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THE MENTALLY ILL FEMALE INMATE: DO LABELS MATTER BEHIND BARS?

By

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ABSTRACT

THE MENTALLY ILL FEMALE INMATE: DO LABELS MATTER BEHIND BARS?

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The major purpose of this study was to determine whether the inmates who were identified by the mental health staff members at Huron Valley Woment's Facility as: 1) chronic care unit (CCU) inmates who volunteer, 2) chronic care inmates who do not volunteer, 3) nonchronic care inmates who volunteer, and 4) general population inmates who are not chronic care unit inmates, differed in terms of: their demographic variables and the factors which discourage or encourage them to volunteer for CCU. Also the study determined whether the inmates in four groups differed in terms of the social distance scale from the ex-mentally ill inmates, in terms of their perception of the mental health unit and also in terms of the mental health scale.

The secondary purpose was to determine without grouping inmates into four groups mentioned above the difference between the inmates who would volunteer and the inmates who would not volunteer for the CCU.

One hundred inmates (purposively selected) in Huron Valley Women's Facility were interviewed. Twenty eight of the hundred inmates were inmates who were chronic care unit (CCU)

inmates who had volunteered for the unit, twelve inmates were CCU inmates who refused to volunteer for the unit (as identified by mental health staff), five were nonCCU inmates who had volunteered for the unit, and the rest (55) consisted of the inmates from the general population who were not CCU candidates nor considered by staff members as mentally ill.

Link's (1987) social distance scale was used to measure inmates' social distance from the ex-mental inmates. Moos's (1975) institution environment and perception scales were used to measure the unit environment and inmates' perception of the mental health unit. Golberg's (1972) mental health scale was used to measure inmates' mental health states.

The chi-square test indicated that the four groups did not differ significantly in terms of the demographic variables. Anova showed that the four groups did differ significantly in terms of staff control as one of the environment subscales. The subgroups also did not differ in terms of the social distance scale. Anova also indicated that the four groups differed significantly in their perception of the mental health unit, and in the mental health scale. A t-test indicated that inmates who would volunteer for the chronic care unit differed significantly from the inmates who would not volunteer for the unit. This study demonstrated that labels do matter behind bars.

DEDICATION

This work is dedicated to my late mother Gabisile Nxumalo who sacrifized the little she had to send me to the University.

Lala Ngokuthula Mkhatshwa
Ngingeke Ngakulibala Nanini.

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CHAPTER I

THE PROBLEM AND STUDY PURPOSE

This chapter describes the problem of the increasing number of the mentally ill inmates behind bars. Additionally it describes both the court order which mandated the state of Michigan to provide or improve mental health services in corrections as well as the Michigan Department of Corrections mental health programs. The chapter concludes with a statement of the rationale behind the need to study female inmates who are mentally ill.

Mentally Ill Inmates in Correctional Facilities

Recent studies (Kalinich et al. 1988, Briar 1983) on jails have indicated that there is an increase in the number of the offenders sent to jails and prisons with mental problems. This increase in the number of the mentally ill in jails and corrections has been attributed by the concerned researchers (Lamb and Grant 1982, Whitmer 1980, Arvanites 1988) to the deinstitutionalization of the mentally ill from the psychiatric hospitals to community based mental health agencies.

According to the most recent National Survey of Inmates (1986), 26% (2802) of male inmates sought professional help for mental health related problems at the time of admission

and 72% (7751) did not. A somewhat lower percentage of female inmates requested to see a professional about their mental health, with 31% (912) making this request and 67% (1945) not making it at the time of admission. About 20% (2167) versus 80% (8610) of male inmates took prescribed medication for their mental health problems. In contrast 34% (988) of female inmates took prescribed medication and the rest, 66% (1913), did not. Twenty six percent (554) of male inmates took prescribed medication before admission and the remaining 74% (1601) did not. A low percentage of females (35% or 342) took medication before admission, 65% (640) did not. It is not clear whether the inmates who offered to see a professional about the mental health problems prior to admission also took prescribed medication for such problems or whether those who did not had some problems but did not offer to see the professional. Nevertheless, the statistics suggest that there are several inmates (whether female or male) with mental health problems channeled through the criminal justice system and that the proportion requesting help is lower for women.

