal rules prison behavior and social relations. These inmates are visibly impaired, “appear” to be mentally ill due to their hygiene, gait, interactions with staff and other inmates, and inability to cope in the prison environment. To the regular inmate population, there is clearly something “not right” with some of the more severely mentally ill inmates in population. In reference to this population of mentally ill inmates, a mental health staff member discussed how the outward appearance of these inmates indicates that they are “dings”, or severely mentally ill.

> The newer security staff get shocked sometimes seeing our guys wandering around general population, thinking they should be in the state hospital. With the severely mentally ill, I have a guy who won’t even talk to me, he’ll only nod…it’s funny, cause he doesn’t shower or change his clothes, and everybody thinks he needs to go to MHI, but he’s going to chow, he’s taking his pills…making his appointments…other inmates do this…where they keep up this gross physical appearance to keep other inmates away from them. If you’re smelly and gross and weird, other inmates just leave you alone. I have the other inmate and he is just loud and obnoxious all the time, but it’s his baseline behavior, so people don’t want to interact with him, both staff and inmates.

Again, as inmates and staff intensely observe each other in the institution, gross physical identifiers, such as poor hygiene and odd behavior indicate that the inmate is a “ding”. An inmate participant discussed that “dings”, and referred in other prison research and histories as “bugs”, are so visibly impaired and symptomatic, that the old school convict code dictates that they should not be interacted with, and left alone, due to their unpredictability. Moreover, extorting

them for money is a pointless activity. They may not have any money as they cannot hold jobs in the prison. An inmate who identified as an Old School Convict stated,

> This guys' so out of it, he may not even remember who you are when you go around to collect your extortion money. He may not even remember if he bought a cigarette from you, that's why he won't pay you back. You keep messing with those dings, one day he's gonna come up on you with the broken off broom handle and stick it in your fucking neck cause he thinks you're a monster or something. You shouldn't mess with those dings, man.

A mental health staff also suggested the same explanation as to why a severely mentally ill inmate may not get extorted,

> I think it's a matter of…if you're poor enough, and people know that. If you're not working, you're indigent, then what's the point of extorting…they don't have canteen.

Regarding victimization, a mental health staff associated victimization of the mentally ill with the "Young Bangers" of the institution, who may not follow a strict convict code that prohibits interaction with "dings".

> The severely mentally ill become of interest to the more predatory inmates around here. How severe and common this type of extortion and exploitation is kind of depends. That is accurate. The newer, younger inmates don't seem to think about it as discriminately. There's lot less empathy or compassion among younger inmates. They're very anti-social, and they're connected or trying to establish themselves within a particular gang, maybe trying to move up the hierarchy. So much of anti-social personality disorder is about status and power, then there's going to have to do these things to move up the ladder in this gang structure. It's a little different in a younger inmate's mentality.

The potential for unpredictable violence may be a pragmatic concern for inmates and may deter some forms of victimization. However, mentally ill

inmates being extorted for their medications is an act that is known and discussed by security, mental health staff, and mentally ill inmates. The implication is that Young Bangers may be the inmates instigating this extortion. Due to the black market drug trade in OSP, Old School Convicts, if they wish to get high, and have the financial means, can obtain street drugs rather than extort "dings" for psychiatric medications with dubious pharmacological effects.

For every older convict who doesn't see any need to interact or attempt to victimize mentally ill inmates, the predatory nature of the penitentiary dictates that this inmate population will be at risk of victimization due to the perception that mental illness is a weakness, and this weakness indicates a vulnerability and susceptibility to control, extortion, harassment, and exploitation.

"Dings", then, are inmates who are so symptomatic and obviously mentally ill that they may not even figure into the general inmate hierarchy. However, within this severely mentally ill category may be other inmates, who are mentally ill, relatively stable on a treatment regimen, are able to interact successfully in the penitentiary with staff and other inmates, but are victimized nonetheless. They may be perceived as weak, and not necessarily as a "ding", an inmate with severe illness that may be unpredictable. An inmate and I discussed this one afternoon,

> A: Vultures stand right outside the canteen door during line movements…and they're waiting for people outside the door they perceive as weak to take it [canteen] away from them.
> Q: It's not just guys who are mentally ill…
> A: It's old guys too…
> Q: Anybody considered weak?
> A: Yeah…
> Q: So it's not just because they're mentally ill they're getting their

> canteen stolen?
> A: I think in a sense it is….because when they do that to a mentally ill person…if they already know the person is mentally ill or getting help through CTS/BHS…so they know the person has a mental health problem…it clicks in…hey, this guy is weak, I can take advantage of him.

For individuals who are mentally ill, it may be the outward appearance of being weak, rather than simply the presence of a mental illness that may contribute to their victimization and extortion. Some inmates may appear so "out of it" that they may be left alone. In the example above, however, this inmate is discussing mentally ill inmates who are functioning well enough to engage in buying food and other items at the canteen line, but just appear "weak" to a general inmate population. The term that staff members use to characterize these inmates is "low functioning".

These inmates who are also severely ill, or who may have developmental disabilities in addition to mental illness, are the inmates who may be victimized "for kicks" or fun, by the more aggressively predatory inmates, and may have difficulty in deciphering the cultural rules of the prison environment. One mental health staff discussed how this contributed to one inmate's exploitation by non-mentally ill inmates,

> I have one inmate who struggles with mental illness, but not the level of psychosis….and he'd get so excited about these friendships he'd made, and when they'd get on a first name basis, he'd get excited and in the end, the guys were getting medications from him, envelopes from him…

A security staff recounted a story regarding how mentally ill inmates are victimized by more predatory inmates. In this narrative, an inmate was abused

and killed because he did not understand the nature of his environment, and was perceived as “weak”.

> A: More than less the mentally ill get victimized. The tough guys in prison, don’t want to put themselves at risk. They use other inmates to do their dirty work for them, and the mentally ill make good targets, to pressurize….There was a kid, he was killed in DSU years ago. And that was just a more powerful inmate taking advantage of him. The inmate wanted to get out of DSU and go to SMU for a few days. And the other inmate said well, ‘*I’ll help you’*. So he said, put your head by the bars, and then hand me two ends of the sheet. And so the kid did, and the stronger inmate choked him out and killed him.
> Q: Why would he do that?
> A: Because it was fun for him, it was excitement, it was a rush. The kid was mentally ill, very low functioning. He was a prostitute, the other inmates sold him, they used him for a mule, if they needed to bring something into DSU, they would have him pack it in for them [*e.g. drugs or tobacco*]. That way, if he got caught, he’d be busted, not them. If not, they made a few dollars.

Another security staff reflected a common concern for extortion, when mentally ill inmates are extorted for their medications

> Well I think the gang activity and the tension that goes on. Any special needs inmates…the mentally ill inmates, other inmates know that if they’re mentally ill, they are getting medications. Some of these medications are a narcotic form that can cause, I imagine, some sort of high, so you go down there and extort an inmate for his medication and now it’s yours.

A mental health staff confirmed that extortion of medications by more predatory inmates, as well as mentally ill inmates not fully understanding the prison environment opens up opportunities for harassment and victimization.

> Q: For inmates that appear ‘normal’, do they have issues where people are trying to extort them?
> A: It’s about them going to pill line and the nurse saying, ‘*Here’s your Seroquel’[*a sedating antipsychotic medication*]*….and the other guys behind them saying, ‘*awesome, mental health meds’* and bugging them. And those are the ones I worry about the most, and the ones on the tier…being extorted for their meds and being pressured into doing stuff.
> A severely mentally ill guy was muling things out to DSU, and he

> thought he was 'helping'…a really nice guy…I had to explain to staff that he really doesn't get it…A lot of these guys are getting anything in return…they're just giving, giving, giving, and they're afraid to tell staff…and some of these guys get assaulted.

The distinctions I have made in the penitentiary's inmate population are far from perfect, nor are they presented as a "definitive" representation of the inmate population. Again, I do not make reference to the older gangs in the prison, or how race/ethnicity also further divides the prison population, for example. This basic representation is a guidepost, rather, to alert the reader of how the inmate hierarchy is generally understood, and primarily from the perspective of staff and "old school convict" inmates who look negatively on "young bangers" and their (perceived) disregard for convict culture rules of behavior. I would also suggest that these convict codes are cultural ideals, and that how they are adhered to, rejected, distorted, or disused and taken up may primarily be a result of the unique social actors, and the context in which they interact.

In summary, during the course of this research at the penitentiary, there was a competing discourse on how mentally ill inmates are vulnerable to extortion, harassment, victimization, and exploitation by more predatory inmates. Although these more predatory inmates were mostly lumped in with the "Young Banger" category of inmates, inmates who were long-term convicts and adhered to some manner of the convict code may also engage in this exploitation and harassment, particularly when muling drugs or tobacco is concerned. Because an inmate may be classified or considered an "Old School Convict" does not

preclude the possibility that members of this inmate population may exploit or extort vulnerable mentally ill inmates for their own benefit.

I provide this background to establish how mentally ill inmates and their relationship to the larger inmate population is perceived by staff and inmates, as well as make some distinctions between different classes of mentally ill inmates. These comments reflect a concern and awareness that if an inmate is mentally ill, this may place them at risk of victimization. However, for inmate participants, narratives of victimization were not prevalent. Rather, inmates who participated in the study were not "dings", or visibly mentally ill individuals who were then discussed as outside of the inmate hierarchical structures, although 2 inmate participants could have been considered "weak" inmates simply due to their small stature, and their lack of visible "convict" identifiers, such as tattoos symbolizing a criminal lifestyle. An inmate discussed this issue of how appearances may influence how other inmates treat him,

> I haven't gone to the yard the past 3-4 years. Now there's a lot of gang bangers here. They see someone who's fat, balding, with glasses, and automatically assume they're in here for a sex crime. And they target them, hit them up, and extort them. I don't want to be around people like that.

In contrast, another inmate discussed how his physical size warded off victimization.

> I remember someone tried to take my shoes from me, when I first fell, but I'm a big person. But some of these CTS guys are small [and can't defend themselves. I was relieved to know that I wasn't going to be a target for somebody to beat up because of my size. I'm not a small person.

In these examples, two contrasting perspectives are shown. If one "looks like a sex offender", you could potentially be targeted for harassment. If you are perceived as "being able to take care of yourself" physically, then more predatory inmates may perceive you as "more trouble than you're worth". Moreover, the inmates in the sample did not associate themselves with the criminal or convict culture of OSP. Instead, I would characterize these inmates as "Stand Up Inmates", the individuals, who, out of necessity for survival, learn the rules of the institution, both formal and informal, and navigate them for their own benefit to diminish the possibility of conflicts with other inmates, as well as staff.

Mentally ill inmates may inhabit several niches in the prison. Mentally ill inmates, or inmates receiving some form of mental health treatment, may fall into any of the categories discussed above. Although mentally ill inmates may be broadly characterized as a vulnerable population, inmates with mental illness can cope and survive in prison. I make this clarification to account for the minimal accounts of victimization provided by inmate participants. I would characterize these inmates as "Stand Up Inmates", due to their knowledge of how the prison environment works, as well as their pragmatic taking up of the convict code to negotiate status within the institution to avoid victimization. "Low functioning" inmates, or individuals highly symptomatic and managing in the general population, may not have been referred by staff for the research. There is also is a possibility that they may not have been able to participate in the research interviews. Moreover, mentally ill individuals more entrenched in a "Young Banger" culture, whom staff characterized as highly anti-social, or criminal

minded, did not appear to be part of this sample, as all of the inmates interviewed discussed this "other" inmate population in disparaging remarks. Admittedly, inmate identity was not operationalized for the purposes of this study, but these broad categories are based on the ethnographic data, and as ideal types to account for the narratives elicited during the course of the study.

Social Relationships with Other Mentally Ill Inmates

For individuals whose illness is managed and they can "fit in" in some manner to the general inmate culture, they will find a niche with other inmates, rather than be completely outside of the prison's social relations. This conception is how I integrate the inmate's reports of social relations in the penitentiary. Although all of the inmates in the sample were severely mentally ill, or assessed as having a high treatment need, 18 of the n=20 inmate sample discussed having social relations with other inmates, either mentally ill or non-mentally ill. Although a group of mentally ill inmates remains at the bottom of the hierarchy due to their status as "dings", or their inability to successfully establish and maintain relationships with other inmates, a number of inmates with psychiatric disorders do indeed successfully maintain social relationships, and of the ones who did report these relationships, all discussed how it was of benefit to engage with other inmates, even if on a limited basis. Moreover, inmates have to be cautious, as any other inmate, in engaging in "friendships". Inmates frequently discuss "associates" rather than friendships, due to the social distance observed in the penitentiary. This social distance is primarily a defense against

exploitation and extortion. An inmate clarified why an individual would have to be cautious in initiating friendships with other inmates due to risks of exploitation.

> You got to be careful about other inmates, what they want out of the situation [*if they check up on you, seem concerned*], They'll say, '*look what I did for you'*, like buy you canteen. You have to be careful about that. In my group, I can count on 3 people that don't want anything out of it. He might say, '*how about a soda?*' after you walk the track. Since I've been in prison, it's been gimme, gimme, gimme. I get this, I get this, for helping you, I get this, for doing this for you, I get this…And if you don't give up, it's '*Screw you, I won't help you again*!'.

This quote reflects a concern for inmates who become to engaged with other inmates; there may be a risk that the "friend" may continue to exert pressure for favors or goods within the institution.

Although friendship is understood as something to be cautiously engage in, inmates did discuss how they had established relationships with other mentally ill inmates and how this was of some benefit to them. These relationships assisted with providing social influence through enabling and reinforcing behaviors that could assist with mental health symptoms; providing social support through provision of instrumental needs such as canteen items and providing social engagement through participation in exercise and hobbies Berkman et al (2000) discuss how these aspects of social support may be germane to understanding how social support may influence health outcomes for individuals, although not specifically for mentally ill inmates. Relationships among mentally ill inmates has not been examined or researched to this date.

Enabling and Reinforcing Positive Mental Health

Inmates discussed how social relationships reinforced positive ways to deal with their mental health issues. Inmates who lived on the mental health tier discussed how it put them in proximity to other mentally ill inmates and allowed them to more comfortably live, as they knew other inmates on the tier had mental illness. A mental health staff explicitly discussed how peer social relationships can assist mentally ill inmates. Additionally, this staff recounts how other mentally ill inmates may monitor their peers, and let mental health staff know if their "friend", or "associate" is decompensating.

> A: I think it's helpful in an institutional setting, in any setting, for people to form relationships with other people who have similar experiences with them. For someone who is psychotic in this environment, they're experience is much different from someone who's not….I think a protective factor for people in our general pop is having them strategically housed with other people who have those same vulnerabilities. It helps, because they're able to share that experience and support, and it separates them from people who may take advantage of those vulnerabilities.
> Q: Have any inmates discussed that with you?
> A: I've had other clients talk to me about a friend that they have, where they're both mentally ill, and the friend is not doing well, the friend is trying to support and encourage him to go to pill line, when he's too paranoid to go…so I've had people tell me about that. I've had people when at baseline they're doing pretty well, and they see their friend not doing very well, they send kytes [written inmate communications] saying they're worried about him, this is what I'm seeing, something's wrong.

This narrative reveals that mentally ill inmates may, at times, "look out for each other", and alert staff of possible psychiatric crises due to a perceived shared experience of being mentally ill in prison.

Inmates discussed how their relationships with other inmates assisted or how they themselves assisted other inmates with mental illness through discussion of their treatment, what works for coping skills, encouraging each other to access services, or using other inmates as a sounding board to ward off negative thoughts.

> ***Inmate A***
> Q: Do you talk about mental health issues on the tier?
> A: A little bit, like what's helped people cope. One topic, is that if people have the right amount of sleep they seem better. That's just one example….people also talk about how visits help them. A lot of them don't get mail and I say keep your chin up.
>
> ***Inmate B***
> Q: Does having friends in here, does that help with your mental health?
> A: It does….the communication, actually communicating with them. Sometimes you have difficulties, and you're like, '*I just want to punch that dude, he said this to me and I just want to get him*'. We talk about it, and we think our way out of the violence.

These quotes reflect mentally ill inmates assisting each other from practical concerns, such as what psychiatric medications may have less side effects, to de-escalating agitation on tier.

