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Correctional Officers and the Incarcerated Mentally Ill: Responses to Psychiatric Illness in Prison

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Abstract

Based on ethnographic fieldwork in a U.S. men's prison, I investigate how this social and cultural context structures relations between correctional officers and inmates with severe mental illness. Utilizing interpretivist perspectives, I explore how these relations are structured by trust, respect, and meanings associated with mental illness. Officers' discretionary responses to mentally ill inmates included observations to ensure psychiatric stability and flexibility in rule enforcement and were embedded within their role to ensure staff and inmate safety. Officers identified housing, employment, and social support as important for inmates' psychiatric stability as medications. Inmates identified officers' observation and responsiveness to help seeking as assisting in institutional functioning. These findings demonstrate that this prison's structures and values enable officers' discretion with mentally ill inmates, rather than solely fostering custodial responses to these inmates' behaviors. These officers' responses to inmates with mental illness concurrently support custodial control and the prison's order.

Keywords

prison; mental illness; correctional officers; illness categories; cultural competence

> We spend more time with these inmates than any other staff. The mental health staff are in their offices seeing these guys, or they come down to the cell blocks for a few minutes to talk to them at their cells. But we spend 8 hours a day with them. We're with 'em all day.
>
> ——Correctional Officer, Pacific Northwest Penitentiary

Introduction

Over the past 30 years, psychiatric illness experiences, the professional constitution and treatment of mental illness, and the discursive practices regarding psychiatric illness categories have become inextricably enmeshed within correctional institutions rather than solely in the community or psychiatric hospitals (Applebaum 2010; Galanek 2013; Redlich

and Cusak 2010; Rhodes 2001, 2004; Waldram 1997, 2012). Published prevalence estimates of serious mental illness in U.S. state prisons have varied due to diversity of measurements used to identify disorders but have nonetheless remained consistently higher than U.S. population samples (James and Glaze 2006; Lamb and Weinberger 2005; Prins 2014). Lower-end estimates of serious mental illness among state prisoners indicate 17% of the U.S. prison population have the presence of a serious DSM mental illness (Lamb and Weinberger 2005; National Commission on Correctional Health Care 2002). Within these total institutions, individuals identified as mentally ill have compulsory interaction with prison inmates and correctional staff (Adams and Ferandino 2008; Dvoskin and Spiers 2004; Goffman 1961; Rhodes 2004). Among these staff, correctional officers are identified as having the most engagement with the incarcerated mentally ill (Applebaum et al. 2001).

Inmates with mental illness are disproportionately housed in state prisons' disciplinary segregation and supermax units, reflecting an unyielding control over disordered behaviors (Fellner 2008; Haney 2008; Lovell 2008; Rhodes 2004). In California, documentation of systematic patterns of staff abuse toward mentally ill inmates reflect a system ill equipped to address the needs of this incarcerated population, a lack of training for officers, and an institutional culture contributing "to the very problems they ostensibly seek to solve—interpersonal violence" (Fellner 2008:1080; Rosen Bien Galvan & Grunfeld 2014). Prisons are embedded within specific social, historical, and cultural contexts, contributing to variations in their social and cultural processes, such as staff–inmate relations (Fleisher 1989; Garland 1990; Liebling 2004). Given the heterogeneity of these institutions, do these findings indicate a systematic and deliberate abuse of the incarcerated mentally ill? Or are there other institutional responses available to prison staff?

Based on nine months of ethnographic fieldwork in a U.S. state prison, I investigate how institutional values and social structures enable correctional officers' responses to mentally ill inmates. I focus on how officers' discretionary responses are possible within a total institution, whose hierarchical structures limit agentive responses to disordered behavior (Foucault 1977; Goffman 1961; Rhodes 2001, 2004; Waldram 2012). Utilizing interpretivist and constructivist perspectives, I identify how officers constitute the category of "mentally ill inmate" and how a prison's context enables and structures relations between officers and inmates with severe psychiatric disorders. I attempt to answer several related questions. How do prison correctional officers construct mental illness within an institution designed to correct disordered behavior and hold offenders accountable (Foucault 1977; Rhodes 2004)? Is there a strict adherence to holding inmates accountable to all violations of prison rules? Finally, how does this prison's cultural values structure help seeking? I explore how the mentally ill engage with officers, and how these officers, charged with overseeing convicted felons, respond to prisoners identified within the illness category of mentally ill inmate. By investigating these processes, I identify what makes these inmates less susceptible to an inflexible use of power and control by prison officers.

Prisons as Local Moral Worlds and the Construction of Illness Categories

There has been a decline in ethnographic research in U.S. prisons over the past 30 years, although this methodology characterized the foundational sociological penal research

(Clemmer 1940; Irwin 1970; Rhodes 2001; Sykes 1958; Wacquant 2002). This has been largely attributed to perceptions of ethnographers being risks within these controlled environments and bureaucratic responses to increasing prison populations (DiLulio 1987; Rhodes 2009; Simon 2000; Waldram 2009). Research within U.K. prisons remains prevalent, particularly in exploration of the prison's social structures and value systems through descriptive accounts of staff–inmate relations. However, there has not been ethnographic research on U.K. officers' work with severely mentally ill inmates (Crawley 2004; Genders and Players 1995; Liebling 2004; Morris and Morris 1963:196; Sparks et al. 1996).