According to Whitmer (1980) the reforms which have been made in mental health laws have primarily affected the criminal justice system. He specifically cites California's Lanterman, Petris, Short Act of 1968 (LPS) which emphasized the element of dangerousness of the mental patient for institutionalization to involuntary commitment to a psychiatric hospital. This Act shifted the focus of treatment

from psychiatric hospitals to community based treatment. Since the deinstitutionalized patients are not closely supervised, and they often encounter hostility and rejection by the public and reluctance of the community health agencies to assume responsibility, some patients do not take their medication, most patients regress, and as a result they commit minor crimes which are symptomatic of their mental instabilities (Morrissey in Gove 1982). Whitmer (1980) cites an example of a man who was arrested for disturbing the peace "after following two men around the lobby of an exclusive Nob Hill Hotel. This man... believed that these men were CIA agents who have kidnapped his benefactress." In other words deinstitutionalization of the mentally ill led to many problems for the mentally ill and to the agencies which were supposed to be rendering services to the patients. Morrissey (in Gove 1982) quotes from Reich and Siegal's (1973:162) article:

> rooming houses, foster homes, nursing homes, and run-down hotels ... take the place of former back wards. Here, the discharged patients are frequently clustered-unsupervised unmedicated, uncared for, frequently the prey of unscrupulous and criminal elements. The mass transfer of patients from state care to diverse city and private accommodations has been without benefit, and often with detriment, to the patients themselves. The state hospital back ward may be no worse, and is in some respects better, than a coffin-like room deteriorated inner-city hotel or Bowery flop house.

Briar (1983) concuring with other researchers concerned with the fate of the deinstitutionalized mental patients,

mentions that communities are not yet properly organized to render services to groups of patients who mostly need such services. This according to Briar (1983) is evident in the number of the mentally ill and the developmentally disabled who have become "prevalent residents of jails". Therefore, jails and prisons are now dumping grounds for the mentally ill patients as more and more of them are entering the criminal justice system.

There is considerable documentation of the increased numbers of mentally ill prison inmates. Lamb and Grant (1982) conducted a study in the Los Angeles County Jail for male offenders. They randomly sampled one hundred and two male inmates from those who were referred for psychiatric evaluation. They wanted to answer questions such as these: 1. What are the characteristics of the inmates referred for psychiatric evaluation for example, living situation before arrest, work history, mental status, diagnosis? 2. To what extent in the past have they been involved in the criminal justice system, the mental health system, or both? 3. Why were these persons booked into jail rather than admitted to a psychiatric hospital? 4. Are there problems that can be identified in the community treatment philosophy and its implementation for this group? Their method of data collection included interviews and review of records. They found that 99% had previous psychiatric hospitalization, 92% had prior arrest records, 75% for felonies, four fifths had

severe, overt psychopathology, and more than three fourths met the criteria for involuntary hospitalization. At the time of arrest more than one third were transients and only 12% were employed. They concluded that the population they were studying is characterized by extensive experience with both the criminal justice and mental health systems, severe acute and chronic mental illness, and poor functioning. More than half were currently charged with felonies and 39% with crimes of violence.

The results of the above study therefore suggest that more and more persons with psychiatric history are channeled through the criminal justice system even though it is clear and obvious that they need psychiatric hospitalization rather than imprisonment.

A study related to the above research was conducted by Carlen (1983) in England where she studied women in Contorn Vale Facility. She interviewed 22 women who were imprisoned for different crimes, fifteen sheriffs, and ten prison officers. The samples were asked different questions. Womens' questions were more geared toward finding out about their mental health status before imprisonment, and their demographic characteristics. Sheriffs' questions were most concerned about why most women who are mentally disturbed are sent to prison rather than mental institutions. Questions for correctional officers were geared toward finding out about

the lives and backgrounds of women who come to prison again and again based on the correctional officers experience with them.

Carlen (1983) found that eleven of fifteen sheriffs interviewed mentioned that they were sending so many severely disturbed women to prison because there were no alternatives. Seven of the ten prison officers interviewed mentioned that "there were in the prison women who appeared to be so "disturbed" that a lay person would most probably deem them to be "mad" rather than "bad", more deserving of treatment than of punishment". Like Grant and Lamb's study, the results of Carlen's study show that most inmates with mental problems have prior mental institutionalizations.