In terms of actually facilitating activity to assist each other, inmates also discussed how they would assist by encouraging inmates to engage in positive activities, such as go to the yard, play sports such as basketball, or go to activities in the prison such as religious services. Inmates associated these activities as having a positive impact on their psychiatric symptoms. Inmates also discussed how they were able to offer instrumental support to other inmates, such as sharing coffee, snacks, and hygiene items such as deodorant and soap,

for individuals who “were a little short” at the end of the month after they had exhausted their monthly $40 salary.

These minor acts of kindness were perceived as “helping out” others who were less fortunate or in need. Inmates in OSP do this for each other and can be done primarily through a barter system. But inmates in the sample who shared their items, discussed it in terms of helping out, rather than a “hustle”, such as bartering soap, coffee, deodorant, or envelopes in order to turn profits or engage in exploitive bartering.

Opportunities for forming relationships can be through mental health treatment, either in mental health treatment groups, which provide some form of community for inmates in treatment, or through being housed in the inpatient psychiatric unit, and re-connecting once discharged from the unit. An inmate discussed how group members “check in” with each other outside of the group setting to monitor each other’s symptoms and functioning,

> If I’m going downhill, and a group member sees that…he says, *’Hey, are you doin’ ok?*’. And I can honestly tell that person, without having to put my shield up or down. That was our agreement in group, if we saw each other during the day, we’d say hi, check in with each other.

This “checking in” was discussed as a way to provide some social support outside of the group setting, and maintaining social ties outside of the group treatment setting.

A mental health staff member also discussed how mentally ill inmates could receive positive peer support through group treatment, and how other

inmates in treatment would show concern and discuss if an inmate was not doing well,

> It's kind of a camaraderie in that group. I kind of believe that mentally ill in prison are on an island. People aren't nice to them, they don't want to hang out with them…they don't talk to anybody…those guys would rarely miss a group. If somebody in the group was decomping [decompensating-*experiencing increased psychiatric symptoms*] a bit, missing meals, stay in the cell, hearing voices, they'd bring it to group, and they'd ask, '*Have you seen so and so*?' They'd ask other group members, '*have you seen him*?' '*Oh yeah, he's staying in his cell!*'. They'd say, '*A lot of cell time is red flag!*'

In this example, also, inmates utilize what they have learned in group, the signs of decompensation, or "red flags", to understand whether their peers were experiencing increased psychiatric symptoms. For the inmates who acknowledged that they received positive peer support from other mentally ill inmates, they discussed this in terms of reinforcing positive strategies to deal with psychiatric symptoms, or as simply someone to talk to about positive things, such as what they have seen on TV, or read in the newspaper. Another inmate discussed, that due to his being in treatment with another inmate, and understanding the seriousness of mental illness, he was able to relate to another inmate he met in treatment and provide some social support when they engaged in exercise on the yard.

> I've tried to kill myself. I know what's it like to almost die, I overdosed on medication. I can relate. I can put myself in their shoes and walk with them. I helped guys, several guys like that. I helped this guy here at OSP, walked the track with him, drank a pop, asked him if he was still using his interventions.

This quote reflects that through this inmate's perception of "shared experiences", he provided social support, and encouraged the use of coping strategies or interventions.

One inmate told me, "When you get two inmates in a cell, they're most likely to talk about crime". Mentally ill inmates focused on discussing positive aspects of their lives in the penitentiary, rather than focusing on the negative aspects of incarceration or their psychiatric illness. The discussions focused on things as simple as news items on the television, sports, or religious activities. Inmates also discussed how this was done cautiously, as their still remained some social distance, and a concern that mentally ill inmates they interacted with might be "unpredictable", or that any information they shared could potentially be used against them for exploitation.

For the inmates that discussed their relationships with other mentally ill inmates, however, these relationships were cast in a positive light due to a shared understanding of their circumstances, i.e. dealing with a mental illness and incarceration, as well as their ability to reinforce positive coping behaviors in the penitentiary. Negative ways to deal with these issues surrounded discussions of the prevailing criminal culture's focus on substance abuse as a way to cope, or getting involved in "drama", or the inmate politics, such as determining who is a sex offender, joining a gang, or negative discussions of officers and "the system". An inmate discussed these concerns,

> I limit my talk to people…cause people will try to steer you in the wrong direction…get you to smoke weed or smoke cigarettes. If you keep kick it around positive people, positive things

> happen…if you kick it around negative people…negative things happen. That's why I keep away from the negativity. To keep positive, you talk about life in here, things you can do not to stay in here, and going home.

For the inmates in the sample, who were functioning well in the penitentiary, peer social relationships were considered an important part of their institutional lives.

Relationships with Non-Mentally Ill Inmates

Not all inmates exclusively associated with inmates in mental health treatment. A finding during the research that inmates were also able to establish and maintain relationships with non-mentally ill inmates. Here, I refer back to my characterization of some of the inmate population as "Stand Up Inmates" who were not so grossly impaired or visibly mentally ill that they could not "fit in" or find a niche in the inmate population. Two inmates commented on some of the distinctions they made between being a "convict" and enmeshed in criminal culture, and their own perspective on their inmate identity,

> ***Inmate A***
> I'm a total loner…I don't socialize with other people…a bunch of criminals as far as I'm concerned…I didn't come to prison to learn how to be a better criminal.

> **Inmate B**
> I think it's dangerous to make friends in prison, for many reasons. These are convicted felons. There is a lot of people here that are criminally minded. I don't consider myself a criminal. I consider myself a criminal because I committed a crime, but I'm not that type of person who's always thinking about crimes. There's a lot of people in here always talking about things that I have no experience with. People talk about drugs. I've never used drugs. I don't like those kind of people, so I stay to myself more.

Here, these inmates discuss how socializing with general population inmates, not in mental health treatment may not be beneficial due to the criminal orientation of many inmates in the penitentiary. These observations by inmates may prohibit mentally ill inmates from establishing relationships with inmates they perceive as enmeshed in a criminal lifestyle, or as referenced earlier, “a straight up thug”.

For the relationships that were formed and maintained, these relationships were established and maintained not along a common bond of participation in mental health treatment, but rather, these were inmates whom they may have known from their home county, or may have met while incarcerated. For example, one inmate discussed meeting “Christian brothers” on the yard when he was first incarcerated, simply because they were playing acoustic guitar, and he was also a musician. These relationships were also discussed as a benefit to mentally ill inmates. Additionally, mental health issues, e.g. symptoms, diagnosis, or medications may not have been shared as readily as between mentally ill inmates due to the social distance characteristic of inmate-inmate relations. An inmate commented on this,

> I usually don’t confide in people about that. They see me go to med line, so they know somethin’, but I don’t get into it. Like being in segregation, cause that’s when the symptoms came on, or why I go to the hole…because of the symptoms…They just know I got some kinda CTS [*mental health*] issue. I don’t divulge in that. It’s my own battle.

Here this quote reflects this inmate’s desire to keep his mental health treatment discrete and separate from his peers in prison.

Inmates also discussed how non-mentally ill inmates may also exert peer pressure to not take psychiatric medications, as the prevailing attitude it can be perceived as a weakness among general population inmates. An inmate discussed how a non-mentally ill inmate provided social support through encouraging coping strategies and training him for his job. This same inmate also discussed how other non-mentally inmates on the cell block "check in" with him during the day to ensure he is doing alright. In the following quote, he discusses how these non-mentally ill inmates assisted him with encouraging the use of coping strategies, and "checking in" with him during his work day on the cell block.

> This inmate went out of his way to help me. He taught me how to communicate, how to be a person that learns how to deal with the voices, cause he went through a lot of classes himself…all the cognitive courses to better himself. He is showing me, that if he can do it, I can do it. It doesn't matter if you have mental problems or not, if you're willing to make that effort, you can do it. The other inmates that work on the block…they don't quite know what my problems are, but they have an idea that I need to…check in. It's funny, cause the one of them is always like, 'Hey, how are ya doin'? Are you ok?' Checking in….he does that 3-4 times a day. The other one is like 'Are you ok, is there something I can do to help?'

This inmate emphasized that these non-mentally ill inmates who assisted him were "old school convicts", i.e. older inmates with long histories of incarceration, long sentences to serve, and integrated into the prison community with established status and with good working relationships with security. In other words, they were not Young Bangers, but older convicts who assisted him. This inmate also discussed how these three old school convicts "took him under their wing" and assisted him with learning how to function in prison, "the way

you're supposed to talk, the way you're supposed to walk, how to do your life at OSP, how to hold yourself up".

Mental health staff also discussed how non-mentally ill inmates may intervene on the behalf of mentally ill inmates with security and mental health staff to ward off decompensation, or alert staff that they are worried about a particular inmate in their social group,

> They were concerned about him, their friend, because he was so heavily medicated and they were telling me about how well he was doing before his last trip to MHI [inpatient psychiatric unit]…so it was cool that they approached it like that, but they were concerned enough to go to the Captain to get a hold of me, and they were 3 non-mentally ill inmates concerned about a guy on the tier.

The support that inmates received from non-mentally ill inmates was structured along how the inmate population was itself segregated. Mentally ill inmates discussed the support they received as being from older, long-term inmates, who followed "old school convict" codes, rather than Young Bangers, who are characterized as generating "prison drama" and offering negative pathways to diminish psychiatric symptoms or the stresses of incarceration, such as substance abuse. An officer provided this perspective on why a long-term inmate, characterized as an Old School Convict, may assist mentally ill inmates,

> A lot of times lifers get a bad rap in the prison. I've talked to them a lot. A lot of them accept the fact that they're going to live the rest of their life here, that this is their home. And how they do that time is up to them. So if they find a way to have their experience benefit somebody else, in a weird kind of way, it kind of makes it worth it.

Other inmates discussed their non-mentally inmates as an acceptance of their need for mental health treatment, and an openness for these mentally ill inmates to be part of their social group.

In conclusion, social relationships between mentally ill inmates, and between mentally ill inmates and non-mentally ill inmates were perceived as of benefit to their illness. In the prison context, this can only be understood through a knowledge of the different types of inmates that one can encounter while incarcerated. Many mentally ill inmates are perceived and understood as a vulnerable population; some are so impaired they appear outside of the normal rules of interaction with the inmate hierarchy. These inmates are seemingly left alone due to their bizarre behavior and appearance. Other mentally ill inmates are well enough and functioning adequately enough to where they can be intensely victimized by other inmates, such as through extortion or muling drugs or tobacco. These "low functioning" inmates are monitored carefully by staff in order to minimize risks of victimization. For the inmates in this sample, I propose that they fell into a category I label the "Stand Up Inmate"; their psychiatric illness is under enough control to where they can establish relationships with other inmates, and integrate themselves into the general population through taking up particular aspects of the "convict code" to ensure their continued functioning and survival within the institutional environment. This may explain particular findings of why "mentally disordered inmates" may display as much criminality as general population prisoners (Morgan et al 2010). In order to function and cope within the prison environment, mentally ill inmates may have to take up some aspects

of the convict code to diminish the risks of victimization. Within this sample of inmates, they reported to establishing relationships cautiously, maintaining them as a means to decrease the stresses of prison and their psychiatric symptoms, and as a way to survive in the prison environment through reliance on instrumental support. Doing time completely isolated presents particular challenges, especially in terms of maintaining individual safety and establishing one's credibility and identity through a peer group to avoid victimization. In conclusion, I quote an inmate who discussed the challenges of forming and maintaining these relationships, with the knowledge that psychiatric illness may be stigmatized among the larger inmate population. Additionally, his quote reveals that seeking out another inmate who understands "his issues" and may provide some support is important, because at some point in his incarceration, he may need *someone* to talk to.

> The concern in prison is that you'll need someone to talk to. It's finding that one person or token person that have the same issues as you….see eye to eye with you…and realizing these are the people that would understand your situation more than the average person that's housed next to you. This is one of the things that people with issues like mine struggle with daily….the fact that I hear voices …normal people wouldn't understand what's that like. I've been made fun of before, because I have these abnormalities…you have to take it with a grain of salt, brush it off your shoulder…just walk past people and ignore them…regardless of what they have to say to you…

Chapter 9: The Cultural Construction of Mental Illness in the Penitentiary

Medical anthropology theory and findings indicate that the course and outcome of psychiatric disorder will be mediated by an individual's construction and understanding of their illness experience as well as how the illness episode or subjective and somatic distress of the sufferer is constructed and understood by the individual's social networks and the ethnopsychiatric systems they engage with for healing. Rhodes (2000, 2004) has provided a framework for investigation of how "mental illness" is constructed within the prison setting through the lenses of custody and treatment teams within a prison's inpatient psychiatric unit. As this is the only anthropological exploration of how mental illness is constructed, known, and treated within a prison setting, unpacking these findings is significant.

Rhodes' observations in the prison setting indicate that inmates' aberrant behavior is construed along professional biomedical psychiatric categories of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) (Luhrmann 2000; Rhodes 2001). Although the DSM does not provide accounts of etiology of disorders, biomedical psychiatric practitioners identify neurophsyiological insults as the prime cause for serious mental illnesses, such as psychotic and affective disorders. Axis II disorders are constructed as ingrained personality traits or interpersonal strategies of coping and interacting with others which may bring emotional distress to the individual sufferer. In the prison setting, this dichotomy is further conceptualized as a means to assign

culpability to an individual's behavior. An individual diagnosed with an Axis I disorder, and exhibiting abnormal behavior leading to rule violations may not be seen as responsible for their actions. These individuals may then come under the attention and gaze of the mental health team within a prison, and not become entangled in the disciplinary mechanisms of the institution (Rhodes 2004).

Individuals assessed and perceived as Axis II, or personality disordered, are seen as responsible for their actions. Their behavior may be addressed by security and disciplinary structures within the penitentiary, rather than solely by the mental health staff. Additionally, the etiology of their pathological behavior, i.e. personality traits that are largely immutable, are not constructed as amenable to treatment. Many individuals who are incarcerated are assumed to have anti-social personality disorder, for example, a host of personality traits which include lack of empathy. These types of mental disorders are not a focus of treatment within mental health systems in prisons. There is "programming", or "cognitive" programs available for inmates that addresses the "thinking errors" of this population. Inmates with Axis II disorders are generally conceptualized as those who "act out" through self harm behaviors. For individuals who are assaultive and attempt to harm others, the penitentiary's disciplinary apparatus addresses their behaviors. Inmates with Axis II behaviors are constructed generally as "borderlines", in reference to Borderline Personality Disorder, a disorder characterized by mood instability, profound difficulties in interpersonal relationships, risk of self harm and suicide attempts, and behavior that "borders" on the psychotic. Axis II individuals may also be termed "Cluster B", individuals

with a cluster of personality traits indicative of narcissistic personality disorder, borderline personality disorder, and anti-social personality disorder.

I draw out these distinctions to allow an understanding of how mental health and security professionals make distinctions among inmates in a correctional institution to account for bizarre or aberrant behavior. Individuals who are "dings" or severely mentally ill, or psychotic, or manic are understood to be "Axis I" by the mental health staff, and as discussed earlier in this dissertation, security officers recognize that this is a unique population of inmates that are "mentally ill" or have a serious psychiatric disorder. Security staff themselves may not make distinctions such as Axis I and Axis II, but both mental health and security staff make the distinction of "behavioral" if an inmate does not fit into the Axis I category. If an individual is labeled "behavioral", then it is understood that their actions are the result of these immutable personality traits, and these inmates are then more susceptible to enmeshment in the disciplinary systems of the penitentiary (Rhodes 2000). Moreover, Rhodes demonstrated that these distinctions themselves between "true" mental illness and "behavioral" inmates is contested and negotiated within the prison setting (2004).

Security staff and mental health staff negotiate diagnosis through working relationships in order to either hold inmates accountable for their behaviors or direct them towards appropriate psychiatric treatment. Moreover, inmates are also involved in this negotiation, as they attempt to ensure their illness is recognized and treated and not simply labeled "behavioral" cases. As Rhodes has demonstrated, inmates who come under the gaze and treatment of mental

health systems in prison may be more likely to avoid the full control of security systems within correctional institutions (2004). A space is created for these inmates to exist, where their behavior may be in violation of prison rules, but due to their decreased culpability, they are not held entirely accountable for their actions.