Recent approaches constitute the prison as a local moral world, with values and cultural meanings arising from interactions within the hierarchically structured "compulsory sociality" of institutional actors (Galanek 2013; Kleinman 1992; Liebling 2004; Rhodes 2004; Waldram 2012:97). Interactional processes, embedded within local social and cultural contexts, construct psychiatric illness categories through interpretive activities of professional psychiatric systems and social networks, such as families and peers (Brown 1995; Kirmayer 1989; Kleinman 1988; Lurhmann 2000; Rhodes 2004). These interpretive activities imbue illnesses with cultural meanings, which, in turn, structure responses to individuals identified within illness categories (Jenkins 1988; Rhodes 2004; Waxler 1974). For example, clinicians may ascribe more personal blame and culpability to U.S. patients exhibiting DSM Axis II personality disorders; Axis I disorders, presumed to be biologically based, are out of the patients' control (Luhrmann 2000). Descriptive accounts of the prison indicate that construction of psychiatric illness does not occur solely through the work of mental health practitioners (Foucault 1977). Interactions among mental health professionals, correctional officers, and prisoners within these local moral worlds construct illness categories and structure culturally mediated institutional responses to these categories (Galanek 2013; Rhodes 2004). As large numbers of individuals with mental illness shift into institutions of punishment and incapacitation, what are the responses of those charged in overseeing their lives?

Correctional Officers: "People Work" and the Incarcerated Mentally Ill

Correctional officers are a heterogeneous group who engage in "people work" (Crawley 2004; Liebling 2004). Officers have variably characterized their work as congruent with rehabilitative goals, merely satisfying basic job requirements, or conflicted in their professional role and relations with inmates; others displayed cynicism regarding rehabilitative efforts in prison (Crawley 2004; Tait 2011; Toch 1978). Toch (1978:27) has noted that exclusive characterization of officers as custodians did not take into account their exercise of discretion in "working with" inmates. This perspective, that officers work with inmates rather than solely using coercive measures, is key to understanding how correctional officers maintain order and conduct their work (Crawley 2004; Farkas 1999; Fleisher 1989; Johnson and Price 1981; Leibling 2004; Liebling et al. 2011; Lombardo 1981; Shapira and Navon 1985; Sparks et al. 1996). Officers may seek bureaucratic loopholes in response to inmates' needs, listen to inmates' concerns, and rely on verbal skills to de-escalate potential violence (Fleisher 1989:174; Gilbert 1997; Liebling 2004; Liebling et al. 2011; Lombardo

1981; Owen 1988; Rhodes 2004; Sparks et al. 1996). Prisoners have also identified how these relationships may be mutually beneficial (Liebling 2004; Sparks et al. 1996).

Officers are identified as having the most contact with mentally ill inmates housed in the general prison population and as having potentially positive impacts on treatment and illness outcomes (Applebaum et al. 2001; Dvoskin and Spiers 2004). Research in Canada and the United States suggests officers' negative attitudes about inmates identified as mentally ill, with receipt of training contributing to positive perspectives and officers being supportive of treatment, even potentially coercive measures (Callahan 2004; Kropp et al. 1989; Lavoie et al. 2006). Officers have opportunities to work collaboratively with mental health staff in ensuring treatment; custodial roles and support of treatment are not mutually exclusive as suggested by a treatment–custody division model of prison staffing (Applebaum et al. 2001; Callahan 2004; Dvoskin and Spiers 2004; Rhodes 2004:152–153; Tait 2011).

Rhodes demonstrated that within a U.S. prison's inpatient psychiatric and supermax unit, mentally ill prisoners may be "partially exempted from custodial expectations" through officers' use of discretion (2004:103). However, Rhodes did not provide accounts of whether officers' discretion was widespread. Additionally, both custodial and treatment staff may be "capable of performing the role usually attributed to the other" (Rhodes 2004:152). Rhodes states that officers in the super-max unit may take time to listen to inmates' concerns, speak with them humanely, and even "asked if they skipped their meds," but does not suggest there are institutional values or illness categories that mediate staff responses to mentally ill inmates (Rhodes 2004:120–121). Investigation of the institutional values that structure social relations provides continued analysis of prisons as local moral worlds and how culturally mediated relations structure responses to the illness category of mentally ill inmate. Questions remain as to how these unique institutional contexts and sites of interpretive activities shape responses to illness categories.

The Research Context—Pacific Northwest Penitentiary

Pacific Northwest Penitentiary (PNP)[1] houses 2,000 male inmates; approximately 1,000 of this population are in two massive cell blocks. These cell blocks are composed of five tiers with two rows of 50 5×8 cells; inmates are housed alone or are doubly housed. Four correctional officers oversee the activities of each block.

In 2009, approximately 10% of PNP's inmate population was diagnosed with severe psychiatric disorder, which includes schizophrenia spectrum disorders, bipolar disorder, any psychotic disorder, and major depression (severe, recurrent). Since the mid-1990s, a team of mental health professionals have been embedded within the prison, conducting assessment and diagnostic services, and pharmacological, psychosocial, and therapeutic treatment interventions. An inpatient psychiatric unit (IPU) provides acute inpatient crisis services. The majority of mentally ill inmates live and work within the general prison population, dispersed in the major housing units. Fifty severely mentally ill inmates live in a specially designated tier in one of the large cell blocks, termed the "mental health tier."