Feinman (1986) reported on the research conducted by Dr. Musk, in which he studied mental illness in women's institutions. According to Feinman, Dr. Musk reported that 85% of 49 state and federal prisons, with a total population of 7,000, responded to his questionnaire. Using women's history of hospitalization prior to incarceration as a criterion for mental illness, Musk found that the majority of women suffered from mental and or emotional ills, but still are incarcerated instead of being sent to mental hospitals. The above mentioned studies confirm that more and more persons with mental disorders are sent to jails and prisons instead of hospitals because of the change of the mental health laws.

The increase in the number of the mentally ill behind bars has led to some problems for the Michigan Department of Corrections (MDOC) as they are required by law to provide, or if unable, to have services provided to the mentally ill inmates.

Court Order to Establish Mental Health Treatment

The abolishment of the hands-off doctrine by the courts has led to the vulnerability of the MDOC since they are now prone to litigations by most inmates.

The United States of America (plaintiff) in pursuent to the Civil Rights of Institutionalized Persons Act of 1980, 42 U.S.C. $ 1997, instituted an action against the State of Michigan and its officials because of the then alleged prison conditions which were said to be in violation of the constitutional rights of the confined persons in the following institutions: State Prison of Southern Michigan (SPSM) at Jackson, including the Reception and Guidance Center (RGC), Michigan Reformatory (MR) at Ionia and the Marquette Branch Prison (MBP) at Marquette, including the Michigan Intensive Programming Center (MIPC). The court ordered, adjudged and decreed that the State of Michigan should comply with several provisions.

The court order is described in detail because it shows how much the MDOC had to comply with in order to assure proper mental health care. The specific provisions are as follows:

Health Care: The Defendants were to provide adequate medical, dental, and mental health services at the above mentioned institutions. Specifically the defendants were to:

1. Make available adequate medical facilities which were to be staffed by licensed, qualified physicians, and psychiatrists, dentists, registered nurses, and other medical personnel necessary to meeting the medical needs of the inmates;

2. Guarantee that immediately upon incarceration inmates should be subjected to initial medical assessment;

3. Provide emergency medical care to inmates;

4. Develop measures to prevent contagious deseases such as tuberculosis, aids, gonorrhea, and syphilis;

5. Make available adequate treatment upon timely identification for those inmates with serious mental illness, including manifest, substantial behavioral or physiological dysfunctions associated with psychosis, suicide, the threat of suicide, self-mutilation, or psychotic episodes involving violence towards others;

6. Provide reasonable protection measures for those inmates identified as suicidal or self-mutilating, including separate housing where necessary and adequate surveillance procedures, (Due to the fact that there are only two female prisons (not camps) in the State of Michigan, Huron Valley Women's Facility (HVWF) and Coldwater, inmates who are suicidal accompanied by schizophrenic, psychotic, depression

and other mental illnesses, are housed in the chronic care unit together with other inmates who have serious mental problems but are not suicidal. However in the male institutions self mutilators and those who are suicidal have separate living quarters);

7. Provide appropriate use and distribution of psychotropic medications, that fully comports with the standards of use and distribution in the medical profession;

8. Provide professional medical record-keeping systems.

The defendants were to achieve compliance with this provision by no later than July 1, 1985 and the Court was to monitor their progress. The defendants were to report to the Court and the United States any time they intended to modify their plan, and were to advise the Court and the U.S. by legal memoranda about whether the modification sought raises constitutional issues. In addition to reporting any modification to the plan, the defendents were to file with the Court and submit to the United States semi-annual reports, indicating for each respective six month period the status of the defendants' compliance with respect to the requirements of the decree. Upon notice and at reasonable times, defendants were to give full access to the United States, its attorneys, staff, experts, and agents to all subject facilities (State Prison of Southern Michigan and its Reception and Guidance Center, Michigan Reformatory, and Marquette Branch Prison) to inspect for compliance with the

decree. The State of Michigan was ordered by the court:

1) To build a new facility at SPSM which was to meet the serious medical and mental problem needs of the SPSM inmates and other referred inmates.
2) At Michigan Reformatory (MR) and Marquette Branch (MB), to upgrade the health assessment area by complying with minimal professional standards as necessary to protect inmate's mental health.
3) To afford to the inmates daily access to a sick call register which will provide an opportunity for them to request care for serious mental illness.