During this research these distinctions between Axis I and Axis II disorders were evident in interviews with staff. All staff recognized that some behaviors were the result of "serious" mental illness, and that other inmates were "behavioral", and thus should be held completely accountable for their actions. Within the following sections, I present a more nuanced and contested construction of mental illness within a prison setting. These accounts of "what a mental illness is in prison" rely on both mentally ill inmates' narratives and staff's narratives. In an environment that is "pathological" and "toxic", as some staff described the penitentiary, what constitutes a mental illness behind the prison walls? Given the serious psychopathologies and pathological developmental histories presumed to be present in the inmate population, how do mental health staff members conceptualize this population in order to provide appropriate treatment? And given the constructions elicited from staff and inmates, how do these constructions then mediate the course and outcome of illness for this sample of inmates? I turn first to some clinical accounts from mental health staff that describe the clinical complexities of understanding mental illness in prison and that characterize the population of individuals termed "mentally ill inmates".

Clinical Perspectives on the Population of Mentally Ill Inmates

One of the phrases one hears when talking with mental health staff is that the clinical work in the penitentiary is “complex” and the population of inmates that are clinically encountered are themselves “complex”. As one staff stated, “Your differential diagnosis is wider, it shouldn’t be, but it is”. What this statement means is that individuals who present to mental health staff may have significantly complex developmental histories, profound history of substance abuse, multiple medical issues such as hepatitis or head trauma, in addition to substantial presentation of Axis II or personality disordered behavior, all within an environment that is radically different than a community setting. As one mental health staff stated, regarding the nature of the penitentiary environment,

> I tell people who come here, interviewing to work in the prison, or students, new hires…I tell them very clearly, you are leaving the U.S. You are going to a third world, paramilitary country…the customs are different, the rules are different…Things that are perfectly ok to do out here, will get you in harm’s way in the prison.

This institutional environment must also be taken into account when understanding the expression of mental illness in prison, not only due to the culturally specific rules of behavior, but also due to the individuals who populate the institution. I propose here that individuals sentenced to prison may have radically different histories and clinical presentations than the “typical” mental health client in the community, based on the narratives of the mental health team. This complexity not only bears out in the diagnostic process, but also in the treatment process. And this complexity often blurs the clear distinctions between Axis I and Axis II as suggested by Rhodes, although it is still utilized within staff’s cultural model of deviant institutional behavior in order to assess

and ascribe culpability to inmate's actions. Moreover, these complex clinical histories and presentations for mental health professionals in the institution create some uncertainty and ambiguity in regards to establishing an Axis I diagnosis with inmates. This confounds Foucault's conception of how professional staff in prisons, i.e., the "experts", exert control on inmates through constructing them through professional ethnopsychiatries. Inmates with clear Axis I diagnoses, such as schizophrenia or bi-polar disorder, may be rarer in the clinical population than individuals whose diagnosis is confounded or murky due to their developmental histories, medical conditions, substance abuse, co-morbidities and their characterological traits. Mental health staff agreed that this clinical population was substantially more complex than community populations they were used to working with due to these factors that created a "wide differential" in diagnosis.

The individuals who are in mental health treatment, or individuals who first come to the attention of the penitentiary's mental health system may have had some engagement with community services, or may have been entirely "under the radar". A mental health staff discussed how the inmates encountered within a clinical setting in the penitentiary are individuals that are rarely encountered within a typical community outpatient setting. If encountered and seen regularly in community outpatient settings, they may present as "doing well" because of the clinician's inability to track their behavior between appointments, and because of a presumed relationships based on "trust" in which the client shares within the clinician.

> These guys in prison are way more complicated than what we see in the community. You aren't gonna see these guys in a private office- they're never going to show up. They won't have a felt need to. What have you got to compare to a seven day meth run? Let's be real, that's a lot more attractive to them. Even in the community county clinics, who will be the ones that treat most of the severely mentally ill…even there, the bulk of the guys we see don't show up there. Not because they shouldn't, not because we don't set them up with what they need when they get out, it's because they're non-compliant. Here, they're in a captive environment.

This mental health staff further elaborated on the "types" of individuals that come the clinical attention of the mental health team. The following composite this mental health staff presents is based on over 10 years of experience providing correctional mental health services, and incorporates some of the profound pathological developmental trajectories documented by mental health staff.

> Q: Can you give me a composite case, of somebody you might see in prison, a composite of all the clinical factors we've talked about?
>
> A: You've got Mom doing drugs and drinking while pregnant. Dad doing drugs and beating on Mom while she's pregnant…the baby's born premature, low birth weight…the baby's probably yellow - jaundiced….in the home it's too many kids, not enough money, not enough space…very distracted substance abusing parents…their usually response is to scream at the kids…scream to get their attention…it's a chaotic environment….kids grow up not knowing whether the parents are going to stroke them or hit them…education is not highly prized…the kid will usually be an average or below average kid…not because there's anything necessarily wrong with their intelligence…it's not rewarding…it's the classic bumper sticker, 'My kid beat up your honor student'. By middle school, they're using drugs…by high school, a fair amount of drugs…a little crime, petty thefts, shoplifting…by middle teens, they're probably dropped out of high school…solidly in the drug culture…maybe just working and doing some drinking….their world is not composed of people with goals, professions….I don't mean doctors, lawyers…I mean people who take pride in what they do, no matter what the profession…car mechanic, whatever. It's that mindset…you do the best you can do at what you do…they don't have that. There's no future associated with what they're doing at

> the time…in terms of the mindset of the people involved. They end up doing some crimes, for which they get busted, with controlled substances…The do some UUMV, car thefts…they've been in fights, car wrecks, head injuries…they end up in prison, early to mid 20's…this is not unusual…And sometimes it [mental illness] comes out when they're in prison, and other times, its simply that they can't get away from where they are, and they can't blame it on a meth run. They really truly are delusionally paranoid…but they can't just move to the next town, or the next street, when it gets in their way. There's a lot of guys like that, where it really doesn't come to the forefront of their thinking, until they can't escape, or go anywhere…and the frustration builds, and there's a conflict, or a fight…or they won't come out of their cell…the grooming goes down…and you got a guy who looks mentally ill, cause he can't use his usual coping mechanisms of moving away from the conflict.

This staff also discusses how these individuals come to the attention of prison mental health staff as they are in a controlled environment, and when psychiatric symptoms arise, they are readily observed within the confines of the penitentiary. This staff focused on the developmental aspects of this population of mentally ill inmates to frame the discussion of how these individuals may be different from the population of seriously mentally ill encountered in other clinical settings. One aspect of this population that was recognized by all mental health staff was the profound substance abuse evident in this population of mentally ill inmates.

> Q: How do you deal with the addition of substance abuse disorders in diagnosing? How do you separate out the substance abuse, the other factors, and the major mental illness?
> A: Substance abuse is in excess of 70% in the prison population at OSP. Substance abuse is a significant factor in these guys' lives. Sometimes you can't, sometimes all you can say is we have this mixed up quiche of clinical presentation…but after everything's baked together, you really can't separate it out.

This mental health staff's quote reveals the difficult in discretely conceptualizing substance abuse, its effects on cognition and affect, and the presence of a psychiatric disorder. One mental health staff described the substance abuse histories he encountered as "garbage can" addiction, meaning that there was no clear "drug of choice", but rather substance abuse histories followed an erratic, and unpredictable trajectory, based quite simply on the drugs available to an individual at the time.

> I see a lot of the polysubstance abuse…that may go a notch higher up the ladder in characterizing heavy abuse. You see people abusing a variety of different classes of drugs…heavy drinkers, heavy meth users, barbiturates, heroin…people in their history trying a little bit of everything…they will identify a drug of choice…but it's panoramic…they've tried so much…huffing gas as an adolescent, smoking pot for 4 years as an adolescent…maybe using heroin a little bit here and there…it's so difficult to do a drug and alcohol history for these guys, because it's so extensive…and you've got different drugs overlapping…their consumption of one overlaps with another as it tapers off…then it rises at another point in time…it's so extensive…

This extensive polysubstance abuse, "baked in" with developmental histories and psychiatric symptoms, can confound the work of clinicians as they attempt to ascertain the presence of a "real" Axis I mental illness, or if the individual is experiencing residual effects from detoxification from street drugs, prescription drugs, and alcohol. In particular, methamphetamines are discussed by mental health staff as potentially responsible for psychotic like symptoms and affective lability. The issues surrounding substance abuse may mimic psychiatric symptoms or mask an already present Axis I psychiatric disorder. Mental health staff also discussed how substance abuse could create a "cluster" of psychiatric symptoms, such as atypical auditory hallucinations coupled with

either dysphoric or anxious affect, or hyperactivity-like symptoms. All of these Axis I psychiatric symptoms are also understood to be potentially concurrent with Axis II disorders, and not mutually exclusive.

In summary, Axis I disorders in the penitentiary are present and identified by mental health staff. However, the population of inmates that are of clinical interest to mental health staff are discussed as "complex", i.e. their developmental, medical, substance abuse, and trauma histories are described as radically different from community populations that clinicians had previous experience with. This substantiates current epidemiologic studies of the "mentally disordered offender", in which co-occurring disorders (both substance abuse and personality disorders) are enmeshed with severe psychiatric disorders, and higher prevalence of serious medical conditions such as infectious diseases (Adams and Ferrandino 2008: 914; Borum 2004: 295; Coid et al 2009; Cuddeback et al 2010; Teplin 1994). This finding is not unexpected, but here staff narratives demonstrate how clinicians in correctional settings actually grapple with the "complex" cases identified by epidemiologic research, and their perspectives on how best to treat these clinical complexities.

Although Axis I disorders are identified and understood by staff, both security and mental health, as "serious mental illness", it appears that this population is a small number when compared with individuals with these complex histories and symptomologies. Mental health staff may have challenges in constructing what an Axis I diagnosis "exactly" is in a population of individuals with such extensive histories that are presumed to profoundly affect etiologies of

psychiatric disorders and clinical presentations. I turn now to mental health staff's understanding and construction of Axis II disorders, as this examination further reveals how mental health clinicians construct illness in the penitentiary, and demonstrates how they navigate the divide between "behavioral" and "true" mental illness.

Relationship Between Axis I and Axis II

The relationship between serious mental illness, or Axis I disorders that have a biochemical etiology such as schizophrenia, and Axis II disorders such as borderline personality disorder, were constructed by mental health as potentially being co-occurring, rather than discrete entities. A mental health staff discussed that Axis II personality disorders can "appear" once severe Axis I disorders "clear up" from pharmacological interventions.

> In school, we were taught that Axis I and Axis II really don't co-exist. The fact is, is that they're independent. Whether somebody has a true Axis I diagnosis is independent of whether they have an Axis II diagnosis. We see it over and over again with the prison population, because there is so much Axis II, when you treat the Axis I, you're not treating the Axis II and it flares, or appears to flare. As someone's psychosis resolves, whether it's meth induced, or brain injury, or whether they have a psychotic disorder in addition to having being anti-social, borderline, or narcissistic…that you see more and more of their personality coming out, because their Axis I illness if less in the way [*due to pharmacological treatment*]. Once you get rid of the psychosis, their true personality comes through.

Mental health staff will discuss this relationships as "pealing back layers of an onion", i.e. once psychiatric symptoms are under control through pharmacological interventions, an individual's "real" personality with come out. Given the nature of individuals coming to prison, mental health staff recognize

that an individual with schizophrenia will also potentially be anti-social, or invested in criminal culture, or an individual who is bi-polar will have traits of a borderline personality disorder once the mania or depression is resolved. This further layers the perceived complexity of the inmate population and adds further components to the construction of mental illness within the penitentiary. In addition to the complexity of "teasing out" whether an inmate has a serious Axis I disorder, as outlined in the previous section, mental health staff must also substantially take into account the presence of an Axis II, or personality disorder within their clinical work. Individuals with Axis II disorders may still come to the attention and treatment of mental health staff due to their self-harm or assaultive behavior, so it is not always assumed that an individual who displays "borderline" behavior will solely be addressed through disciplinary measures. Mental health staff also recognized that the behaviors observed in prison, by individuals assessed as Axis II can contribute to the stress of doing mental health work in a prison,

> The nature of this environment is so drastically different from the community, and the complexity of the clients we work with. Part of what makes them so complicated, is that there is no one dimensional clear cut kind of mental illness or problem, particularly in this population. There's layers of psycho-pathology. It's very challenging to work with these folks. It's very challenging work. Primarily, the axis II piece gets in the way of things…that is often times a very strong component of the client we work with in here. The hard ones are the ones that combine substance abuse disorders, personality disorders, and axis I. All that co-morbidity converges and comes together in a perfect storm…throw a little axis III, because these guys are in terrible shape with their medical conditions and health, and you have a pile of psychopathology to sort through. You're dealing with some egregious behaviors, people without empathy, and very immersed in drama and create reactions in staff, self-mutilating…episodes of self-castration….feces smearing…using

> bodily wastes to assault staff with. Exposure, sexually exposing themselves. Assaults…staff assaults, and on inmates. You have pretty behaviorally disturbed individuals. If you have a caseload of these individuals with some of those patterns of behaviors, that can be very challenging for a mental health clinician…it can exhaust them. That's just a lot to absorb for a human being, for someone who doesn't live in prison and abides by society's rules. That's just a lot to absorb. It seems so abnormal and beyond comprehension. It can take a toll of staff member's emotional wellness.

This narrative reveals not only the complexity of inmates in the institution, but the significant challenges clinicians face in providing mental health services within the penitentiary. The severity of the Axis II disorders encountered within the prison setting are constructed by institutional mental health staff "on the front lines" as being extraordinarily dissimilar from community settings. I highlight these distinctions that mental health staff use to construct mental illness in the penitentiary to emphasize the inseparable nature of the different components of an inmates in treatment, i.e. their biochemically induced psychiatric symptoms, their personality traits, and their medical issues. These three domains correspond to the DSM's Axis I, Axis II, and Axis III diagnoses respectively.

Axis II disorders also create conundrums for mental health staff in terms of diagnosis, and staff did discuss, as established by Rhodes (2001, 2004) that attempting to arrive as what is volitional behavior, and what is "true" mental illness may be a matter of negotiation between security and mental health staff, as well as between mental health staff with differing professional training.

> There's a difference in perspectives on diagnosis. There's a wide variety of professional backgrounds. It does depend on what you're training is. Two different clinicians can see an inmate 10 minutes apart and see two totally different presentations.

Additionally, the clinical presentation of an Axis II disorder may also be dependent on the environment in which the individual is seen. For example, mental health staff discussed how an individual may present differently in general population, the inpatient psychiatric unit, the disciplinary segregation unit, or in an office visit. A mental health staff discussed this specifically,

> The debate is whether he's anti-social personality disorder with borderline features, borderline with anti-social features, if he's schizophrenic, schizo-affective…or maybe he's just depressed or bi-polar. Because he presents in ways, that depending on when you see him, he could in fact meet criteria for any or all of those things. It just depends where are they on the day that you see them, and what do you need to accomplish now.

This context of the clinical encounter, is crucial, whether it be in the disciplinary segregation unit, cell-side, in the office, the inpatient psychiatric unit, or on the control room floor, may all influence the clinician's perception of "what they are seeing". For example, an inmate could potentially display more aggressively in a disciplinary segregation unit setting than in a private office.

This staff also referred to "NOS", or not otherwise specified diagnostic label. It is utilized in the penitentiary to describe an individual displaying a cluster of various symptoms that do not fit neatly into DSM diagnostic categories of Axis I or Axis II, but have traits of several disorders. This further complicates the diagnostic perspective for mental health staff, but it appears that mental health clinicians attempted to address this ambiguity with focusing on symptoms of dysfunction that were displayed within the prison environment. This same mental health staff is quoted below, discussing how symptoms, rather than diagnosis may be more salient in providing appropriate treatment.

> The diagnostic label isn't as important to me, although it does indicate who gets services, but what's important is the degree of impairment. They may have the diagnosis, but is it impairing them in this environment? It ties back to how much resources we have and how do we spend it? One of the things I've learned professionally is that diagnoses are useful short hand…in a way they blind me as a mental health professional. I can look on my bookshelf and see evidence based treatment for x, y, z diagnosis is *this*. But that makes some assumptions about the individual, and for this inmate that we're talking about these assumptions may not be true. So you have to work with him regardless of the label, where he is, and set realistic goals for him.