[1]This is a pseudonym. For more detailed descriptions, see Galanek (2013).

Mental health staff, in conjunction with correctional staff, determine the appropriateness of housing severely mentally ill men there, providing institutional clinicians opportunities to engage with officers. Officers working the mental health tier know these inmates have a disorder that warrants treatment, although they do not have access to confidential medical files, which are HIPPA protected. Mental health staff meet with officers to discuss "warning signs" of increased symptoms for specific inmates, such as poor sleep, difficulty concentrating, or bizarre speech. In this manner, officers, in conjunction with departmental training, assignment to units such as the IPU, and collaborations with mental health staff, were prepared to work with inmates with severe mental illness.

Methods

All research protocols were approved by the State Department of Corrections and the university's institutional review board (IRB). Approximately 430 hours of observations of the prison and interviews with 23 staff and 20 inmates were collected during fieldwork. Written informed consent was obtained for all participants with ongoing informed consent obtained for inmate participants. Semi-structured, open-ended interviews of 45–60 minutes in length were conducted in a private office four times with staff and seven times with inmates and transcribed verbatim. I had status as a volunteer and successfully negotiated for access throughout the institution. Establishing credibility as a participating observer hinged on maintaining visibility, interacting with staff and inmates, communicating the study's goals, and maintaining routinized observation in cell blocks and common areas to accustom staff and inmates to my presence (Bernard 2011:34–59). No formal, recorded interviews were conducted in public institutional spaces. Field notes were taken during or immediately after observation periods. Observations and interactions among staff and inmates consisted largely of the cell block that contained the mental health tier.

Staff participants included seven correctional officers, three prison administrators, six mental health staff, two medical staff, three correctional counselors, one education staff, and one work supervisor. All PNP staff self-identified as having long-term experiences working with inmates with severe psychiatric disorders and knowledge of institutional practices related to this prisoner population. For inmate recruitment, a purposeful sampling strategy was employed to access experiences of psychiatrically stable inmates who were functioning well in the prison to answer this study's broader questions on psychiatric recovery (Ulin et al. 2005). Inclusion criteria included: (1) diagnosis of severe psychiatric disorder; (2) living in general prison population; (3) assessment by mental health providers as psychiatrically stable to provide informed consent, participate in research; (4) low number or no days in disciplinary segregation or IPU in the past 12 months; and (5) adherence to programming (education, mental health, employment) in the preceding 12 months.

Inmates who were symptomatic were identified as not being able to participate in informed consent processes by the IRB and the DOC's office of research. Participation could also potentially interfere with treatment. A list of 51 eligible inmates was created by mental health staff, with 22 declining participation, and 9 dropping from the study due to disinterest in continuing (2), work schedule conflicts (4), increased symptoms (2), or transfer to another prison (1). A private office was provided to discuss details of the research, informed

consent, and conduct interviews. Staff were not present during inmate recruitment nor were they informed of inmates' participation or refusal to participate. The inmate sample characteristics are presented in Table 1.

Consenting inmates also signed a HIPPA waiver, providing access to diagnosis to ensure eligibility requirements. Diagnoses and treatment needs were arrived at through clinical judgment of PNP mental health staff and through consultations with other DOC mental health professionals. Due to length of incarcerations and time in treatment, diagnoses were assessed as accurate, although no formal diagnostic interview schedules were used. All inmates reported taking psychiatric medications.

All data were analyzed using Atlas.ti (version 5.5), a qualitative analysis software. Data for this article were derived from two questions for inmates: (1) Can you describe your relationship with correctional officers? (2) Have these relationships have helped you cope with living in prison or with your mental illness? Data were also derived from one question for staff: Can you describe what it is like to interact and work with inmates with mental illness? The open-ended questions allowed for exploration of non-security staff's experiences and observations of officers' work with mentally ill inmates. A priori codes were utilized along with codes derived from an iterative inductive and deductive process. Compiling coded sorts of interview and observational data allowed for review of discrepancies and generalizations in data. Conclusions were drawn from triangulation of observational data, and interview data, contributing to credibility and dependability of findings (Ulin et al. 2005).

Relationships between Staff and Inmates

The DOC identifies officers as positively impacting inmate behavior while concurrently maintaining institutional safety and security. Participants discussed that opportunities to positively influence behavior resulted from officers and inmates establishing working relationships within the context of officers' custodial work. An inmate living on the mental health tier discussed how officers needed to establish and maintain a relationship with inmates to run the housing unit: "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 has to develop some type of relationship with the inmates."

Intensive interactions, encouraged and structured through PNP's administrative policies, enabled working relationships between inmates and correctional officers. In the late 1990s, the state DOC implemented the *Accountability Model*, based on social learning theory and cognitive behavioral principles. This policy mandated high levels of staff–inmate interactions, providing opportunities for staff to model pro-social behavior, reinforce inmates' positive behaviors, and redirect negative behaviors while maintaining institutional safety.