Mental Health Care

According to the State Plan for Compliance, mental health care concerns the care of "serious mental illness." According to the MDOC Consent Decree (1985:16-17), serious mental illness is "the manifest, substantial behavioral or physiological dysfunctions associated with psychosis, suicide, the serious threat of suicide, self-mutilation, or psychotic episodes involving violence toward others." This definition, according to the decree, excludes several mental conditions like, for example, the mental retardation, personality disorders, psychosexual disorders, impulse control disorders, anxiety disorders, and other similar conditions. Following is the plan which was to be adopted by the MDOC in compliance

with the court decree on the United State of America v. State of Michigan and others.

1. The Department of Corrections in the new hospital wing at SPSM will include a 21-bed fully licensed psychiatric unit for treatment of serious mental illness.

2. MDOC is to provide for each subject prison, subject to the court order, suitable separated housing which would be adequate to house inmates who exhibit a serious threat of suicide or attempted suicide. This housing was to be staffed continuously for twenty four hours daily, and staffed by people appropriately trained. Seriously mentally ill inmates were to be housed only in appropriate housing as determined by the psychiatrist, separated from all non-patient inmates.

3. At its discretion the MDOC was to deliver in-patient services for serious mental illness (other than screening, observation, emergency care, and suicide care and prevention) at a central, fully licensed facility. Within 270 days after the implementation of this plan, the MDOC was to submit a professionally designed plan to assure that prisoners with serious mental illness have adequate access to the Riverside Psychiatric Center or other similar facilities fully licensed or operated by the Michigan Department of Mental Health. The MDOC also planned to provide access to the inpatient care facility (with the exception of the involuntary admissions), within 48 hours after diagnosis for those needing inpatient care for serious mental illness. It also had to provide for

the systematic outpatient care, follow-up care, as well as continuity of care for inmates with serious mental illness. "The plan shall include appropriate provision for staffing for outpatient services and staffing for inpatient services to be available to each inmate for care of serious mental illness. Staffing provisions shall meet contemporary professional mental health standards to provide necessary outpatient psychiatric and psychological care for seriously mentally ill inmates (MDOC Compliance Plan p. 19)."

4. Access to mental health services for serious mental illness was to be available 24 hours a day. Immediate access to professional mental health staff was to be provided an inmate suspected by any staff member to be seriously mentally ill.

5. At each subject prison, at least twice a month, a clinical psychologist or psychiatrist will visit each housing unit that houses any segregation inmate. During these visits the psychologist or psychiatrist would be informed of the current mental status of each inmate housed in these areas.

6. A psychiatrist or in a mental health emergency a physician will provide initial assessment for psychotropic drugs. Mental health audits were to be provided by psychiatrists of the Office of Health Care or of an independent agency annually.

Current Health Services in Michigan Prisons

Its been six years since the United States of America v. State of Michigan. The following section provides the description of the mental health program as it now operates.

The Michigan Department of Corrections houses the Bureau of Health Care Services, which is responsible for providing necessary physical and mental health care for prisoners in the correctional facilities operated by the Bureau of Correctional Facilities (BCF). Prisoners who have been identified as having serious mental illness/severe mental disorder receive a range of mental health care depending on each inmate's need for treatment.

There are seriously mentally ill inmates who do not need inpatient unit treatment. These inmates receive outpatient mental health care in one of the following two settings: 1) a protected environment (PE) unit; or 2) a general population housing unit with outpatient mental health follow-up. There are also mental health services which are provided to the general prisoner population. These services include:

1. case identification, evaluation and referral services at intake and throughout the period of incarceration;
2. behavior management services such as crisis intervention coverage, procedures for the prevention or management of suicidal behavior and other forms of self-injury, and non-emergency interventions;

3. individual and group psychotherapy for sex offenders, assaultive offenders, offenders with severe institutional adjustment problems or extremely deficient coping skills; and 4. provisions of programs for developmentally disabled prisoners.

The mental health delivery system is a continuum with 5 levels of service. Namely:

1) Outpatient Services

2) Protected Environment Unit

3) Intermediate Care Program Unit (HVWF does not have this level)

4) Inpatient Chronic Care Unit

5) Inpatient Acute Care Unit (females in HVWF who need acute care are admitted voluntarily or involuntarily with the court order to the Forensic Center).

The focus of this dissertation is on inmates at HVWF who are in receipt of services from the Chronic Care Unit (CCU) and the Protective Environment Unit (PE).