This pragmatic approach, where the clinician understands that inmates' clinical picture is quite complex, dictates that the symptoms and dysfunctional behavior are to be addressed rather than strict diagnostic criteria. Another mental health staff discussed how she addressed the co-morbidity of Axis I psychiatric disorders and Axis II symptoms. One clinician discussed how these two axes are conceptualized as profoundly intertwined, rather than discrete entities. For this clinician, *both* "symptoms" (Axis I) and "character" (Axis II) may create distress in the inmate that warrants treatment interventions.

Within these narratives, mental health professionals construct distinctions between Axis I behaviors, understood as not under the control of inmates, and Axis II behaviors, constructed as volitional, and immutable aspects of the individual's personality. Axis II behaviors are frequently associated with manipulative behavior, either for medications, cell assignments, attention from staff, or simply to be in mental health treatment as a "perk" of their incarceration. Mental health staff interviewed had a nuanced and complex view of this relationship between an individual's unchanging "personality" and psychiatric symptoms based on neurophysiological insults to the brain. These two aspects

of psychiatric pathology were understood to be potentially co-morbid within the inmate population they treated, but staff did suggest that the “gaming” or attempts at manipulation could drain mental health resources away from individuals with Axis I disorders, for example, the inmates who remain “quietly” psychotic who do not have flagrant displays of bizarre behavior.

The presence of Axis II disorders in inmates treated was also associated with “staff burn-out”. The profoundly deviant behaviors associated with these DSM disorders in prison were understood as quite simply testing the tolerance of mental health staff for deviance within the prison setting. Mental health staff who were interviewed also discussed how inmates’ treatment needs were understood pragmatically. For example, rather than focusing on the presumed presence of an Axis II, or “manipulative” or “criminal” behavior, the mental health staff interviewed discussed how they focused on diminishing the incidents of negative, self-harm, or assaultive behavior among the individuals they worked with, regardless of the etiology of the behavior. There was recognition that inmates needed to be treated for some of these behaviors constructed as Axis II, but mental health did discuss how intensive long-term individual therapy, understood as one way to address personality disorders, was prohibited under DOC policy. Staff did acknowledge Dialectical Behavioral Therapy, a form of distress coping therapy, was utilized in group settings, as it was evidence based, and this was one way to address these problematic behaviors for inmates.

Mental health staff members construct mental illness within the penitentiary along Axis I and Axis II domains, but the relationship is often viewed

as a complex co-morbidity that is also affected by developmental histories, trauma histories, medical issues such as head injuries, as well as substance abuse. All of these domains make diagnosing and "constructing" mental illness profoundly challenging in the prison environment. This final scenario discussed by a mental health staff reveals the difficulties at arriving at some clinical "truth" within the penitentiary, as clinicians attempt to take into account "true" mental illness such as psychotic symptoms, and possible "manipulative" behavior indicative of "behavioral" or Axis II disorders.

> A: I saw a guy this morning, a crisis call, huge pandemonium…his Mother died…he's has an Axis I psychotic disorder and was recently taken off involuntary meds and placed on voluntary meds. I'm treating it as a crisis. I saw him for an hour, set it up for him to see a contractor, and I'll see him again Friday. I can't call home and say, 'Did Mom really die?'. There's nothing I can find collaterally in the system to say Mom died, so I get a hold of his correctional counselor who called his home…The counselor says, *'No, Mom didn't die, everyone's doing fine*'. So now what am I working with? Someone who feels they needed to get up here to see me because they feel they're really decompensating or somebody where's there some other gain that they want. The inmate didn't want a single cell…so I'm just trying to weave through how I'm going to handle it when I see him tomorrow and Friday. I'll have to confront him, '*We called home and your Mom didn't die'*, and we'll take it from there….and see what his response is to that.
> Q: Is he delusional?
> A: We don't know…is it the voices that told him Mom died, and that's what set him off…and he truly believed that his Mother died, and he's delusional and paranoid around this or is it some of his axis II traits he displayed real strongly in MHI [*inpatient psychiatric unit*] and to his prescriber - it's throughout his chart. So when I confront him and tell him his Mother didn't die - I'll have to see how he reacts to it - if he firmly believes his Mother died, and he has this look of horror on his face, maybe it's more of his axis I, and he truly believes it happened, and maybe MHI [*inpatient psychiatric unit*] can reconsider the meds or a better option.
> Q: So even though you're dealing with people with an axis I diagnosis, you have to be concerned about manipulation?

A: Absolutely…

Even for inmates with known histories of severe psychiatric disorder, there may still be nagging questions of which disorder is "presenting" itself to the clinician. In the narrative above, the presence of a "behavioral" or a "true" mental disorder is recognized by staff as being indeterminate, or co-occurring.

Inmates' Constructions of Illness Experience

I have focused primarily on mental health staffs' understanding and construction of the inmate population under their care in the penitentiary. These constructions of illness were found to be informed by professional biomedical psychiatric categories of Axis I and Axis II disorders as established by Rhodes (2001, 2004). I now turn to inmate's own constructions of their illness experiences. For this research I hypothesized that for an inmate sample characterized as stable and functioning well in the penitentiary, their own constructions of illness would be congruent with the professional biomedical psychiatric categories utilized by mental health staff within the institution. Variations among ethnic groups in understanding the construction of "mental illness" has been recently demonstrated through thick descriptive ethnographic work (Alverson et al 2007). Alverson et al (2007) has framed this variation as a means to establishing therapeutic rapport and alliances with urban ethnic minorities. The findings of this ethnographic research are significant in that it establishes that for individuals engaged in treatment, their own conceptions of what it is "to be mentally ill" and how they construct their own illnesses may be discordant with professional ethnopsychiatric cultural constructions of "psychiatric

disorder". That is, an individual may still be engaged with a professional mental health treatment system, but may have varying accounts of their illness. In unpacking inmate narratives, I will also discuss how these narratives are similar to, resistant to, or entirely discordant to the professional constructions of mental illness in prison. I turn first to the primary means of treatment in the biomedical psychiatric paradigm, psychiatric medications, and how inmates and staff perceive this treatment strategy.

Psychiatric Medications: Accepted and Contested Treatment

The use of psychiatric medications within the penitentiary is now part of the cultural tapestry of "inmate management". Three times a day on the main control room floor in the penitentiary, the most visible aspect of the institutional context, inmates line up to receive their medications. Inmates and staff will both state that the majority of the inmates in "pill line" are receiving "ding biscuits" or psych meds. Although other inmates may go to pill line to receive heart medications, or high blood pressure medications, pill line is primarily associated with the distribution of psychiatric medications. Staff and inmates interviewed commented on the increasing numbers of inmates seen in pill line, presumably to receive some type of psychotropic medication. As one inmate stated to me, "They're making this place into a fucking pill factory! Half the institution is on psych meds!". Point well taken, as anthropological examination of professional biomedical psychiatric treatments have demonstrated the primacy of the medical model for psychiatric treatment (Luhrmann 2000). Within the penitentiary, this also appears to be the case.

Psychiatric medications are a primary form of treatment within the penitentiary for mental illness, either serious mental illness, or minor mental illnesses such as dysthymic disorder or anxiety disorders. Inmates receiving mental health services, regardless of their mental health code designation or acuity level generally receive psychiatric medications as a first line of treatment to decrease psychiatric symptoms. Within the professional biomedical paradigm of mental illness, these medications are understood as affecting neurotransmitters such as dopamine or serotonin to assist with "chemical imbalances". Inmates interviewed shared many of these models of psychiatric medications, although their articulation of medication action was not always specific. The following quotes from inmates revealed how they understood the importance of psychiatric medications in alleviating symptoms of major mental illnesses.

Inmate A

It helps my chemical imbalance…my brain, I guess. I think…I'm not a doctor, I think that's what it's supposed to do.

Inmate B

Q: What helps mental illness?

A: Medication, you have to take your medication.

Inmate C

I understand about the Risperidol, it made the voices go away, and made it easier to figure out what's real and what's not real. It calmed me down. It affects your mind, I think. It's unclear how it works. It affects the thinking part of your mind.

These quotes reveal that for inmates interviewed, medications were acknowledged as offering relief to their psychiatric symptoms, and allowed them to function adequately in the penitentiary. Inmates in the sample also discussed how taking psychiatric medications allowed a decrease in symptoms so they could work, go to classes and programs, and attend to their daily needs. Within the penitentiary, taking psychiatric medications was perceived as beneficial for inmates with mental illness. Although this may seem obvious to an outsider, I provide a narrative from a security officer with a long history in the institution which reveals how psychiatric medications came to be understood by security officers as crucial to the treatment of "problem" inmates.

> Q: How do psych meds fit into the scheme of mental illness in prison?
> A: Before we started doing a lot of the psych meds, a lot of these individuals had chemical imbalances, aggression…and we were constantly combating these individuals. Once they got on the medications we noticed that these individuals were able to exist and live in general population. Years before, they were never able to live in general population. Maybe they aren't functioning at the level of a normal inmate, but lots of time staff maybe cut the individual more of a break, cause they understand they're a CTS inmate. But they're able to be able to function a lot better than in the past.

Here the officer discusses how he has observed how inmates with assaultive and aggressive behavior underwent substantial behavioral changes, and security did not have to address these more dangerous behaviors from mentally ill inmates. Other security officers who were interviewed reflected these statements; psychiatric medications were important because they effected observable changes in behaviors that allowed inmates to function and cope within the prison environment. This same officer discussed how even among

security staff, the use of medications may be contested. Officers may not have contact with mentally ill inmates, may not have worked special housing to see how medications may be of positive benefit, and some officers may still not make distinctions between psychiatric medications and street drugs or the abuse of prescription medications.

> Q: Do other officers have this understanding of psych meds?
>
> A: Some do, some don't. It's hard for individuals that have been around for a long time and have never worked special housing or worked around these inmates. I think a lot of them still think, 'They're getting high'. Oh my god, can't you see the difference in the individuals acting out? And they don't quite see it. Newer staff coming on board, I think they're more aware. They probably think the inmates are manipulating so they can walk around high. They don't get to see how it's helped, how these medications have helped these individuals. These were they inmates who acted like gorillas in the past, and now they can interact and you have a conversation with them.

This officer presents a pragmatic approach to understanding psychiatric medication use in the penitentiary, i.e. medications have appeared to assist some of the most dysfunctional inmates in the penitentiary cope and function within the institution, and because there is less risk for aggressive behavior, he has made the connection with how this treatment regimen has assisted this inmate population. He also reveals how psychiatric medications, among certain security officers and staff, are perceived as no different from "street drugs", for example valium or other benzodiazepines. Inmates and staff also discussed the "Thorazine Shuffle" a phrase used to describe the observed sedating effects of older neuroleptic medication, and a reference to an older construction of psychiatric medications' primary efficacy centered on their ability to sedate, or create a "chemical straightjacket" for problematic mentally ill inmates. The

current culture of the penitentiary accepts the fact that inmates need psychiatric medications to function and cope within the prison environment due to the severity of their mental illness, however.

Mental health staff also recognized that psychiatric medications were the first step in treatment and recovery from mental illness. An inmate could not engage in other forms of treatment such as group treatment, unless psychiatric symptoms were at a manageable level and tolerable through the use of psychotropic medications.

> The meds are a tool, and that's all they are. Sometimes, they are the single most important tool, in the sense that without the meds, nothing else is going to happen. Then, every step in the chain becomes important. Once that step in the chain is in place, then every step after that becomes important. If you have a chronic schizophrenic, and they're not taking their meds, and they're hostile and psychotic, the therapeutic relationship is moot. Once they get stable, you have to be able to get them to *stay* stable. It may be simply that they're impaired socially, and a lot of work with them is to help them develop a way to work with people, even if they don't trust them.

For mental health staff, medications is a crucial first step in the treatment of inmates, in that without relief from severe psychiatric symptoms, other treatment interventions will simply not work. The presence of florid psychosis precludes the possibility of a therapeutic relationship, and more cognitive-based interventions to assist in recovery.

So far I have discussed narratives which reveal and acceptance of psychiatric medications by both staff and inmates. The efficacy of these newer

atypical antipsychotic medications and mood stabilizers demonstrate to both inmates and security staff the important role they play in the treatment of mentally ill inmates. Further, staff also discussed how they saw specific inmates undergo positive transformations in their behavior in the institution. Inmates who previously were housed in segregation units "walked the mainline", with minimal difficulties as their psychosis or mania had been brought under control through pharmacological interventions. When I observed this "pragmatic" acceptance of psych meds in the penitentiary, a mental health staff repeatedly used the phrase, "the proof is in the pudding" to explain why there had been acceptance of the use of psychiatric medications as appropriate treatments. The newer atypical medications *worked*, staff and inmates both experienced the positive benefits of these interventions, and thus it was now an accepted part of the penitentiary's culture that large portions of the inmate population took psychiatric medications.

Psychiatric Medications: A Contested Treatment Strategy

I now turn to how this acceptance of medications was contested among inmates *and* staff. I would characterize these attitudes as ambivalent, i.e. both staff and mentally ill inmates recognized that medications were the first line of treatment, but they were at times critical of their use. A mental health staff stated,

> It seems to me more and more for people at OSP, the treatment of choice is the medication of the week, often times overmedicated. They receive the magic pill. That tends to be the first thing that comes from CTS. What has surfaced is a medication mentality that says, do this, do this quick, get them in, get them out. Medication is an important piece of that, but it isn't the treatment. I've seen amazing, positive things with meds,

> people clearing up from not knowing their name. And the person's clear, thinks rationally, can relate to their own schizophrenia, knows where they're at. So I'm not anti-meds. But the correctional setting at OSP, meds are the treatment. The emphasis is there because it's expedient, it's quick.

This mental health staff offered these criticisms of the biomedical model of psychiatric treatment due to its primacy within the penitentiary. This staff member discussed how working with individuals to learn about and cope with their illness did not appear to be emphasized, as in individual therapy sessions or group treatment. Another mental health staff member further emphasized the need for a "more than meds" approach to working with inmates with mental illness. This approach centered on this staff members' professional orientation, and a focus on teaching the inmate interventions and coping skills to manage symptoms.

> My professional orientation is as a cognitive behavioral therapist. Yes, there are some physiological reasons for mental illness, but there are also choices that they make that make the symptoms better or worse. I think it makes a difference in their outcomes…if not, we're devaluing them as a human being…like the old medical model…*"Take the pill and shit up*!'. "*Yes doctor*". And the other thing is, I am professionally not oriented to medication as a solution. Generally its benefit is to make the symptoms manageable enough so that they can work on some of the other underlying causes of their behavior. But its not a fix-it. I dislike the arrogance of the medical model, which is *doctor knows best*….because it assumes you're lacking the brain capacity, and that's not true, some of these guys are extremely bright. They need to have that knowledge…my assumption is that they need to be informed consumers.

These quotes from mental health staff recognize that more is needed for individuals with severe mental illness than medications. I present these quotes as examples of the tension between the medical model of psychiatric treatment and as one mental health staff called it, the "humanist" perspective that attempts

to take into account the individual's recovery. I do not present this material as an "expose" of the Department of Corrections and its treatment of mentally ill inmates. Clearly, individuals are receiving treatment, and for the inmates that do receive treatment, they perceive its benefits. However, going beyond "management" with psychiatric medications is challenging, given the resources available to the mental health team.

I now turn to inmate narratives which mirror the statement of mental health staff. Some inmates in the sample had ambivalent statements regarding medication treatment, or they indicated in interviews that simply taking medications and "checking in" with a mental health case manager was not, in their opinion, adequate for their treatment needs. One inmate in particular discussed his frustrations in dealing with the mental health treatment system,

> A lot of these case managers, they understand…ok, this person is in here for murder because he heard voices. OK, but…instead of them understanding him, all they do is, '*OK, take this drug right here, it'll make you feel good. Take this drug here, it's a new one, we're experimentin', see how it does you*'. That's not gonna help our problem out. It's basically gonna make it worse- you're still not understandin' us - you still don't understand our symptoms. Each individual got a different symptom… a different thing goin' on in their mind. We know we have a mental illness, but we don't understand it. Nobody tellin' us about it, nobody teachin' us about it. All they want to do is, '*Here's some drugs, come in my office for five minutes*. *Ok I talked to you for five minutes, you're cured, get out of my office*'. That's not understandin' us. I say, '*Oh, I was hearing voices today, I was feeling down today*'…They say, *'Oh, what kind of medication are you on, let me up the dose!*'. That's not helping my mental illness, that's going around it.