Following from the DOC's paramilitary organization, these statewide policies were implemented through formal meetings with institutional and state administrators among correctional staff. Ranking officers (captains, sergeants, and lieutenants) were expected to use this model to structure the day-to-day management of the inmate population through

communication of expectations with officers during shift change meetings and informal interactions. A lieutenant told me: “Staff inmate interaction is basically treating the inmate like how you want to be treated. I think staff were doing it a long time before the state put a name on it.” These comments refer to PNP’s institutional culture: Prisoners and staff engaged with each other to manage the prison’s day to day activities and to maintain order (Liebling 2004). A cell block sergeant reflected this, stating: “We all have to communicate to make things run smoothly around here.” Staff and inmate participants acknowledged that respectful interaction, mandated by the accountability model, was absolutely necessary for the institution to run effectively safely.

Officer and inmate participants acknowledged that this mandate for pro-social interaction was differentially enacted by inmates and staff. Participants identified portions of correctional staff and PNP inmates as “never getting it” and not understanding the benefits of managing the prison in this manner. PNP’s physical structure contributed to the informal interactions which enabled staff to engage in the accountability model’s tenets; common areas and open institutional spaces provided opportunities for communication and informal requests outside of official channels (Galanek 2013).

For example, cell block and common area observations revealed that officers and inmates engage in idle conversation, inmates interact with officers to make requests, and officers speak with inmates to maintain the housing unit’s operations. The prison’s paramilitary culture gives these interactions a brusque flavor, but as often, inmates and staff attempt to neutrally engage to maintain order within the cell block. Heated exchanges also occur between staff and inmates, and inmates are written up for disrespecting officers. An officer commented on how PNP’s institutional social structure and culture may be unique among state prisons: “In some institutions, like in California, inmates have to walk on a painted line, or they get taken to the hole, taken down, or shot. I think that’s why there’s less assaults on staff. We listen to the inmates. A rapport, you might call it.” This comment reflects acknowledgment that U.S. prisons are not uniform in inmate management due to diverse institutional cultural values that structure staff–inmate interactions.

Prisons are low trust environments, but *within particular prisons*, staff–prisoner relations may be structured through institutional cultural values of trust and respect (Fleisher 1989; Libeling 2004; Owen 1988). Liebling (2004) identifies that trust within U.K. prisons is not an either–or proposition; gradations of trust may exist between prisoners and staff. Given that the social structure of PNP encourages sustained levels of interaction, gradations of prisoner–staff trust are enabled through demonstration of character traits within institutional interactions.

An officer explained how mutual respect and trust is based on consistency of behavior and following through on your word: “If you prove yourself to them [inmates], 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.”

A mental health staff discussed how inmates assess trustworthiness of staff of being trustworthy, and ultimately worthy of respect:

> Trust works experientially. That's about when staff follows through with what they say they're going to do. It commands respect. Inmates respect that. There's some staff who won't do it and the inmates don't respect that. The trust that gets built is 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.

Consistent behavior indicates who can be trusted and whether an individual's "word" has credibility, contributing to gradations of trust in institutional relationships.

However, three inmates characterized officers as being there solely to guard over the inmates, officers' livelihoods were dependent on imprisonment of citizens, and these inmates verbalized resentment that officers ultimately have control over them. One inmate indicated that his symptoms interfered with interactions with staff. Inmates perceived officers variably, which limited working relations and opportunities to establish gradations of trust and respect.

"Mentally Ill Inmate": Institutional Illness Category

Officers discussed how increasing identification of mentally ill inmates necessitated knowledge acquisition to effectively work within the prison. Mental health staff and correctional officers discussed that rotating through various posts, such as the IPU or mental health tier, allowed officers to acquire experience and training on how to work with mentally ill inmates. The looping effects of the prison (Goffman 1961) enabled observation of inmates across institutional contexts, providing opportunities to observe psychiatric symptoms firsthand, or as one officer noted, "people talking to the walls," and inmates' psychiatric recovery. This demonstrated to officers that psychiatric illness was present in the prison and treatable. Mental health staff also have interactions with officers, providing on-the-job training about behaviors that are warning signs of psychiatric decompensation, strategies that work best with inmates, and how to minimize risks of decompensation (Applebaum 2010). This knowledge contributed to officers' constructions of inmates' psychiatric disorder. As front line staff, they saw the immediate effects of, for example, medications and the prison environment on an individual's symptoms.

An officer who worked on the mental health tier emphasized that medications were an important part of treatment, but that environment also played a crucial role in inmates' psychiatric stability:

> I worked in disciplinary segregation. I've seen these guys improve. Guys used to be smeared with feces, fighting you. They were warehoused. Now they're in general population, doing well, on meds. If someone needs their anti-psychotic meds, I'll make sure they get 'em. I've seen the meds work. This one inmate is on his meds now, living on the mental health tier, and he's adjusted and doing well. The environment is equally, if not more important, than meds. You could give someone all the meds in the world, but if you put them in a hostile part of the cell block, it won't work.

Pharmacological treatments had become part of the institutional culture since the implementation of the mental health program, and all officers indicated that medications

were a critical aspect of inmates' psychiatric stability. Observations revealed that three times a day, inmates lined up in a common area by the cell blocks for "pill line." This medication distribution from nurses demonstrated to officers that large numbers of inmates were assessed as needing psychiatric medications to function in the prison.