The Chronic Care Unit: The specialized staff for the inpatient CCU consist of the: psychiatrist, psychologist, social worker, psychiatric nurse, general nurse, recreation therapist (RT), and outpatient team (OT). At the present moment the Inpatient CCU at Riverside Correctional Facility (RCF) has 173 spaces and 33 are under development, and HVWF

has 20 beds. Services offered in this unit are evaluation, crisis intervention, referral, individual therapy, group therapy, chemotherapy, behavioral intervention, recreational therapy, prevocational guidance, limited nursing care, counseling (rehabilitation), substance abuse counseling and educational services which are offered by the custody staff, and emergency treatment and nursing care. Patients who enter the unit are those inmates who have been referred from the OPMHT (Out Patient Mental Health Treatment), PE (Protective Environment), ICP (Intermediate Care Program) and ACU (inpatient Acute Care Unit). The people referred are inmates who require long term care for chronic mental disorder, and patients who need an increased level of nursing care and intervention.

The emphasis in CCU is on psychiatric/clinical support services by the treatment team. Patients in this unit are discharged when they are referred to another mental health service (e.g., PE), or to the general population or another special unit (e.g., segregation unit in HVWF). They also are discharged: if they refuse treatment; when they are no longer harmful to themselves and others, and can attend to their basic needs, or if they had repeatedly violated major institutional rules like assaulting staff members or other inmates.

Protected Environment Unit (also known as the Transitional Living Unit): The PE unit is staffed by the psychiatrist, psychologist, social worker, psychiatric nurse, Resident Unit Manager/Assistant Resident Unit Manager (RUM/ARUM), counselor, activity therapist (these are referred to as outpatient team members). Services provided include the following: evaluation, crisis intervention, referral, individual and group counselling, chemotherapy, limited nursing care, recreational therapy, and vocational and educational services which are offered by custody personnel. Inmates in this unit are those who have been identified as mentally ill, require support services during (up to) six months or more of transition into the general population, and have been referred from the inpatient Acute Care Unit, from CCU or from the Out Patient Mental Health Treatment (OPMHT). Inmates in this unit can be discharged after six months, when they are referred to another mental health service, the general population or a special unit, if they refuse treatment and when the signs and symptoms of mental illness have been ameliorated.

The Outpatient Service, the ICP unit, and the inpatient Acute Care Unit are distinguished from the two units described above in that the outpatient service provides care to inmates with minor psychiatric problems or inmates with previous psychological history, inmates who have been referred from the psychologist, and from the PE, ICP, CCU, and ACU. Inmates in the ICP unit are those who have been transferred from the CCU

and who need support extended beyond the 6 months transition period before being intergrated back into the general population and who still have behavioral problems indicating mental illness. The inpatient Acute Care unit may be operated by the DOC or the Mental Health Department. Inmates who enter this unit include those with serious mental illness, inmates who are agitated, depressed, suicidal, psychotic, a danger to self and others, and inmates who need intensive inpatient care for an acute mental disorder.

The life of the inmates in the mental health units differ in accordance with each level of service (i.e whether outpatient, PE, ICP, CCU, or Acute Psychiatric Care Unit. It is obvious that inmates in the CCU and APU are more restricted in behavior than the other three lower levels, and the outpatient unit, PE and ICP more restricted in behavior than the general inmate population. However they are all subjected to similar disciplinary measures as the general population because the regular prisoner disciplinary policy and procedures contained in the prison discipline policy fully apply.

Appropriate Placement of the Mentally Ill Inmates

It appears that there are inmates who are thought of as mentally ill but who do not volunteer to use mental health services or who refuse treatment. The MDOC mental health unit personnel and correctional officers do not coerce such inmates

into using services if their illnesses do not require immediate intervention by the mental health staff. The seriously and severely mentally ill are referred voluntarily or involuntarily to the Department of Mental Health (forensic center) which is not MDOC operated.

When this researcher was gathering information on the mental health programs of the Michigan Department of Corrections, an experienced MDOC psychologist mentioned that there are also inmates who are thought of as not mentally ill who seek to use the psychiatric services so that they can be segregated from the rest of the prison population. The inmates who fake mental illness in order to be admitted in the unit are said to do this (by another psychologist in the MDOC) for several reasons:

1. to escape harassment or physical victimization by other inmates;

2. to be closer to one's enemy to act out revenge against his/her enemy (this would be more so in men's facilities because male inmates physically victimize one another more often than female inmates);

3. Not to be assigned to laborous work within an institution;

It would be beneficial to the researcher and the MDOC to study these assumptions empirically because these assumptions suggest that there are inmates who are not physically secured (or who are targets for victimization), who prefer the

attachment of the word "mentally ill" than to be among their assailants, and that there are aggressors (those who perpetrate violence against other inmates) whose revenge is so intense that they can use any tactic to get to the enemy or to be within the reach of their targets.