This inmate discussed in several interviews how he had hoped the mental health case managers could provide him with more than “checking in”. His own illness narrative identified childhood physical trauma as being the primary etiological agent in his psychosis, and he had ongoing concerns and anxiety regarding his family. He identified psychotic thought processes which caused him great distress, but he felt that due to the primacy of the biomedical psychiatric model, he did not have an opportunity to discuss these thoughts and anxieties. Rather, he was provided more medications for his nightmares and sleep disturbances, and did not have an opportunity to discuss his own theories as to why he experienced auditory hallucinations.

Other inmates in the sample also discussed how medications were not the only answer to their mental health issues. They discussed medications in ambivalent terms, i.e. they recognized that it could be of some benefit, but they also discussed how side effects such as sedation or high cholesterol were a concern. One inmate discussed how he did not feel talking to staff or taking medications was beneficial, primarily because he did not distinguish between the effects of marijuana and psychotropic medications, and he felt that the racial discordance between mental health staff and himself was a barrier to effectively working with the treatment team.

Another inmate discussed how he felt medications were being used unlawfully on inmates, and how medications would be forced on inmates if their behavior became too disruptive. Involuntary medications are utilized in the penitentiary, so this inmate’s concerns cannot be discounted. This particular

inmate also discussed how psychiatric methods are “treatments” and not “cures”, and he discussed how mental health treatment is in place in the U.S. simply to make profits. Finally, one inmate in the sample denied he had a mental illness, although he recognized mental health staff had diagnosed him with schizophrenia; he grudgingly accepted the fact that he was prescribed medications, and took them so as not to draw attention to himself and so he could be let out his cell at a particular time for pill line. In total, n=5 inmates discussed either a negative attitude or ambivalent attitude toward psychiatric medications, and of these 5, four inmates were African American. From these small numbers of narratives, there is a suggestion that there was a discordance between biomedical psychiatric models of “treatment” for mental illness, and what these four inmates expected out of treatment.

Inmates who were engaged in mental health treatment, and were functioning adequately in the institution did not all agree with medications as a primary form of treatment. Mental health staff also voiced concerns regarding the focus on medications as a primary method of treatment in the penitentiary. From the interviews, this primarily stemmed from a lack of talk therapy or group treatment, which is also understood as a deficit in resources for mentally ill inmates, i.e. there is simply not enough in the DOC’s budget to provide intensive group and individual therapy to all inmates. This was primarily discussed as a “lack of resources”. Moreover, for the talk therapy that was available, inmates had to wait for appointments with contractors, as mental health case managers discussed that their role was not to provide “individual therapy”. What these

findings suggest is that for individuals engaged in mental health treatment, there may still be a resistance to the dominant medical paradigm of psychiatric treatment, and its focus on medications. And for mental health staff, although they continue to work in the system, make referrals to prescribers, and attend to inmates' mental health needs in the institution, there is a recognition that this population of inmates needs more than just medications to assist them in their recovery.

"More than Medications": A Model of Mental Illness in the Penitentiary

The previous section of this chapter outlined how the biomedical psychiatric model informs and constructs mental illness within the penitentiary. Psychiatric medications, being the first line of treatment within the institution, are tied directly to this model; mental illness is then constructed as a host of biologically based diseases. I now turn to an examination of what exactly is "more than meds" within the penitentiary. Here, I explore inmates' and staffs' responses to what assists mentally ill inmates in their functioning and coping in the institution, and the contextual factors discussed in the penitentiary as also mediating the course and outcome of illness episode for this inmate population. Within exploration of these narratives is found a focus and emphasis on factors other than psychiatric medications which contribute to positive outcomes for psychiatric disorder among these inmates.

Housing: Living in the Penitentiary

Housing within the penitentiary is identified by both staff and inmates as a substantial factor in "managing" mentally ill inmates. When an inmate arrives at

OSP, there is no choice as to where he is housed. New inmates, or "A n O's" are housed in D block on the second tier in two man cells. These 5 x 8 cells were originally designed to be single man cells, or as they are known in the institution, "single cells". Due to increased numbers of inmates over the decades, most housing in OSP is made up of two man cells. On D block, where the majority of my observations were done, the first tier, or 1 bar contains single cells only. The third and fourth tiers are double man cells, and the fifth tier has single cells. The staff at OSP do take into consideration age, crime, or previous incarcerations for cell-mates or "cellies" in order to decrease the likelihood of victimization, harassment, and extortion. For example, an 18 year old who had never done time in state prison before would not automatically be put randomly into a cell with a long term older inmate. However, this can and does occur.

Inmates are expected to live together in the cell and work out their living arrangements with minimal staff intervention. Inmates do have some minimal control over their housing, as they can request a "cellie", and go through appropriate procedures to ensure they are celled up with someone they are compatible with. Some inmates do prefer to have a cell-mate, and other inmates adamantly discuss how "they can't live with anybody". Single cells are "a premium". They are sought out by many inmates, both mentally ill and non-mentally ill, to achieve some modicum of privacy and quiet time away from other inmates. These cells are housed in areas of the cell block that are generally quiet, as many long term inmates or industry workers live in these single cells, and there is an expectation that creating "drama" on the tier, yelling from cell to

cell, or disrupting your neighbor will be absent from these tiers. A mental health staff described the cell blocks and the challenges mentally ill inmates face in living in the "big blocks".

> The housing is a factor in trying to arrange things to enhance the likelihood of the inmate doing well. Mostly, housing is a negative factor at OSP. There's large cell blocks, a lot of severely disordered inmates…either mentally ill or personality disordered. You have large cell blocks with 500 inmates, right out the 1930's…they're loud, they're noisy, they're poorly heated, cooled, and ventilated. There's no sense of security other than being locked in your cell with your head toward the back. That's a daily thing that they might be able to tolerate for a short period of time, but over time, it's a real negative weight.

The negative, or "toxic" environment of the cellblocks were recognized by staff as significant in the lives of mentally ill inmates. However, mentally Ill inmates' housing was conversely understood by staff as one way to "assist" and "manage" this inmate population. A security officer remarked discussed the variability in housing that can contribute to psychiatric stability for these inmates.

> Q: What about housing?
> A: Sure, it's all about a comfort level. If they feel comfortable in their house, you know they're going to behave better, go along with the program. Some people might see it as coddling them, but it's more of getting a comfort level for them to succeed. That's the whole outcome for them, right? To succeed. There's no set rule - it could be two man or single cell. Some people would rather be in a single cell. Some people prefer a double cell. I think it's a little more important for people with special needs - to keep a little more attuned, to have a better outcome for them. It's also not just single or double cell, it also could be a certain block that the feel more comfortable on.

The most obvious implementation of this understanding of how housing affects mentally ill inmates was the creation of the mental health tier on D block. This tier of single cells housed approximately 40 mentally ill inmates and were

kept segregated from other inmates in the cell block. Another security officer explained the tier could provide some sense of safety as well as opportunities for social interaction with peers.

> The tier - it's 40 cells and they feel safer because they're with other inmates that have mental illness, and it makes a little more comfortable. I absolutely think that's it's a more relaxed environment for them, I've talked to a few…and if you try to move them their symptoms would just exacerbate, because they feel so comfortable on that tier, and they don't have to worry about mingling with the other inmates.

This narrative unpacks a key understanding of housing within the penitentiary: where a mentally ill inmate is housed can either decrease or increase the symptoms of their psychiatric disorder. For example, an inmate who had a history of self-mutilation was discussed by this same security staff as having his psychiatric symptoms increase when he attempted to move into a two man cell.

The most prominent example of this provided in the penitentiary is the conventional treatment wisdom that when mentally ill inmates are admitted to disciplinary segregation or the supermax unit, psychiatric symptoms may be exacerbated by the noxious stimuli of other inmates in these housing units, or the decreased ability to engage in coping strategies to manage residual psychiatric symptoms. For example, an inmate participant was admitted to the disciplinary segregation unit during the course of the study. When he was released from the unit and returned to the study, he had lost 40 lbs while in the segregation unit due to increased psychiatric symptoms, and he himself accredited his time in segregation as a chief factor in the increase of his psychiatric symptoms.

Housing was also discussed by a mental health staff as being a consideration when treating an inmate for increased psychiatric symptoms,

> Q: So from a clinician's viewpoint, you're looking at the stressors of the prison affecting inmates with severe mental illness, with the noxious stimuli of the prison can cause decompensation?
> A: Yes, it definitely can. Housing is one of those things in prison that can be both a very stabilizing thing in a place where you can be monitored easily. If they're in a housing unit they don't feel safe on, and they don't feel safe coming out of their cell, they don't go to med line, if they don't go to med line, they don't get their meds. *If an older schizophrenic is celled with a young gang member…what am I gonna do, load him up* on a neuroleptic? It's a primary block in a chain of events that lead to decompensation.

Where an inmate is housed in the penitentiary is correlated with exposure to particular noxious or neutral stimuli of the prison environment, such as more aggressive and predatory inmates, or noise levels. Staff and inmates also discussed how the mental health tier was a positive treatment strategy for mentally ill inmates, in that they could socialize with each other on the tier, not be open to victimization or extortion, and be let out of their cells together to attend meals. In essence, it created a ready-made social support system for inmates who wished to engage each other socially. Inmates also discussed how, due to their close proximity, could "look out for each other", or assist with instrumental or socials support, as outlined in previous chapters.

The model of mental illness utilized by staff here points to contextual factors outside of the inmate's own medication adherence or individual level factors as mediating illness and contributing to positive outcomes for their psychiatric disorder. For example, the area of the penitentiary in which an

inmate is housed may decrease or increase psychiatric symptoms. Staff also discussed how assessment of whether an inmate needed a single or double man cell was dependent on the individual; there was no "one size fits all" model to house mentally ill inmates. Some mentally ill inmates were understood as being better able to cope with a cell-mate, and other inmates were discussed as not being able to tolerate another individual in such close quarters.

Within this discussion of housing for mentally ill inmates, staff identified contextual or structural factors which may contribute to positive or negative outcomes for inmates with mental illness. The model of mental illness in the penitentiary is informed also by an ecological understanding of psychiatric disorder; where an inmate is housed, who they are exposed to in the cell block, and their distress level based on these factors may mediate the course and outcome of their psychiatric disorder.

Getting a "Program" and Keeping Busy in the Penitentiary

Inmates and staff at the penitentiary discuss how "keeping busy" or "getting a program" is a key factor in adjusting and coping within the institution. "Getting a program down" means to create a routine for oneself that includes obtaining a job within the prison, attending the programs such as education, going to the yard for exercise or socialization, or engaging in one of the "clubs" in the institution, such as the lifers club or the veterans club. Mentally ill inmates also discussed participation in mental health treatment was part of their "program". Keeping busy in the penitentiary decreases the amount of "cell time", i.e. staying in one's cell with no stimulation other than reading, drawing, watching

TV, or talking to a cell-mate. Work was perceived by staff as a key element in keeping busy within the institution. Work provided "money on the books" in order to obtain necessities such as personal hygiene items (these are not provided by the state), or comfort items such as extra food (snacks), a good pair of sneakers or shoes, books, a radio, a television, envelopes, and other consumer goods sold through the canteen. In addition to providing this comfort items, work also provided a distraction from the nature of the institutional environment, largely characterized by staff and inmates as negative and toxic. A mentally ill inmate discussed how keeping busy with work assisted him,

> Q: Does having a mental illness make it hard or easy to work a job in prison?
> A: For me, it's kind of easier, so I can forget…I got to stay busy…If I ain't busy, then I end up going to the hole or something…I got to stay busy. So the job keeps me busy, and keeps me from thinking negative stuff. At work, we're joking around, and kind of having a little bit of fun…there ain't really a time back there being quiet…it's cool. It helps me to kind of push everything to the side…then it comes back when I'm in the cell looking at the wall…it all comes back. I can sit there and think and figure stuff out…when all that stress comes back. When I'm at work, I just push it aside…when I'm in the cell, it just comes back. If I didn't have a job, I'd end up in the hole.

Another inmate further expanded on his daily routine, or "program", and how this assisted him. In his opinion, keeping busy with his routines decreased the likelihood of increased psychiatric symptoms.

> Q: When you have a job like this, being busy all day….Do you think that this helps with your mental health?
> A: For my mental health issues, it keeps my occupied, so I don't have time to relapse or go into a negative spin, because I'm thinking about other things.
> Q: How does that work? If you're not busy, you have problems?

> A: When I have free time, I have to be really careful, either watching TV, or writing, or doing something different, because if I don't, I go into a spin - my voices attack me more, I chew my fingernails more…I go into a relapse.
> Q: Sounds like if you're not busy, you feel your symptoms?
> A: Yeah

Centering his routine on his employment was discussed as critical to keeping symptoms, and negative thinking, to a manageable level. On his days off, when he had free time, he had to engage in other coping strategies such as writing, to ensure idle time did not negatively impact his mental health.

Obtaining employment in OSP had to be negotiated by inmates, in some instances, and the procedures for getting a job could be laborious. An inmate recently released from disciplinary segregation discussed the challenges of getting employment,

> You have to campaign to get a job…talk to the sergeant or corporal…tell them you need a job and just got out of the hole.

Although employment was understood as a positive factor in keeping inmates stable, they still had to abide by the penitentiary's rules for obtaining employment, which was perceived as an involved and time intensive process.

Employment was not guaranteed to alleviate psychiatric symptoms, however. Inmates and staff discussed how all inmates, in order to start their employment in the penitentiary, must start as a "line server". This position in the chow hall is essentially a food serving position, in which the inmate provides measured portions to inmates coming through the food line. This is an area of intense stress, as inmates are pressurizing food servers to provide them more

than the measured amount, and threatening servers if they do not comply with their demands. This was discussed as an area of "high stress" although inmates with mental illness were known to cope within the position. Additionally, inmates discussed that depending on their job area, they could be exposed to more predatory inmates or gang members. One inmate discussed how a mentally ill inmate was "run off his job" since gang members "ran" a part of the kitchen mop crew, and filled the emptied position with a member of their gang. Finally, an inmate discussed how his job in the prison provided more interactions with inmates involved in the drug trade, and given his history of substance abuse, he found it difficult to refuse their supplying him with drugs for doing slight favors for them within the scope of his job duties. Although work was discussed as a positive contextual factor, I provide these contextualized experiences to demonstrate that the type of job, and the inmates' exposure to other inmates through employment could also increase psychiatric symptoms, access to drugs, or increase the likelihood of victimization. Clearly a particular job with particular staff and inmates was significant for each individual, not simply "being employed".

Other inmates in the sample did discuss how the monotony of the penitentiary's routines was difficult at times. Working was not the only routine that individuals could engage in. Even for inmates who did not work, or could not obtain employment, keeping busy and distracted was seen as important in diminishing symptoms and keeping their minds and hands busy. One inmate

who did not work also discussed how cell time, particularly in a single cell could be of benefit,

> A: I do everything I can to get through the day. A lot of self talk…I draw, and I read…that's what I do. I got a TV and stuff, but I spend my time reading and drawing, cause it keeps me from having…I mean, sometimes I still have issues, but it's not that bad.
> Q: Sounds like the drawing and reading helps your symptoms?
> A: They keep you distracted, in a positive way.
> Q: If you're not distracted in a positive way, could mental health symptoms bother you more?
> A: Absolutely.
> Q: You need distractions in here?
> A: Absolutely….to deal with anger, frustration, bitterness. It creeps up on you all the time. And then you hear the external nonsense going on around you. If you're engaging in something, you don't hear the noises as much…see the faces going by or anything like that.

Here, this inmate focused on activities he could engage in within the confines of his cell, which paralleled employed inmates' focus on routines and decreasing opportunities for idle time.

When specifically asked whether psychiatric stability was dependent solely on medications, an inmate remarked stated that these individual coping strategies were key to his stability. Medications were only one element of several which assisted in keeping his symptoms at a low level, and activities such as listening to music or exercise were found to be beneficial for this inmate.