However, rather than a biological reductionist account of psychiatric illness (Lurhmann 2000), officers understood mental illness as being significantly affected by pharmacological treatments *and* social context. Consequently, officers were attentive to the significance of inmates' context, including housing assignments, interactions with other inmates, and activities such as employment. Of the latter, an officer commented: "It keeps their mind off of things, gives them some self-worth. Cell time is bad. It gives them more time to think, problems with hearing voices. The more they're out, thinking, getting daily stimulus from their job, the better."

Officers acknowledged that keeping busy, by focusing on external tasks, could contribute to *most* inmates maintaining positive functioning in the prison, but viewed this coping strategy as particularly applicable to mentally ill inmates.

Inmates discussed how officers' acknowledgment of mental illness positively structured their working relationships with officers. An inmate stated:

> There's certain security that work with you better. Sergeant Smith[2] is one of the few that know about mental health. When they work in the cell block, it makes a difference. They know about it [mental illness], and they know some of the things that people go through. They'll just come down and talk to you at the cell.

This inmate discusses how mental health knowledge structured officers' interactions with him, such as taking time to talk by the cell during his shift. An officer emphasized that these responses were mostly voluntary, as officers could treat mentally ill inmates as any other inmate (i.e., not utilize additional time to observe or engage with them). "You have to want to work with them," this officer noted, which suggests that this prison's structure allowed agentive responses to individual inmate needs. The inmate quoted above discusses that some officers work better with inmates than others, suggesting that the category of "mentally ill inmate" was still contested among correctional officers. Interviews with staff indicated variability among PNP officers' knowledge of mental health, from disinterest in working with these inmates, to assessing all mentally ill inmates as potential malingerers (Rhodes 2004).

There was also variability in how officers understood mentally ill inmates. While acknowledging the presence and severity of mental illness in PNP, officers emphasized that even the mentally ill engage in manipulative behaviors and discuss how mentally ill inmates "turn it on" (exaggerate symptoms) when they want something, such as unwarranted phone calls to mental health staff. Although acknowledging the illness, officers may still take custodial approaches to their interactions. Officers and staff also indicated that attentiveness to the mentally ill was simply "part of the job," and discussed responsiveness to mentally ill

[2]This is a pseudonym.

inmates as demonstrating their credibility. Assuring that mentally ill inmates' needs were met contributed to the order of housing units; highly symptomatic inmates are perceived as unpredictable threats by other inmates. In this way, officers' responses were intertwined with responsibilities to maintain safety and security and "keep the peace" within the cell blocks.

Correctional Officers' Responses to Mentally Ill Inmates

Observation

Officers' work consists of observing inmates as they go to and from cell blocks, recreate on the yard, or work. Behavioral changes are used in officers' assessments as to whether a mentally ill inmate needs crisis intervention and are predicated on getting to know inmates firsthand. Officers were discussed as being "first responders" and crucial in heading off decompensation through communication with mental health staff. Psychiatric symptoms, such as hallucinations or paranoid ideations, create risks for mentally ill inmates to be either victimized or to harm others. Disruption in prison also creates further risks. Officers' inattentiveness to other inmates while breaking up an assault increases risks for escalating disorder and decreasing safety for staff and inmates within the institution.

Although officers' observations, reports to mental health staff, and checking in with mentally ill inmates are understood as ensuring treatment, it also serves a dual purpose of maintaining the prison's safety and security. Similar to Rhodes's (2004) finding of custodial and mental health staff roles converging in the response to mentally ill inmates, officers in PNP embedded their work with mentally ill inmates in maintaining safety and security. An officer who had worked at PNP for 15 years discussed how checking in with mentally ill inmates maintained security, made his work days easier, and enabled inmates' access to crisis services.

> It's like five dollars in the bank every week. It keeps you from having to deal with them later. They're just waiting for that 5 minutes of your time, and you get to know just where they're at, and if they're getting to the point of where they're going to cycle [decompensate],[3] or if they're just angry at that moment. But you just find out where they're at, take some time to find out how their day is going. You can cut if off if they're starting to spin [decompensate] and call mental health. You have the same individuals you see every day. I tell new staff spending some time with this individual is going to save you a lot of time and frustration when he's gone off his meds or cycling or whatever. If you go by the administrative rules, this is just doing your job.

Attentiveness to mental status through supportive checking in with mentally ill inmates contributes to the officers' primary responsibility of maintaining safety and security of the institution, and of the inmates themselves. The mental health tier was embedded within a 500-man cell block that also housed non–mentally ill inmates, offering a contrast in how officers engaged with mentally ill and non–mentally ill inmates. Officers would walk on the non–mentally ill inmate tiers in a cursory fashion, with checks to ensure safety or briefly

[3]This refers to an inmate's increasing symptoms and precipitation to IPU admission.

respond to questions. Officers on the mental health tier checked in with inmates cell side, having brief conversations, and noting any behavioral changes that would warrant contact with mental health staff. An inmate discussed the importance of this checking in: “The cops are treating us differently on the mental health tier. Most of the cops are showing us concern, checking up on us. They want to make sure we’re not distraught or suicidal.” This quote reveals that inmates themselves identified positive benefit to officers’ interactions, interpreting this observation as supportive of their mental health.

Flexibility and Discretion

Rhodes (2004) observed that prisoner accountability is a paramount concern for custodial staff. Officers at PNP discussed, however, that strict enforcement of rules may not be the best approach in working with mentally ill inmates. An officer stated:

> I think writing them up is the wrong thing to do in most cases for mentally ill inmates. A lot of these guys, in dealing with them over the years … they’re not aware of the consequences. It’s much easier in the long run to work with them. When they do go to disciplinary segregation, they go downhill.