It also is not clear why some mentally ill inmates do not volunteer to use psychiatric services. It may be that the services rendered in the psychiatric unit do not meet their needs, or it may be because they do not want to be labeled as "crazy" or they just do not want to be too restricted in terms of their behavioral movements.

The number of the psychiatric outpatients within the Department of corrections had been estimated at approximately 1700 in July 1987. However, it is not clear whether the number of the psychiatric outpatients has increased or decreased. Given the population size of Michigan prisons, approximately 23,158, and the aforementioned increase in the number of the mentally ill people in prison, the number cited above is small. The small proportion of psychiatric patients also raises questions about why mentally ill inmates do not seek psychiatric intervention.

The concern of this research among other things was to address the following questions: 1) who volunteers for the mental health services? 2) what are the characteristics of the inmates in the PE and CCU 3) what are the factors contributing to volunteering or not volunteering for

psychiatric services? and lastly 4) how does the general inmate population respond to the inmates discharged from CCU and PE. These questions were addressed with a study of the female inmates who had been diagnosed by the psychiatrists as having mental problems as well as a group not thought to have such problems.

As has been mentioned above, the mentally ill inmates (like those in the free community) have a right to refuse treatment or to voluntarily seek psychiatric evaluation and help. Correctional institutions usually have a separate unit in the same institution for the mentally ill. However very few inmates take advantage of psychiatric services. In addition to determining the characteristics of the female inmates more likely to seek psychiatric help, the study therefore tried to determine the institutional factors (e.g environment of different units within HVWF and both verbal and nonverbal behavior by both staff members and inmates) which encourage or discourage inmates from seeking psychiatric help.

Concentration of the study was on female inmates because they are often stereotyped as mentally unsound. Inmates who commit certain crimes like infanticide and murder are usually the ones regarded as mentally unsound. As shown in the theory that follows, it is important to understand the effect of stereotyping and related labeling on volunteering for mental health treatment. Because women are more labeled, it is important to focus the study on them.

Theoretical Framework and Past Research

There are studies (Goffman 1963, Goffman 1969, Scheff 1969, Link 1987) which suggest that most mentally ill patients are reluctant to seek help because of the labeling and stigma associated with mental illness. Other studies (Gove 1982, Gove 1980, Crocetti, Spiro, and Siassi 1974, Clausen 1981, Kirk 1974) disagree with the above view and assert that labeling an individual makes no difference as to whether the mentally ill seek psychiatric intervention or not. The researcher in the present study assessed the labeling theory as to its effect on the female inmate population behind bars. For example, do mentally ill inmates refrain from seeking help because they do not want to be labeled as "crazy" or are there other reasons that they avoid treatment, like for example more behavioral restrictions within the psychiatric unit than other units, fear of rejection by other inmates or staff members, fear of double stigmatization by the outside free community i.e being a criminal and a "luney"? Additionally the concerns of those inmates who are mentally ill but who do not seek help may be with the postimprisonment period. That is, what happens to them when they reveal they are ex-convicts and ex-mental patients? There is research (Weinstein 1983) that reveals that mentally ill patients and ex-patients are concerned with their discrimination by employers as soon as they reveal they are ex-mental patients. However none of the research that deal with the mentally ill and ex-mental

patients address the concerns of the mentally ill and ex-mentally ill inmates while still in prison.

The above cited past research does not address the attitudes of the female inmates towards mental illness nor does it address the issue of who volunteers and who do not volunteer for psychiatric services even though having been diagnosed as needing such services. Beside that, the above cited research does not specifically address psychiatric services rendered nor determine which programs are more often used by the mentally ill. The issues just mentioned are the concern of this study.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter shall review the literature on the concept of mental illness in general. The types of mental illnesses will be mentioned but particular attention will be paid to bipolar depression as it is prevalent among females. First, issues raised about the label of mental illness will be discussed. Then the chapter will give a definition of mental illness as developed by scholars and the Diagnostic and Statistical Manual of Mental Disorders (DSM) III-R. Third, reasons for expecting high levels of depression in the female inmate population will be outlined. Fourth, the attitudes of the free society towards mental illness as revealed by different studies are reviewed. This literature on the attitudes of the free society is reviewed because it is assumed that inmates are not immune from stereotypes accorded the mentally ill and that in part may explain why there are few female inmates who seek psychiatric intervention when the literature review and interviews with personnel working within corrections suggest that there are more female inmates in the total female institution with mental problems than the number who volunteer for treatment.