> Q: Does any other things help with mental health symptoms or is it strictly the medicine that helps you?
> A: It's definitely different things you can do. Music is one of them. It's one of the best stress relievers. And if I'm feelin' like I'm goin' to lash out - whether it be voices or schizophrenia or whatever…or I'm gonna *do* something I can just go out to the yard, hit the weights and work out my frustrations

> Q: If you just took your medication and you don't go to yard, don't have a radio or television you just go to chow and your cell, could the medication help you or do you need to do other things?
> A: No. This medication, Zyprexa [*an atypical antipsychotic*], helps but it's not a total answer to it.
> Q: Sounds like you have to do the other things?
> A: All of them together. It helps you cope.

Although these activities are what "regular" inmates engage in to deal with the frustrations and stressors of prison life, these activities also assisted mentally ill inmates in coping with their psychiatric symptoms.

Examining inmates' and staffs' perceptions of "keeping busy" reveals another significant aspect of how mental illness is culturally constructed within the penitentiary. Although both staff and inmates discussed the importance of medications, other factors such as keeping busy with a program were perceived by staff and inmates to positively affect psychiatric symptoms. Inmates correlated idle time with increased psychiatric symptoms, or simply, negative thoughts and attitudes. Staff and inmates discussed "getting a program" as providing structure within the institution for inmates' daily lives, which was discussed as a positive aspect of incarceration and beneficial for mentally ill inmates. One medical staff discussed the penitentiary's structure as "milieu therapy on a grand scale". A security officer noted how this structure, in the context of staying busy and getting a program down could be a positive factor in a mentally ill inmate's recovery. Particular aspects of a "total institution" such as provision of medical care, appropriate nutrition, education, and employment were all viewed as contributing to mentally ill inmates' recovery from illness within the penitentiary.

> Here the mentally ill have access to a bed, access to a regimen their used to, access to medications, access to meals, a lot of them don't eat. The come in here, they get their housing, meds, food, a roof over their head, they have people to interact with – mental health professionals. There's a lot of benefit for a mentally ill inmate coming in here. They get training, too. Once they're even out on their meds, they can live a normal life in here - get a job, earn some money, develop relationships with other inmates, and live a somewhat normal life within the walls. They can also go to school, too. It's not all negative, I see a lot of pluses for coming in here. Just the benefit of having a schedule to keep, they learn a discipline on how to be certain places at certain times. And they learn how to interact with people in a more socially acceptable way, so they can get a long and not get in trouble.

All of the factors identified in this security staff's discussion are understood to be positive factors for mentally ill inmates' recovery within the prison. Both staff and inmates recognized that getting a routine down, or a "program" was an essential component to functioning and coping in the prison. For inmates with mental illness, decreasing idle time was a means to cope with psychiatric symptoms. These strategies included drawing, writing, listening to music, socializing, exercise, reading, watching Television, or in some instances, utilizing meditation techniques or church attendance as a means to cope within the prison. I label these activities individual coping strategies, and in some instances inmates were taught to utilize these through their mental health providers, or they themselves learned how these strategies assisted them in their coping with their illness and functioning in the prison.

In conclusion, I articulate the culturally constructed model of mental illness utilized by staff and inmates within the penitentiary. First, inmates and staff recognized a biological component of psychiatric disorder, following from a

professional biomedical psychiatric construction of mental illness. Psychiatric medications are understood as essential to treating mental illness due to this construction. This model was contested by staff and inmates; inmates in the sample did not entirely endorse a strictly medication model of treatment for their illness as they focused on their desire to receive individualized therapy. Additionally, some mental health staff also voiced this concern. Security staff revealed that outside of the "official" discourse of the DOC, which endorses medication use for inmates, some security staff with no experience working with mentally ill inmates still perceived psychiatric medications as "a way to get high".

When asked further about how mental illness is constructed within the penitentiary, staff and inmates identified a host of contextual factors that diminished the impact of psychiatric symptoms, including housing, work, programming, and individual coping strategies. Medications were not viewed as the "sole answer" to an inmate's psychiatric symptoms. Staff and inmates recognized that environmental conditions could exacerbate or decrease psychiatric symptoms for mentally ill inmates, and that the structure of the penitentiary itself could offer recovery from mental illness due to the provision of food, medical attention, safety, appropriate mental health care, education, work opportunities, and opportunities for pro-social behaviors.

No staff or inmates endorsed a "meds only" approach in their conceptualization of psychiatric disorder. Rather than endorsing a biological reductionism in which professional ethnopsychiatric practices provide a "magic bullet" for psychiatric disturbances, inmates and staff acknowledged that

recovery from mental illness in prison was dependent on more than medication adherence. Context and environment were discussed as important as pharmacological interventions in maintaining psychiatric stability. In conclusion I present a security officer's description of a seriously mentally ill inmate who had an extensive assault history and long history residing in the segregation, the IMU supermax unit, and the inpatient psychiatric unit. This narrative summarizes penitentiary staff's perception of how recovery from mental illness can occur, and this officer reiterates some of the major themes of this chapter, which include staff relations, work, appropriate housing, intensive monitoring by staff, enacting relations with other inmates (albeit limited ones), as well as support from his family.

> He was a huge problem for staff. He was always going to disciplinary segregation, always acting out. When he came here, he was up in SMU [*inpatient psychiatric unit*]. So he had a lot of troubles not wanting to come to population, not being able to interact with other inmates. To come out here and live and work with these other inmates…for an inmate with mental illness, this is a pretty scary place. Mental health staff in SMU started working with him, programming with him, and slowly he came transitioned to general population. He had relapses, and had to go back to SMU sometimes. So it was baby steps. He got a job, and got a single cell on the mental health tier and we talked to him, '*Why don't you try moving upstairs and be an orderly*?' That put him near inmates that were not mental health inmates, so he slowly got acclimated to it, and started growing, doing things. He did have the support of his mother, so when he left here he had that. So he's s success story.

Chapter 10 Conclusion and Discussion

This dissertation attempted to identify the social and cultural processes within a state penitentiary that mediate the course and outcome of psychiatric disorder for a sample of inmates diagnosed with mental illness. Specifically, I attempted to identify, through inmate and staff narratives and direct observation, how these processes may contribute to positive outcomes for inmates with psychiatric disorder.

In terms of social processes, I was able to characterize and describe the specific social context of Oregon State Penitentiary. The social processes at work within this institution were profoundly affected and structured through a high level of staff and inmate interaction. This interaction, professionally constructed as the Oregon Accountability Model, provided the opportunity for staff and inmates to engage in "working relationships" that I consider the foundation for how the social fabric of the penitentiary remains intact and functions. This "milieu therapy on a grand scale" encouraged staff to interact with inmates in a prosocial manner. Rather than the penitentiary solely being constructed as a site of control as formulated by Foucault (1977), this specific correctional institution displayed opportunities for inmates and staff to, at times, work outside of the custodial and inmates roles.

I refer specifically here to the narratives provided by correctional officers and inmates that revealed how officers may assist mentally ill inmates in "checking in" with them, closely monitoring their institutional functioning, and on

rare occasions, providing collateral social support for this inmate population. This process could have only occurred in an institutional environment that sanctioned this high level of staff-inmate interaction. This seemingly goes against correctional security measures that limit high levels of inmate movement; restriction of inmate movement diminishes security risks (see for e.g. Blakely 2007: 12). At Snake River Correctional Institution in Ontario, Oregon this high degree of control of inmate movement was seen at work, and did decrease opportunities for inmate-staff interactions. Yet at OSP, a prison of "mass movement", the presumed security risks of unmitigated inmate movement appeared to work in favor of inmate-staff interactions. This has implications that run contrary to a "control" strategy of prison management.

Staff noted that this high degree of contact with mentally ill inmates was not obligatory in the scope of correctional officers' work. Rather, officers could, as they saw necessary, interact to a high degree with mentally ill inmates. Correctional officers did discuss this pragmatically. Investing the time, those "extra 5-10 minutes" with individuals identified as mentally ill could, in officers' opinions, make a difference in the functioning and outcomes of this inmate population. I focused significantly on officers and inmates within this dissertation because officers are indeed the "front line staff" or "first responders" when it comes to assessing and working with mentally ill inmates. Although officers are indeed the agents of control within the institution, there was a responsiveness to inmates' mental health needs that could allow some flexibility in how this control was exercised. The "safety and security of the institution" is always paramount to

correctional officers; however, within this mandate, officers interviewed found ways to “work with mentally ill inmates” that “made sense”. As one officer stated, writing up mentally ill inmates and sending them “to the hole” didn’t work. A flexible approach distinct from the prison’s paramilitary environment was taken by officers interviewed. Appelbaum et al (2001) have provided some insight into how officers may play key roles in mental health treatment of inmates, and within these narratives I provided some insight into how officers may enact this flexibility of approach.

Inmates also confirmed that being able to rely on officers’ responsiveness to their mental health needs could be critical when seeking help for acute care, or simply as being a social support. These open lines of communication stemmed again from the social structure of the penitentiary that encouraged and opened up the possibilities of working relationships between security officers and mentally ill inmates.

This monitoring and extra attention given to mentally ill inmates by security officers would have little benefit for these men if there was not a mental health system in place within the penitentiary. Here was an unexpected finding of this research – that the relationships among staff, between security, mental health staff, and medical – could at times be critical in order for inmates to receive appropriate care for their illness. As one mental health staff discussed, this “multidisciplinary approach” encouraged substantial interaction with, and dialogue between these three sectors of prison staff charged with “managing” the inmate population. I initially formulated relationships in the penitentiary as

dyadic; i.e. staff-inmate and inmate-inmate. Inmate and staff narratives provided insight that officers needed to have positive working relationships with mental health staff in order to meet the needs of mentally ill inmates. Conversely, mental health staff rely on their working relationships with correctional officers to receive observational reports on the functioning of inmates on their caseloads as well as initiate treatment plans on housing units. Medical staff were perhaps more peripheral to this central relationship between custody and treatment staff, but staff narratives also revealed that medical staff's observations and insights into the functioning and behavior of mentally ill inmates could at time be a crucial piece in this inmate population's "management". Dvoskin and Spiers (2004) has provided some initial explanation of the importance of correctional officers in the mental health treatment of inmates, and within this dissertation I elicited narratives and contextualized examples that provided insight into how officers may facilitate positive outcomes for these individuals.

Mentally ill inmates' relationships with mental health staff were mostly perceived by these men as positive. However, an understanding of the history and context of the mental health treatment system also accounted for some discordance between inmates and mental health staff. For the past several years, there had been significant mental health staff turnover, and some inmates discussed how this was difficult for them as they had to adjust to new staff, re-tell their stories, or "get to know" the new mental health counselor in the office. Inmates did report that their relationships with mental health staff were beneficial. Some mentally ill inmates also discussed how they felt there was a blurred

distinction between mental health staff and security staff, as they were still employees of the penitentiary. Revealing “too much” within the context of a therapeutic encounter or having mental health staff misinterpret self-reporting was a concern for inmates in the sample. This misinterpretation could have serious consequences that could enmesh mentally ill inmates in a more restrictive housing unit, or it could also warrant an engagement with the disciplinary apparatus within the institution. Morgan et al (2007) have discussed that for inmates reluctant to engage in mental health services, they are concerned with issues of “self preservation”, i.e. that information could be used against them within the clinical encounter. Here, this was validated among certain inmates, although within this sample of mentally ill men they still engaged in psychiatric treatment, aware and conscious of the “pitfalls” of engaging too readily with mental health staff.

Inmates in the sample who were also functioning well in the institution with good objective outcomes measures and who were psychiatrically stable also discussed how relationships with other inmates assisted them. Relationships were not only established and maintained with other mentally ill inmates, but also with non-mentally ill inmates. From providing instrumental support, such as coffee, to allowing for opportunities for social engagement such as playing sports or meal partners, these relationships were considered as a positive factor that assisted them with their functioning.

One can only truly understand the nature of these relationships between inmates if one understands the inmate hierarchy within Oregon State

Penitentiary, and the place mentally ill inmates hold in this institution. Outside of the hierarchical structures are “dings”, mentally ill individuals so grossly impaired, that they do not fit within this institutional social structure. I characterize the inmates within this sample as “Stand Up Inmates”. These are individuals who are not obviously mentally ill as “dings”, nor are they seemingly invested in the “Young Banger” groups who are perceived as agitators by “Old School Convicts” and staff. Rather, these inmates follow some form of the Convict Code in order to survive within this environment and “fit in”. This may account for Morgan et al’s (2010) findings that mentally ill inmates may meet a clinical profile for both psychiatric patients *and* criminals. Within this inmate sample, inmates largely discussed attempts to associate with pro-social inmates, rather than “Young Bangers” or other institutional agitators. This is not to say that these inmates did not engage is criminal thinking; this was not a goal of the dissertation.

There were no objective measures of criminality obtained for this inmate sample, and no method to evaluate levels of criminality at the onset of their incarceration. Some of the inmates in this sample may have undergone a process of “prisonization” (Clemmer 1940) in order to mainstream themselves into the inmate social structures, and to minimize risks of harassment, extortion, or victimization. A security officers in this study noted that the prison itself is run on the convict code, and a “soft” adherence to some of its values may account for how some inmates in this sample adequately adjusted to the institution.

Relationships within the prison were structured along lines of trust and respect. Gaining trust in staff and inmates appeared to be a result of consistent

behavior – regardless of whether it was perceived as positive or negative. Consistently predictable behaviors among staff were discussed by inmates as a precursor to establishing trust. Respect was then established, and this respect was crucial to maintaining these relationships. Staff and inmates in the prison both maintain relationships through mutual respect. Respect is given to individuals who are consistent in their behavior, and follow through on "their word". This issue of consistency versus predictability is a fine point; here, the importance of maintaining respect is centered on inmates and staff to "predict" particular culturally shaped behaviors. Individuals who may be *predictable* in their behavior, either negative or positive behavior, may warrant respect. Inmates or staff who are consistently unpredictable, for example, may not warrant respect and trust simply due to their lack of uniform action and reaction within the prison. Not all inmates or staff could articulate this ethic, but I provide my own insights into these cultural values as a framework for understanding how relationships are enacted with this prison.

Finally, I turn to some concluding remarks on the construction of mental illness within Oregon State Penitentiary. Inmates were perceived by mental health staff as having profoundly pathological developmental histories; mental health staff discussed the inmates they worked with as quite different from community populations in terms of these developmental histories, their medical issues, their substance abuse histories, and the dysfunctional behavior observed in the prison. A primary finding was that for inmates and staff who were interviewed, a biomedical psychiatric model of mental illness was explicit in their

narratives. For example, inmates perceived medications as being a relief from psychiatric symptoms, and acknowledged that it was of some benefit to adhere to a regimen of psychiatric medications. One inmate discussed how OSP had become a “pill factory” in his opinion, as medications were seen as a first line of treatment, regardless of the issues present in the clinical assessment. Although medications were seen as a benefit, both staff and inmates contested the primacy of pharmacological treatments within the institution. For inmates who contested this primacy, there was a desire for more communication and therapy with mental health staff. Additionally, for mental health staff who contested medications as a first resort, they were invested in “talk therapy” and skill building for inmates in their care.

Although medications were perceived as a significant treatment modality, a finding of this research was that it was “more than meds” that assisted the functioning and coping of mentally ill inmates. In this regard, mental health staff observed that the prison environment itself could entail such toxicity that no dosage of psychiatric medication could stem the effects of the prison’s confines. This was particularly salient if an inmate was being harassed, victimized, or was fearful of his surroundings. This “more than medication” approach was tied intimately to ideas of “management” of mentally ill inmates. Penitentiary staff took a holistic approach to the treatment and management of mentally ill inmates. Appropriate housing, appropriate work assignments, pro-social interactions with staff and other inmates, ability to recreate, education, and other activities were seen as significant in maintaining stability within the prison. Inmates also echoed

this approach in terms of “keeping busy” and “getting a program”. Too much down time was associated with increased symptoms, or susceptibility to the toxicity of the institution. In terms of the construction of serious mental illness in the penitentiary, we find here an equal focus by staff and inmates on contextual factors within the institution rather than a strict biological reductionism that may be characteristic of some professional ethnopsychiatries (Gaines 1992b). Mental illness was not only constructed as a biological “problem”. This biological pathology was understood as being profoundly affected by the individual’s context.