This quote reveals that officers understood that mentally ill inmates had cognitive deficits, and may not respond to disciplinary measures. Mentally ill inmates are admitted to disciplinary segregation, but outcomes of these measures may be negotiated between security and mental health staff (Adams and Ferrandino 2008).

An inmate diagnosed with bipolar disorder and living on the mental health tier discussed how an officer exercised discretion following an incident on the housing unit:

> A: Well, somebody left a note on my bunk, in my cell. Real fire and brimstone, that I was going to hell. So I threatened the person that I thought did it—threatened to beat him to a pulp. He told the sergeant. The sergeant 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 talked to my case manager.
>
> Q: Could the sergeant have written you up?
>
> A: Yes.
>
> Q: Did he cut you a break?
>
> A: Yeah.
>
> Q: ‘Cause he could’ve just put you in the hole [disciplinary segregation unit], right?
>
> A: Yeah. He recognizes we’re on the mental health tier.

Here is a clear rule violation. The inmate threatened another inmate, but the officer, because of his intensive interaction with mental health tier residents, decided to defuse the situation by not sending the inmate to the disciplinary segregation unit. This placement creates risks for increased symptoms due to this unit’s noxious environment: locked down 23 hours per day and pervasive harassment from inmates. The inmate could have lost his job, cell assignment, or time in intensive programming. This reveals that PNP officers can take an agentive, pragmatic approach to mentally ill inmates, based on knowledge stemming from

intensive interactions. Black and white perspectives, prevalent in the paramilitary prison structure, were not seen as appropriate when working with mentally ill inmates. Discretion, or flexibility in approach, was warranted.

Checking in on mentally ill inmates in their cells and taking "that five minutes" is not the standard work of officers. There is a boot camp mentality in the cell blocks, where inmates "do your own time," without needing to be "coddled." It is the inmate's responsibility to determine institutional routines and conduct himself accordingly. Mitigation of this boot camp mentality, through officers' flexible approaches to mentally ill inmates (such as checking in and increased observations), was enabled by meanings associated with this institutional illness category. Mentally ill inmates were understood by officers as needing more attention, more discretion, and a different approach to their management than general population inmates.

Officers' approaches to working with mentally ill inmates were observed one morning as I was talking to the sergeant of the cell block in which the mental health tier was housed. During his morning duties, the sergeant gruffly engages with inmates, fielding and deflecting requests, when an inmate approaches us. The sergeant speaks softly to me that this is a mental health tier resident, indicating his appearance to confirm his illness.[4] The inmate appears visibly anxious, or "shell shocked" as some officers term the expressions of the mentally ill. The inmate has wide eyes and a flat expression, much different from the serious, angered expression that inmates cultivate to detract exploitation from potential predators. As we stand together, the inmate keeps his distance and silence, but his presence indicates he wants to speak to the sergeant.

I back away, giving them room to speak, and they converse in hushed tones to provide confidentiality. After they finish, and the inmate returns to his cell, the sergeant tells me, "He needed to see his counselor. I'll call mental health for him. If you tell him you're going to do something, you're only as good as your word." Rather than tell the inmate to send a kite[5] to his counselor, the officer will intervene to ensure a more rapid communication to the mental health staff. Additionally, completing the call contributes to this officer's credibility.

Abruptly, the sergeant switches back to the curt officer I've seen all morning, directing loitering inmates on the cell. "What do you want!? Shouldn't you be at work?" he barks. This interaction between the sergeant and this inmate reflects an officer's discussion on effectively communicating with mentally ill inmates: "You have to approach them differently. You can't bark at 'em or treat 'em like any other inmate. It ends up winding them up. Barking at them could set them off, 'cause a lot of them are on the edge anyway."

Later that week, I observe officers on the cell block fielding requests from other inmates. Inmates make requests to call a lieutenant for a housing change or their correctional counselor to make a personal call. These requests are uniformly responded to with a short reply that the inmate needs to go through the institutional channels, such as writing a kite. When an inmate asks for a form to have something fixed in his cell, the sergeant form states:

[4]This inmate was not a participant in this research, and I did not know his name or his medical history.
[5]This refers to written inmate communication.

"You know, you can ask for these things when it's not the busiest time of the day," and with regard to a cell change: "You need to fill out the form and send it to the lieutenant." Later, I observe the cell block sergeant discussing the mentally ill inmate he assisted with other block officers, offering suggestions on how to assist him with his hygiene: "You gotta make sure he showers and you get him clean sheets. If not, he'll get stinky." Obtaining linen is the inmate's responsibility. But officers taking the time to ensure this inmate received clean bedding reflects the extra attention officers will provide to mentally ill inmates due to perceived cognitive deficits.

These examples show that PNP officers' responses to mentally ill inmates are based on these inmates' inclusion in an illness category. Constituted as mentally ill, they are understood as needing extra attention. Those extra 5 minutes of additional monitoring ensures their psychiatric stability. The inmate on the cell block, with his history being housed on the mental health tier, is pragmatically deemed by the cell block sergeant as needing additional attention, and the boot camp approach to inmate management is mitigated by identification of this inmate as severely mentally ill.