Mental Illness As a Label

There has been some controversy as to how the psychiatrists come to the conclusion that a person is mentally ill. Rosenhan (1973) among others questions the reliabilty of measures used to diagnose mental illness. It seems that the psychiatrists themselves can not definitively differentiate the sane from the insane, and that patients' symptoms, even those that can be categorized, do not help to distinguish the sane from the insane. This according to Rosenhan (1973) is because the environment plays a major role as to whether one will be diagnosed as mentally ill or mentally sound. For example, the usual behavior of a normal person (i.e a person without any mental illness) in the psychiatric hospital setting might be interpreted as abnormal, and therefore be attributed to his/her alleged illness.

To answer the following question: "do the salient characteristics that lead to diagnoses (as mentally ill) reside in the patients themselves or in the environments and contexts in which observers find them?", Rosenhan (1973) found eight normal persons (i.e "persons who do not have, and have never suffered, symptoms of serious psychiatric disorders"). They were admitted to twelve different psychiatric hospitals to test whether they would be discovered to be sane. The majority of them (11) were diagnosed as being schizophrenic and one had a diagnosis of manic-depressive psychosis. Rosenhan concluded that the normal are not detectably sane.

Once a normal person has been labeled schizophrenic, he/she is stuck with that label even though his/her behavior is normal. The label colors other persons' perceptions of him/her and his/her behavior i.e anything he does (even normal) will be attributed to the illness. In other words psychiatric diagnoses locates abnormality within an individual not within the environment in such a way that any behavior which is a response to the environment will be "misattributed" to an individual's disorder. He gives this example: "One kindly nurse found a pseudopatient pacing the long hospital corridors. "Nervous, Mr. X.?" She asked. "No, bored," he said."

Rosenhan (1973) took this study a step further. He wanted to find out whether the tendency towards diagnosing the sane as insane could be reversed. He arranged for an experiment at a research and teaching hospital whose staff had heard about the findings of the first study and doubted the results. "The staff was informed that at some time during the following 3 months, one or more pseudopatients would attempt to be admitted into the psychiatric hospital. Each staff member was asked to rate each patient who presented himself at admissions or on the ward according to the likelihood that the patient was a pseudopatient..."

The staff judgements were obtained from one hundred and ninety three (193) patients who were admitted for psychiatric treatment. Forty-one patients were found to be pseudopatients,

twenty-three considered suspect and nineteen were suspected to be insane. According to Rosenhan (1973) "no genuine pseudopatient (at least from my group) presented himself during this period." Based on these findings he concluded that "any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one."

Rosenhan's study can be criticized for a number of flaws. First, the numbers seem to be inconsistent. For example on page 381 he says "eight sane people gained secret admission to 12 different hospitals" (the data from the ninth excluded). At the bottom of page 384 (footnotes) he says "Interestingly, of the 12 admissions, 11 were diagnosed as schizophrenic and one, with the identical symptomatology, as manic-depressive psychosis." It is not therefore clear how many "normal" people got entry to psychiatric hospitals, eight or twelve? If twelve, what happened to the other three? If only eight got admitted where did he get the other four?.

His definition of the concept "normal" is also confusing for it can be interpreted differently by a reader of the article. He defines it thus: "people who do not have, and have never suffered, symptoms of serious psychiatric disorders (p. 380)." It may be that the people who were admitted to the psychiatric hospitals have had psychiatric disorders or suffered psychiatric disorders which were not serious.

There is no mention in the article of how the pseudopatients nor 12 hospitals were selected. We therefore

do not know how represantative was Rosenhan's sample of the "normal people" and the 12 hospitals, and thus we can not generalize his results to the target population.

Part two of his study also suffers from the inconsistency of numbers. For example, on page 386 he mentions that "judgements were obtained on 193 patients who were admitted for psychiatric treatment." He reports that 41 patients were alleged to be pseudopatients, 23 to be suspects, and 19 to be suspected of being sane. Forty-one, 23, and 19 do not add up to 193. It means that judgements on 110 patients are not accounted for. Therefore how serious, reliable, and valuable can the results of this study be given such inconsistency in the reporting of the results?