Finally, in terms of clinical perspectives, mental health staff did acknowledge the differences between Axis I and Axis II disorders as outlined by Rhodes (2000). However, mental health staff provided a nuanced account of how these disorders were related. An individual with severe mental illness could also have a concurrent personality disorder which might “emerge” after psychotic symptoms were under control with psychiatric medications. Although the presence of both disorders was present in clinicians’ models of mental disorders, clinicians also understood that so called “behavioral” or Axis II disordered behavior could also be the result of reactions to the prison environment. Moreover, assessing manipulation in inmates (associated with “behavioral” or Axis II inmates) was understood as a dynamic process with no clear end point. Clinical staff also used pragmatic models within their work and did not “label” inmates in the concern that it may color their clinical judgment. The distinction between Axis I and Axis II disorders in Oregon State Penitentiary provided a

means to frame aberrant behaviors, but how disorders were constructed along the DSM's major axes appeared more dynamic in its workings that suggested by Rhodes (2000).

In terms of the anthropological literature which seeks to understand the relationship between social and cultural processes and psychiatric disorder, this dissertation was able to contextualize how these processes may mediate illness. The most important finding in this regard was that there was an institutional acceptance and acknowledgement that serious psychiatric disorder was present in the inmate population. Within the culture of the penitentiary, mental illness "existed", was readily observable, was understood as treatable, and there was an expectation that mentally ill inmates could improve in their functioning within the prison environment. At face value, this may not appear to be profound. However, peripheral discourse within the institution revealed that mental illness was not always part of the institutional landscape, and inmates exhibiting aberrant behavior became ensnared in custodial systems of discipline, rather than having access to intensive mental health treatment. Because there was a category of "mentally ill inmate" constructed within the penitentiary, this allowed officers to exercise considerable flexibility in their regimens of control. The meanings attached to mental illness in the prison centered on knowledge that these inmates had difficulty functioning, and that extra attention had to be provided to ensure their psychiatric stability. Moreover, the culture of the penitentiary recognized that these individuals could benefit from the treatment systems within the institution. Mental illness was then constructed as a *treatable*

condition in which inmates could improve if provided appropriate psychiatric treatment. This parallels the findings of Jenkins (1988a, 1988b) in which Mexican-American families constructed schizophrenia as *nervios*; this construction of the illness episode demanded a particular cultural response to ill family members. This culturally proscribed response benefited the ill family member and contributed to decreased incidences of relapse for these family members in Jenkins' study. In the same manner, if an inmate was deemed "mentally ill", this warranted a different response from staff, particularly security staff, that contributed to positive outcomes for this inmate population. As outlined earlier, staff and inmates all discussed how it was "more than meds" that mediated the course and outcome of psychiatric disorder. Psychiatric symptoms were understood as being alleviated through a host of strategies, in which medications were one component.

In terms of the social processes, this dissertation provided insight into how these social processes, mediated by cultural models of friendship, trust, and respect, provided mentally ill inmates resources to manage their lives within the institution. The thick descriptions included in this dissertation demonstrate that for individuals with severe psychiatric disorder, social support was identified by most all participants as a key factor in facilitating recovery from illness. Officers provided instrumental and social support; mental health staff provided social support through individual meetings; other inmates provided social support through encouragement of engaging in behaviors that contributed to mental well-being; activities such as work and exercise diminished the impact of severe

psychiatric symptoms. Within an environment recognized as toxic to both staff and inmates, this speaks to the agency of the staff and inmates within a challenging and pathological social context. Desjarlais et al (1995) have suggested that contexts of violence and substance abuse may contribute to the onset and poor course for psychiatric disorders. Here, this dissertation research suggests that even with a state penitentiary, individuals may recover from their illness and attempt to re-construct their lifeworlds, albeit within a radically negative environment. How these social processes were enabled, enacted, constructed, and contested were substantially mediated by a prison culture based in "milieu therapy on a grand scale" as well as how mental illness was constructed by staff and inmates.

Limitations of the Research

One of the limitations of this study was a lack of comparison with inmates who could be considered "negative" cases within the institution. That is, inmates who were not psychiatrically stable, had frequent admissions to the inpatient psychiatric unit, were not working, programming, or engaging in mental health treatment, or who had frequent admissions to segregation units. Inmates within OSP meeting this profile would not have been considered appropriate for the research sample, as due to their instability, they may not been able to engage in discussions of informed consent. Moreover, due to ethical concerns, attempting to engage inmates who were functioning poorly in the above domains may have caused a substantial burden on these inmates' time and could have potentially been a further stressor. An issue that remains unanswered is: for inmates

functioning poorly in the prison, do they also report to having positive social relationships with other inmates and staff? Do they also work and program, but periodically go to segregation or the inpatient psychiatric unit due to fighting, drug use, or discontinuation of mental health treatment? These questions were not answered in this dissertation, so accessing negative cases to determine if these domains were similarly experienced by inmates functioning poorly in the institution was not done.

Additionally, I allude in several instances of "peripheral" discourse in the institution among staff that challenged whether mental illness was a "reality" within the prison. Staff who participated in the research self identified as having experience working with mentally ill inmates. Staff who did not participate in the research may also have had experiences working with this inmate population, but may have contested several aspects of the construction of mental illness I present. For example, it is not know whether other correctional officers who exercised a "flexible" approach in working with mentally ill inmates actually had "buy in" to constructions of mental illness within the institution. Correctional officers may "grudgingly" accept mental health treatment staff and the presence of "mentally ill" inmates in the prison, work as necessary with the staff and inmates on their caseload, but contest these processes. Officers participating in the study could not be classified as such.

The sample of staff in this dissertation may have been biased in some manner, then, in that they all had positive experiences working with mentally ill inmates, they had "buy in" to mental health treatment, and wanted to share their

experiences with a researcher. Further research would be appropriate to determine how staff that do not have "buy in" to mental health in the penitentiary interact and engage with mentally ill inmates and treatment staff. For example, are negative interactions (however defined) or non-flexible approaches to inmate "management" associated with negative experiences for mentally ill inmates? This dissertation did not address those issues concretely. Could mentally ill inmates who have negative interactions with staff or other inmates also display the resilience and positive functioning of inmates in the sample? These questions were not addressed through this research, and warrant further study.

Finally, within ethnographic study the position and role of the ethnographer must always be taken into account in the findings. As I had substantial professional experience in this prison, as well as significant personal and professional investment in the creation and implementation of the mental health program, my own opinions and ideas as to what constituted "good institutional functioning" for inmates must also be taken into account. Specifically, I re-entered this environment to conduct research with explicit notions of what it meant to recover from mental illness, as well as domains to explore with staff and inmates in interviews.

My own "reputation" from previous work experiences may have biased recruitment as well, as inmates and staff may have known my name or remembered my presence from 1996-2002, and this may have influenced the structure of the sample. These issues also contributed to my ease of navigating the prison environment, my ability to recruit participants, and my insights into the

prison's cultural and social processes. So in this sense, my own experiences in the penitentiary were a "double edged sword", i.e. it allowed me to access a hidden population of individuals with mental illness and the staff who worked with them, but it may have also incurred biases in my recruitment of discrepant cases and alternative discourse, narratives, and contexts in the institution. It also allowed me to understand the complexities of this environment more rapidly than a researcher with no experience working in prisons, but it may have also incurred a bias in that I focused on particular environmental conditions salient to the research questions, and not entirely for discrepant examples of particular situations in the institution.

It may be also difficult to generalize these findings to other correctional settings, which may have quite different approaches to inmate "management" or cultural values related to inmate-inmate relations, staff-staff relations, and inmate-staff relations. Moreover, replication of the study could prove challenging, given ethnographic researchers' limited access to prison environments. The Oregon Department of Corrections is unique among state correctional agencies in that the mental health treatment programs are strongly funded, well staffed, and have been in operation for over a decade. Applying these results and theories to other correctional systems may prove challenging, as ethnopsychiatric systems and biomedical systems are not monolithic entities (Gaines 1992a, 1992b). There is an expectation that "correctional mental health" is enacted differently throughout different regions of the United States, and even among different prisons in the same state. However, the findings of this study

can be used as an ideal case to provide other correctional systems a pragmatic outline of how best to address the needs of this psychiatric population.

Implications for Prison Policy

Staff Training

The primary implications for prison policy based on the findings of this dissertation is that the interactions between staff and inmates, inmates and inmates, and different sectors of prison staff may be crucial to the well-being of mentally ill inmates. In regards to staff, correctional officers have been a focus of training sessions in correctional systems; making them aware of the presence of mentally ill inmates, how to appropriately address their behaviors, as well as providing some education in psychiatric treatment has been acknowledged as an important piece of correctional mental health treatment. Within this dissertation, officers discussed how a flexible approach to working with mentally ill inmates appeared to be the best strategy to address their management. This remakes the role of correctional officers as mere "turnkeys", and places them instead as key staff in the treatment of mentally ill inmates (Dvoskin and Spiers 2004).

A focus on staff training on how to appropriately work with mentally ill inmates *and* staff involved in their institutional care should be a consideration for security and treatment administrators as well as mental health and security line staff. It has been acknowledged that treatment and custody staff are of two distinct "cultures" (Appelbaum et al 2001). But simply providing trainings to

correctional officers on how to work with mentally ill inmates (Parker 2009), although effective in the provision of tools to work with this inmate population, does not entirely address the complexities of enacting mental health care in a correctional setting. A focus on bridging the perceived differences between "treatment" and "custody" staff is crucial in mentally ill inmates receiving appropriate care in prison.

Rather than focusing solely on the attitudes and perceptions of security officers or corrections administration, mental health staff should also be included in trainings on how to best work with security staff to ensure inmates on their caseload may receive appropriate care (Appelbaum et al 2001: 1346; Harowski 2003). Moreover, mental health staff should be attuned to the institutional climate, or culture, which includes staff attitudes and perspectives on working with mental health professionals and the inmates on their caseloads (Dvoskin et al 2003: 253-255; Lavoie et al 2006). Rather than learning these crucial issues during the course of their clinical work, mental health staff should also be the focus of training, not only of institutional orientation, but also how to best work within the complexities of a prison environment. As the relationships in the prison are not dyadic, neither should be training and orientations. Focusing on the interactions among different sectors of staff can ensure a flow of information regarding inmates in treatment as well as build critical relationships that may impact the psychiatric outcomes of mentally ill inmates.

Housing of Mentally Ill Inmates

Mentally ill inmates who participated in this research were primarily housed on the mental health tier on a large cell block in general population. The cost of segregating mentally ill inmates in this manner was minimal to the Department of Corrections. Creating a safe and secure environment for this smaller sub-set of the mentally ill inmate population was done within a larger cell block; no additional security staff were put in shift to attend to these section of the cell block, no additional mental health were hired to specifically work on this housing unit, and inmates went about their routines as any other inmates on D block. The ability to house these inmates in areas that would decrease risks of victimization appeared to be of great benefit to the inmates, and staff also reported that this housing strategy was a factor in keeping these inmates stable and secure in the prison environment. However, due to the physical limitations of the penitentiary, the mental health tier was still housed within the context of a large cell block and unfortunately in close proximity to an A/O tier of inmates who were reported by security staff as disruptive and intermittently verbally harassing inmates with mental illness, who were located on tier below them.

In other institutions in Oregon, housing units were organized in a “pod” system, in which mentally ill inmates could be housed together, 100 men to a housing unit, and have no contact with other inmates in the institution. Again, this strategy was identified as minimizing victimization by more predatory inmates, as well as providing staff a focal point for their treatment efforts, i.e. they did not have to go to several housing units to see inmates on their caseload. Additionally, officers who rotated through these housing units on bid were also

aware of the issues in the unit due to it being known as a “mental health housing unit”.

At the completion of this research in November 2009, a new housing unit at OSP was created for mentally ill inmates. A segment of the Intensive Management Unit (IMU), OSP’s supermax unit, was to specifically be allocated to house mentally ill inmates and the inpatient psychiatric unit. These changes in OSP’s housing of the mentally ill reflected this strategy of affecting the inmate’s housing to diminish the effects of the penitentiary’s toxic environment. Whether this was assessed as cost-effective by the Oregon Department of Corrections is unknown, as research had concluded once the final move of inmates occurred in 2010. For other state correctional systems, the design and creation of housing units similar to other institutions in Oregon may hold promise for structuring the prison environment for mentally ill inmates. Keeping 1-2 housing units segregated for the severely mentally ill may offer possible solutions to the vulnerability of this population to predatory inmates. It may also facilitate the intensive treatment this population of inmates may require, such as mental health staff being able to spend periods of time on the housing unit without concerns for the observations of non-mentally ill inmates. Structured prison environments for mentally ill inmates are discussed in terms of therapeutic communities or intermediate care, in which the housing units are specifically for treatment (Adams and Ferradino 2008; Lovell et al 2001). The question administrators may ask is whether these are cost-prohibitive. This dissertation, as well as housing strategies in other Oregon prisons points to one system’s ability to structure

housing for inmates using available resources rather than construct new prisons or housing units within existing prisons.

Programming for Mentally Ill Inmates: More Than Medications

In terms of the treatment of the mentally ill in prison, this dissertation has addressed a host of domains that may assist in the functioning, coping, resilience, and recovery of individuals with severe mental illness in correctional settings. These include employment, programming such as education, exercise, pro-social interactions with peers, and encouragement of individual coping strategies (broadly construed as leisure activities). All of these activities, in conjunction with a responsive staff and appropriate housing, were identified by inmates and staff as critical components to recovery. Whether all of these activities are available across corrections systems is not known. However, in regard to special housing for the incarcerated mentally ill, it should not be initiated at the cost of losing the aforementioned contextual factors that may also contribute to positive functioning for these individuals. It may not simply be enough to provide medications to diminish psychiatric symptoms, but it may also be paramount to provide structure and opportunities for pro-social engagement with inmates and staff. Sequestering mentally ill inmates away in special housing units, even for treatment purposes and for their safety, may not be appropriate if they do not have access to the larger institutional activities such as education, the recreation yard, or opportunities for employment in the prison.

Moreover, inmates and staff participants also discussed a need for "more than meds"; i.e. treatment groups and individual therapy and counseling were reported as being needed and wanted by both inmates and staff. In particular, group treatment in the ODOC centered on distress management (DBT therapy), and within treatment settings such as in the inpatient psychiatric unit, inmates were taught how to manage their illness through symptom and medications management psycho-education modules. All of these activities, from structured programs to "more than meds" are suggested by this research as key components to recovery from mental illness while in prison. However, as with any other program or initiative, costs may be of consideration. The "success" cases presented in this dissertation, as well as staff opinions as to "what works" demonstrates that medications are but one component in a host of interventions and institutional initiatives that can contribute to positive outcomes for mentally ill inmates.

Implications for Social Theory

The findings of this dissertation also have implications for social theory, specifically for the theories of Foucault (1977) and Geertz (1973). First, the thick ethnographic description of this penitentiary challenges Foucault's conception of the prison as a site of total control in which "disciplined bodies" of the inmates are subjected to regimentation and surveillance (Foucault 1977). The ethnographic data of this dissertation reveals that inmates themselves are not under surveillance through a Panoptical view, in which all inmates' behaviors are under constant observation, and thus "to induce the automatic functioning of power"

(Foucault 1977: 201-202). Rather, inmates also observe staff as intensely as Foucault theorized that staff do with inmates. As discussed in this dissertation, Goffman's "looping" (1961: 35) is particularly salient here, as inmates' and staffs' behaviors can come under close scrutiny through communication among the warders and inmates of this total institution. Inmates are not passive bodies, observed through custodial mechanisms; they also observe through their own surveillance techniques.

Foucault conceptualized institutional control of inmates' deviance through Knowledge, i.e. knowledge of the roots of this deviancy. Moreover, unique "subjectivities" are created by the prison experts in which the prisoners' personhood are matched against an ideal "self" constructed by the state (Foucault 1977: 191; Garland 1990: 145). Within this dissertation it has been demonstrated that this "knowledge" of mentally ill inmates, and their "constitution" is not a seamless process enacted by the prison staff. Rather, as Rhodes has discussed (2000), "constructing" mental illness in the prison does entail a negotiation among custodial and treatment staff as well as with inmates.