Help Seeking: Trust and Respect

Officers' acknowledgment of serious mental illness in PNP's population and discretion also structured responses to mentally ill inmates' help seeking. Inmates in treatment have scheduled appointments with mental health providers, but may also request to see mental health staff on an emergency basis. If inmates are not known as being mentally ill and they request an immediate appointment with a mental health provider, officers will frequently tell them to fill out a written request. If officers know the inmate, through personal experience or institutional memory, they will facilitate rapid access to mental health services. Since a number of inmates were housed on the mental health tier, and thus observable, this aided officers' assessments as to when to make calls to mental health. An inmate discussed this:

> You got to ask the officer. That's how it works on the cell block. The officer will call up to mental health, and write you a pass if it's alright for you to see them. If they say no, you got to write a kite and wait. You have to rely on the officer, especially if you need to talk to the 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. If they know you, they'll help you. If they really don't know you, or think you're playin' [manipulating], they'll tell you to write a kite. If the officer likes you, and you're for real with them [officers], they'll do you a favor, they'll help you. There's trust there.

The inmate discusses that some type of relationship with an officer, and the officers' knowledge of the inmate as critical in the help-seeking process. If the officer questions whether the inmate is mentally ill or is malingering, the officer will tell the inmate to go through the prison bureaucracy for an appointment. Of importance is the inmate being "real" with the officer, establishing trust between the officer and himself. Inmates, by virtue of their incarceration, are construed as manipulative and deceitful. In this prison, however, some gradation of trust with officers is sought out and maintained by prisoners with mental illness. This inmate discusses how help-seeking behavior is structured through relationships

of trust with officers. Officers trust that inmates with serious mental illness are being truthful in their requests for emergency appointments with mental health staff. Officers will also check in with mental health staff to ensure appropriateness of requests.

Officers had to judge the legitimacy of these help-seeking requests. Inmates who experienced increased symptoms could become aggressive, assaultive, or engage in self-harm acts that would jeopardize institutional safety and security. It was in the officers' best interest to be responsive, having a gradation of trust to inmates' requests for assistance, thus decreasing chances of inmates acting out due to psychiatric illness. Inmates discussed how being "up front and honest" about symptoms facilitated relationships of trust and respect. For example, officers could trust in an inmate's word that he truly needed assistance and consistent help seeking without manipulation contributed to officers' respect of inmates with mental illness and these inmates' credibility.

Another inmate living on the mental health tier discussed how relationships with officers structured reality checking:

> It does matter if you have a professional relationship with security staff. Sometimes you might be having delusions about what reality is and you want an officer's perspective. Sometimes the officers will help, 'cause they'll say, "The situation is not that serious, look at it this way," and talk you out of doing something. I can work with the cops on the cell block if I have issues.

This quote reveals that trusting in the officer's judgment and having a good working relationship to discuss delusional thoughts and "check" reality was an important aspect of this relationship.

Trust centering on consistent behavior and being as good as one's word was equally salient for inmates' assessments of officers' behaviors. An officer discussed how a working relationship and knowledge of a severely mentally ill inmate facilitated the inmate's admission to the psychiatric unit, and decreased the likelihood of the use of physical force, or extraction from the cell (Rhodes 2004):

> Why make things harder? It doesn't make any sense. Why extract this guy and risk getting hurt and the staff hurt when there's other ways to get him out of the cell? I knew an inmate, I had worked with him before. I knew him from special housing and general pop. He was off his meds. He needed to go to the IPU and he wasn't backing up [in his cell] to get cuffed up, and they were going to call a cell extraction team. I said, "Wait a minute, let me go talk to him." So I went down the tier, and I said, "Hey man, just back up, or these guys are going to come and get you. Let's do this the easy way. Would I lie to you? C'mon." And he backed up and we cuffed him and took him to the IPU. We didn't need to extract him. You gotta use your head with these guys [mentally ill inmates]. It can't all be muscle. Back in the day, we'd *just get him*. You can take that home with you—you just can't hit the gate and forget that.

This officer reveals that his consistent behavior and relationship with the inmate headed off a volatile situation. Good as his word, he did not lie to inmates and was consistent in his

behavior so that even though severely ill and decompensated, the inmate could still have a gradation of trust to leave his cell and be escorted to the IPU. Of interest here is that the inmate would have been sent to the IPU regardless of the officer's attempts at negotiation. If the inmate did not leave his cell when directed, an extraction team would have come to physically remove him from it, forcibly taking him to the IPU. This possibility reflects the inherent power of prisons' hierarchy; officers ultimately exercise total control of inmates, either through cooperative activity or physical force.

What is of importance is that an inflexible exercise of power is not the primary strategy in dealing with mentally ill prisoners' disordered behavior. Instead, this officer aims to decrease the likelihood of making his complex and challenging job more difficult. He said that in the past, institutional responses may not have taken into account his relationship with the inmate or the possibility of mental illness. In conclusion, he reflected that even in the PNP, deemed the "toughest institution in the state," officers could experience psychological repercussions from an inflexible exercise of control.