However, this dissertation reveals that this "construction" of mental illness goes beyond this expected negotiation between staff and inmates. Rather, this dissertation demonstrated that due to the complexities of the inmates' developmental, substance abuse, medical, and psychiatric histories, constructing this "perfect storm of pathology" and matching it against an "ideal" self, or even a "deviant" self as outlined in the Diagnostic and Statistical Manual proves to be an

open ended and challenging process. Clinicians working within the system itself are confounded by the aberrant behavior they observe.

The complex comorbidities found within the penitentiary also confound professional biomedical conceptions of psychiatric disorder, in which discrete psychiatric categories are enumerated through elicitation of symptoms (Good 1993: 428). Within this ethnography there is an intermingling and overlapping of pathological developmental histories; (presumed) neurobiological insults due to head injuries and substance abuse; "true" psychiatric symptoms such as delusions, auditory hallucinations, and affective instability; and "personality" or immutable characterological traits. Moreover, these "perfect storms of pathology" occur within an environment of profound pathology, a maximum security prison. These individuals' illness experiences and the penitentiary clinicians' perspectives are provided in the thick description of psychiatric disorder as it is experienced and witnessed. This is substantially different than "representing the diagnostic prototype as an upper middle class Anglo", in which psychopathology "suddenly" erupts in an otherwise healthy individual's life (Good 1993: 436). This construction of psychiatric disorder, according to Good, places biology as the prime etiological agent, as well as reproducing class assumptions about the "normal" individual (ibid). Within the penitentiary, biology as a domain is emphasized, but the individual's prior context (e.g. criminal lifestyle or poverty), current context, and developmental history are equally as relevant and come to the foreground more for clinicians in the penitentiary. Moreover, this ethnography describes how these individuals under the care of the penitentiary

clinical staff may indeed be “radically” different than the individuals accessed to inform the “discrete” diagnostic categories of the DSM.

Instead of constructing inmates’ illness behaviors as reified diagnostic categories, clinicians were more apt to use these categories as guideposts as they pragmatically assessed current behaviors and symptoms within the penitentiary’s complex contexts. Moreover, inmates themselves constructed their illness experiences as “mental illness”, congruent with prison “experts” models of psychopathology. This was discussed by inmates as being of benefit, as engaging in treatment as “mentally ill” provided relief from psychiatric symptoms as well as respite from the toxicity of the institution. Within the context of the penitentiary, “normalizing” activities such as employment, school, recreating, individual coping strategies, and pro-social interactions are all acknowledged by inmates to being beneficial to their mental health as well as something they desire within the institution. In actuality, the mechanisms within the penitentiary to “correct” deviance are processes and opportunities that are sought after by inmates to lessen the “pains of imprisonment” (Sykes 1958).

Foucault’s notion of the prison as being a site of total control does not take into account the agency of the individuals working and living within the penitentiary. This is not “resistance” to Power (Garland 1990: 173), but instead this ethnography revealed that individuals enact agency within this regimented institution. Correctional officers could “choose” to work with mentally ill inmates and provide ancillary social support if they wished; inmates could “choose” to form working relationships with staff; inmates themselves could “choose” to

engage with other inmates to establish relationships; and staff could also "choose" to work with other staff in the context of providing appropriate observation and treatment of mentally ill inmates. These cooperative acts served to keep the institution "running smoothly" which was recognized as a paramount goal for inmates and staff.

All of the narratives provided in this ethnographic account of the prison demonstrate that individuals, both staff and inmates, have agency and work cooperatively toward particular goals in the prison. These goals may be as simple as "going home safe each day" for staff. For inmates, it may be as critical as maintaining their employment to diminish the likelihood of increased psychiatric symptoms. This cooperative behavior discussed in this dissertation challenges Foucault's functionalist account of the prison as an institution that "works" on its charges, or inmates, in order to "correct" deviance. Instead, this dissertation re-figures the prison as a community, a "city within a city", with its own unique social structures and cultural processes (Clemmer 1940; Fleisher 1989; Sykes 1958).

The most current anthropological research on prison has continued to utilize the work of Foucault as an entry point and a means to "think through the prison" (Rhodes 2000; 2004). This research instead suggests instead a reformulation of this theoretical framework and entry point with a re-focus on the prison as a unique community, which is structured through social relationships and social categories. Here, individuals may enact agency within these

presumed sites of “total control”, attempting to construct life worlds that provide meaning and value.

Further, when the agency of social actors is revealed within the institutional context, it re-affirms and re-asserts the importance of utilizing a model of culture as first endorsed by Geertz (1973), in which the social world is constructed through societal interactions. This interpretivist model of culture, that seeks to uncover the meanings associated with action, and grounded in the theories of social action proposed by Weber, asserts that culture creates reality from the “ground up” through the interactions of social actors within particular social, cultural, and historical contexts (Lewis-Fernandez and Kleinman 1995: 434). This conceives culture as dynamic, processual, and contested. Monolithic, acultural, ahistorical entities such as “the prison”, “the state”, “experts”, “inmates”, and “prison staff” do not access the lived experiences of individuals embedded in these unique contexts. Here, this dissertation provides an alternative means of accessing institutional landscapes through thick description of cultural processes that imbue meaning to social action. Within the context of this dissertation the meanings which are attached to social categories, *illness categories*, create social action within the institutional context. Social categories such as “mentally ill inmate” are culturally created through the interaction of staff and inmates, and dictate particular responses from staff and other inmates. How these categories are enacted, contested, and experienced reveals the social and cultural processes at work within the institution. These social categories also generate a social structure and people’s place in it; because there is a social category of

“mentally ill inmate” within the institution, a space is created for these inmates in which institutional control is modified and enacted with flexibility. This formulation of social theory as applied to institutional contexts provide a more fertile starting point for explicating the workings of these moral worlds, as it can adequately address how social actors make sense of and navigate within a “society of captives”

Appendix A: Interview Questions

Research Questions for Inmate Participants

I. Prison Adjustment, Adaptation

1. Can you describe for me what it has been like adjusting to the prison? By adjustment, I mean adapting to the prison. How have you been able to make a life for yourself here in the prison? Can you describe how you are managing and coping with this incarceration?
2. Can you describe for me what has been easy, what has been difficult?
3. If you have been previously incarcerated, can you describe if this adjusting to this sentence is different or the same as before?
4. Can you describe what it is like adjusting to the prison while also dealing with your mental illness? For example, is it difficult? Easy? Both?
5. Since our last meeting, can you describe for me how you have been coping with life in the prison, and what you have found works for you to adjust, cope, or adapt successfully while dealing with the issues surrounding your mental illness?

II.Experiences of Daily Life in the Prison

1. Can you describe for me what your daily routine is? What do you do during the course of your day?
2. Describe for me how your daily routine does or does not help you in coping with the prison environment

3. If you have a job, can you describe for me how you cope with working in the prison? Does having a mental illness make it difficult or easy to work within the prison? Explain
4. Can you describe what programming you are involved with in the prison? Explain what that programming is (for example: education, cognitive programming, substance abuse treatment)
5. What do you do in your leisure time? Can you describe how you spend your time when you are not working or attending prison programs?
6. Do you have any contacts with community members? Friends? Family? Do you receive letters or visits?
7. If you have contact with either friends or family through phone calls, visits, or letters, can you describe how this helps you cope with prison? Or how it doesn't help you cope with prison?
8. If you have contact with either friends or family through phone calls, visits, or letters, can you describe how this helps you or doesn't help you deal with your mental health issues?
9. Do you have any friends that are also inmates here in this prison? In other prisons? Can you describe how this friendship does or does not help you cope with your incarceration?
10. If you have friends who are also here in the prison, can you describe how this friendship does or does not help you deal with your mental health issues?

11. What has occurred since our last meeting regarding your daily activities? Have things changed? If so, how have they changed?

III.Subjective Experiences of Mental Illness

For the following questions, I am asking you about your ideas about mental illness, and your experiences of dealing with a mental illness while being incarcerated. I am not asking specific questions about YOUR symptoms, and you do not have to share with me anything that you do not want to. I am trying to understand how someone deals with their mental illness in prison, what a mental illness is, how someone "gets" a mental illness, and what your experiences are like in the prison and also dealing with a mental illness. Share only what you feel comfortable sharing. You do not have to answer any question that you do not want to answer. You can stop this interview at any time, or drop from the study at any time during this or any other interview, or at any time while you are participating in the study.

1. How would you define a "mental illness"? What exactly is a mental illness? Tell me in your own words what it is. You can include what others have told you, or what your own ideas are, if they are different from what others have told you. I am interested in what YOU think.
2. What do you think causes mental illness? Can you describe for me how someone "gets" a mental illness?
3. Do you think being in prison causes mental illness? Or do people come into the prison already mentally ill? Or is it both? Explain.

4. Can you explain and describe for me what it is like to deal with a mental illness and also deal with your incarceration? How do you cope with incarceration and also deal with your mental illness?
5. Can you describe for me how your treatment is going? Can you describe for me how you know your treatment is or is not working? Describe for me what has happened in the past 6 months in how you are doing. You DO NOT have to share the names of your medicines (if you take any), your symptoms, or anything else you feel uncomfortable sharing. You do not have to answer this question if you do not want to.

IV.Interactions with mental health, security, administrative staff

When I say "relationship", I mean your working relationship with a staff member, your interactions with them, how you get along or don't get along with them, how you treat them and how they treat you. Share only what you feel comfortable sharing. Remember, I do not share any of this information with staff in the Oregon Department of Corrections, or anyone else. Everything you tell me is confidential.

1. Can you describe for me what your relationship is like with mental health staff?
2. Can you describe what your relationship is like with security?
3. Do you have any relationships with a job supervisor, correctional counselor, teacher, doctor, dentist, nurse, etc? If so, what are these relationships like?

4. Can you describe examples of how these relationships have helped you cope or not helped you cope with your prison adjustment?
5. Can you describe examples of how these relationships have helped you cope or not helped you cope with your mental illness?
6. Can you describe for me how, if at all, these relationships have changed since our last visit?

V. Experiences within the prison and with other inmates

1. Is life in prison different than life on the streets for you? Can you describe how prison is different from the community? For example, the rules of how you behave and conduct yourself, who you can trust, how to deal with other inmates, and how to survive in prison as compared to surviving on the streets. How does prison "work"? How do you know how to do the right thing in prison to survive and avoid trouble?

2. Do you socialize with other inmates who are not in mental health treatment? If so, can you describe these relationships? Are these relationships positive? Negative? Both positive or negative? Explain.

3. Do you socialize with other inmates who are in mental health treatment? If so, can you describe these relationships? Are these relationships positive? Negative? Both positive or negative? Explain.

VI.Social and Cultural Factors that Contribute to Positive Outcomes for Mental Illness

1. Can you describe for me what you think contributes to helping you deal with your illness while in prison? Besides personal factors such as your

own desire to be well, or your age, for example, what factors help you deal with your mental illness? For example, do friendships help? Does family help? Does having a job help? Or do none of these factors help you?

2. You told me earlier what you think a mental illness is. Describe for me how you think this understanding of mental illness helps you or doesn't help you deal with having a mental illness.

Questions for Staff Participants

1. Can you describe for me what a mental illness is? In your own words, and your own understanding, tell me what you think a mental illness is.
2. What does it mean to have a mental illness in the prison setting? For example, does it mean the inmate will never get better? Does it mean they will be constantly victimized? Does it mean they will always get into trouble? Describe what you think it is like to deal with a mental illness in prison based on your work experiences with these inmates.
3. Can you describe what it is like to interact and work with inmates with mental illness? How do you approach them? Deal with them on a daily basis? For example, do you treat them like any other inmate or do you treat them differently?
4. Can you describe for me what factors you think contribute to positive outcomes for inmates with mental illness? For example, do you think not working helps a mentally ill inmate cope and adjust? Does a good housing assignment help? Provide examples from your work.

Appendix B: Codebook

Codebook			
First Order Code	**Second Order Code**	**Defined**	**Example**
1.0 Adjustment to Prison	1.1	When inmates and staff discuss how mentally ill inmates cope and function within prison environment	I'm happier when I'm staying busy.
2.0 Model of Mental Illness	2.1 Etiology	Explanations of what causes mental illness	I think it's something you're probably born with.
	2.2 Medications	Explanations of psychiatric medications	It helps my chemical imbalance…my brain, I guess.
	2.3 Treatment	Explanations of treatment for mental illness	I don't hear the voices no more, I'm stable…my mood swings are stable,
	2.4 Stigma	Discussion of stigma in prison	Inmates would make fun of you if you said you heard voices.
3.0 Peer Social Relationships	3.1 Mentally Ill Inmates Supportive	Examples of social support with other mentally ill inmates	Oh yeah, it helps. 'Cause we're both goin through the same thing… being locked up you need someone to understand…
	3.2 Non-Mentally Ill Inmates	Relationships with larger prison population	I know they don't like me, cause I ain't with their clique…I sit over there and eat real fast and leave
	3.3 Non-Mentally Ill Inmates Supportive	Examples of social support with non-mentally ill inmates	If they're havin' a bad day, it's like, 'What's up, wanna go play some basketball or shoot some pool?'….get their mind off their problems.
4.0 Relationships with Security Staff	4.1 Help Seeking	When officers assist mentally ill inmates with mental health	On our tier, if we're having a mental health crisis, they'll be sure to do something about it.
	4.2 Positive	Inmates idenitfy examples of positive relationships with officers	Security staff in general have an understanding [of the illness] and they don't use their symptoms against them.
	4.3 Negative	Negative Experiences with officers	Unfortunately there's a few staff here that think it's fun to poke sticks at these folks…

First Order Code	Second Order Code	Defined	Example
5.0 Relationships with Mental Health Staff	5.1 Negative	Inmate expresses dissatisfaction with mental health staff	
	5.2 Positive	Inmate discusses positive relationships with mh staff	I talk to my counselor. A counselor is a professional…they're paid to talk to people about situations like that,
6.0 Prison Behavior	6.1 Convict Code	Inmates and staff specifically refer to prison's convict code	The inmate code - the real old schoolers talking to staff is not cool to do, so you really have to respect them.
	6.2 Friendship	Inmates define friendship within prison	I personally don't make the claims of friends in here cause what I've seen of people has caused me
	6.3 Hierarchy	Inmates and staff discuss social hierarchy of prison	I don't think they'd make fun of ya, I think they'd keep their distance from ya. Cause they'd see ya as something weak or different,
	6.4 Trust	Inmates and Staff define and discuss "trust" in prison	And so these young officers get caught in a contradiction of their own conversation - it's over…the trust is over.
	6.5 Gangs	Inmates and Staff discuss gang activity in prison	Finally he stole some drugs from some gang members, and they killed him…he died….8 years ago.
	6.6 Extortion	Inmates and staff discuss extortion	I've seen extortions and people getting beat up.
	6.7 Fighting	Inmates and staff discuss inter-personal violence	Most physical fights will end in minutes, cause they guards will come.
	6.8 Harassment	Inmates and Staff discuss mentally ill inmates' harassment by other inmates	I always felt like my mentally ill clients were a vulnerable person in a very predatory environment…
	6.9 Malingering	Inmates and Staff discuss malingering behavior with mental health staff	Mental health can tell if you just want medication to get high or sell it.
	6.10 Rat	Inmates and staff discuss "snitcing"	They don't fit in with the standard inmate culture. The don't snitch, don't rat…
	6.11 Respect	Inmates and staff define and discuss "respect" in prison	Apparently he though I was disrespecting him when I said he wasn't there the first time I rang the bell. I think he felt disrespected.
	6.12 Masculinity	Inmates and staff discuss constructions of male gender	This is a male dominated culture, survival of the biggest and toughest.

First Order Code	Second Order Code	Defined	Example
7.0 Prison Environment		Inmates and staff characterize and discuss aspects of prison environment	Every sub group in here is dependent on every other group….like the officer letting the inmate out of his cell for his job.
8.0 Work		Inmates and staff discuss mentally ill inmates' employment in prison	Working helps. Doing physical labor is exhilarating, it soothes the mind
9.0 Staff - Staff Relations		Staff discuss their relationships with other staff in prison	The relationship between security and mental health is getting better. Security sees that there is a benefit to having mental health staff
10.0 Housing		Staff and Inmates discuss importance of where mentally ill inmates are housed	We have most of these inmates monitored more closely in regards to their housing

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