Discussion

This article contributes to the analysis of prisons as cultural contexts (Galanek 2013; Garland 1990; Waldram 2012), which directs attention to how meanings associated with institutional illness categories structure institutional staff's responses. Within this framework, prisons are *cultural* institutions, as much as medical systems, and thus accessing institutional meanings are paramount in analyzing this context's social processes (Gaines 1992; Garland 1990; Good 1994; Kleinman 1988). From this perspective, prisons are not *acultural*, *ahistorical* institutions, but are embedded within specific social, cultural, and historical contexts (Garland 1990). This heuristic provides a framework for understanding the observed variability across U.S. prisons and offers an explanation for officers' diverse responses to mentally ill inmates. The social and cultural processes at work in PNP may indeed be unique to U.S. prisons, particularly when compared to conditions in California.

The ethnographic specificity presented here provides evidence that U.S. prison staff do not respond uniformly to inmates identified as mentally ill. This article offers insights into how there may be institutional spaces that allow for officers' discretionary agentive responses and how officers and mentally ill inmates have opportunities to engage in gradations of trust. Brodwin's (2013:56) discussion of workplace ethos, or the "ideals woven into everyday action," is particularly relevant here, as it enables officers' "standard recipes for action." These ideals are reflected in the accountability model, and although differentially taken up by officers, the ethos this model endorses enables staff to find their way through the extraordinary challenges in maintaining safety and security of the institution and mentally ill inmates.

Correctional officers now parallel community staffs' engagement with individuals with severe mental illness. Similar to front line clinicians, officers at PNP appear to display "ethics narrow," or context specific decisions in the face of local constraints (Brodwin 2013:17). Officers' responses to mentally ill inmates are concurrently grounded within the meanings associated with this institutional illness category. This category offered officers an

alternative responses to inmates' disordered behavior and the prison's "near-at-hand contingencies" (Brodwin 2013:19). Leveraging personal relationships rather than using a singular strategy of physically coercive power to meet institutional needs demonstrates the alternative "tools in hand" available within these officers' responses (Brodwin 2013:129). In contrast to community staff, officers articulated specific principles to maintain the psychiatric stability of inmates in their charge, and these actions were based on how they understood mental illness within the prison. The "hegemony of biopsychiatric's thinking" (Brodwin 2013:102) was not challenged, but was complementary to officers' pragmatic approach to effectively manage inmates. Ensuring inmates received medications was another tool, among managing other contextual factors, that contributed to mentally ill inmates' stability.

PNP officers' work with mentally ill inmates is enabled by policies encouraging high levels of staff–inmate interaction and structured through ideal institutional values of trust and respect (Fleisher 1989; Liebling 2004). Officers recognized that a particular illness category or prisoner role (Irwin 1970) was now prevalent, and responses were pragmatic. Although officers were invested in maintaining these inmates' psychiatric stability through monitoring and facilitating help seeking, this did not circumvent or limit officers' options to enact force.

Officers' constructions of inmates identified as severely mentally ill were based on experiences such as in the IPU and the mental health tier, and their interactions with mental health staff, rather than accessing mental health files (Foucault 1977; Waldram 2012). These processes contributed to a model of mental illness that identified contextual factors such as housing and employment as contributing to psychiatric stability, rather than solely on pharmacological treatments. It also demonstrates that officers' understanding and responses to mentally illness included possibilities for these men's psychiatric recovery. Although mental illness was acknowledged in this prison, officers had differential responses to mentally ill inmates, substantiating findings that officers respond variably to rehabilitative measures and the incarcerated mentally ill (Tait 2011). Officers' discretion, generally displayed with non–mentally ill prisoners, was enacted by with mentally ill inmates, but due to their inclusion in an illness category. PNP's social structure enabled agentive responses to inmates identified as mentally ill because of the meanings associated with this institutional illness category. Presumed cognitive deficits warranted enhanced observation and interactions. Thus, officers denied being locked into rigid roles or stringently responding to disordered behaviors, which enabled responses to these illness categories.

Inmates discussed how officers' acknowledgment of their illness, observations, and discretion in disciplinary matters also benefited their lives and illness. In particular, inmates identified that relations with officers, structured on gradations of trust and respect, enabled help seeking and access to mental health services or to reality check troubling symptoms. Inmates identified that being honest, not exaggerating symptoms, and allowing officers knowledge of their illness—operating within a relation of trust—provided opportunities to access mental health services outside of institutional bureaucratic processes bureaucratic processes.

Institutional values, whose maintenance is critical to the order of prisons (Liebling 2004), also structure and enable the relations between mentally ill inmates and officers. As in other contexts, officers' responses to mentally ill inmates were structured by meanings associated with psychiatric illness. Discretion was enacted due to perceived cognitive deficits and affective lability; observations ensured psychiatric stability; and help seeking was facilitated. All of these processes were embedded within mandates to maintain safety and security, indicating the institutional context mediated officers' interpretations of their work with mentally ill inmates. Officers' responses, contributing to mentally ill inmates' stability, also preserved institutional order. These intersecting goals—safety and maintenance of inmates' mental health—did not appear to be contradictory within this prison. Rather, responses to the incarcerated mentally ill are structured at the intersection of systems of control and treatment

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Table 1

Pacific Northwest Penitentiary Inmate Sample Characteristics (n = 20)

Mean Age = 46 Diagnosis	**Age Range = 26–57 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
Race/Ethnicity		
Anglo/Euro	12	60
African American	7	35
Native American	1	5
Total	20	100
Number of Years at Pacific Northwest Penitentiary		
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