Consistent with Rosenhan (1973), however, according to Szasz (1963:17) there is no such thing as "mental illness" but labeling of behavior which seems to deviate from expected norms. He says "we call people mentally ill when their personal conduct violates certain ethical, political, and social norms." However, Szasz (1963) does not question why the conduct of these people violates certain ethical, political and social norms. And what is it about them that makes them different but not really different from the rest of those people whose conduct does not violate the expected societal norms? Besides, if mental illness is a myth or a label, why is the term used universally? This therefore makes one tempted to say that there is something in their behavior

that makes the word "mentally ill" suitable, though it is possible that the label is applied for political reasons in some cases.

Schrag (1978) argues that there is really no single criterion that is used to diagnose people as schizophrenic, manic depressive or psychotic. According to him even doctors (psychiatrists) are not sure what mental illness is other than what appears in the DSM. Symptoms which do not fit snuggly in the categories of mental illness as they appear in the DSM are classified under "schizophrenic". He says "Schizophrenia is one appellation, or 'label', which may be easily applied to those residual rule breakers whose deviant behavior is difficult to classify." In other words, there is little agreement on symptoms and definitions. In general, Schrag (1978) writes, "the depressive disorders" are said to reflect inappropriate feelings and mood while schizophrenia is regarded as distortion of thought. He further says that though schizophrenia and depressive disorders have been somewhat categorized, "the blacks are more likely to be labeled "psychotic" or "schizophrenic" than whites with similar symptoms or that what American psychiatrists call schizophrenia, their British counterparts are almost as likely to call personality disorder, depression, or mania." This therefore shows how inconsistent diagnosis of mental illness is from at least North America to Britain, and that in North America most people are more likely to be diagnosed as

schizophrenic than in Britain, because their definition of what schizophrenia is, is particularly broad. Schrag (1978) further says that there is no evidence that there is any single ailment that can be called schizophrenia and schizophrenia is a label for "several overlapping symptom clusters" and not for any organically or chemically identifiable malfuction."

Like schizophrenia, there is little agreement as to what depressive disorders are or to the diagnosis, epidemiology, causes, and effective therapy, but that "depression is ubiquitous and universal, and that it appears to be part of the human condition ranging from a normal mood state to severe illness... Locating the critical line that separates health from illness is very difficult."

Spitzer and Williams (1982) give a comparison of DSM-II and DSM-III Definitions of schizophrenia. They believe that the definition as it appears on DSM-III is clearer and therefore DSM-III more reliable than DSM-II definition. The following is the definition or description of schizophrenia as it appears in the DSM-II and DSM-III.

In the DSM-II the description of schizophrenia reads thus:

> This large category includes a group of disorders manifested by characteristic disturbances of thinking, mood and behavior. Disturbances in thinking are marked by alterations of concept formation which may lead to misinterpretation of reality and sometimes to delussions and hallucinations, which frequently appear psychologically self-protective. Corollary mood

> changes include ambivalent, constricted and inappropriate emotional responsiveness and loss of empathy with others. Behavior may be withdrawn, regressive and bizarre. The schizophrenias, in which the mental status is attributable primarily to a thought disorder, are to be distinguished from the MAJOR AFFECTIVE ILLNESS which are dominated by a mood disorder. The PARANOID STATES are distinguished from schizophrenia by the narrowness of their distortions of reality and by the absence of other psychotic symptoms."

The DSM-III-R is more elaborate as to what constitutes the schizophrenic person. In general, its key features are persons with the following psychotic symptoms:

a. delusions (bizarre)

b. prominent hallucinations

c. incoherence or marked loosening of associations

d. catatonic behavior.

The full description of the diagnostic criteria for schizophrenia using the DSM-III-R appears in Appendix A.

Goldman (1983:31) defines the chronically mentally ill persons as those persons "who suffer certain mental or emotional disorders (organic brain syndrome, schizophrenia, recurrent depressive and manic-depressive disorders, and paranoid and other psychoses, plus other disorders that may become chronic) that erode or prevent the development of their functional capacities in relation to three or more primary aspects of daily life--personal hygiene and self-care, self direction, interpersonal relationships, social transactions, learning, and recreation--and that erode or prevent the development of their economic self-sufficiency." Goldman's

definition of the mentally ill differs from definitions mentioned above in that his is broad and does not take only one aspect of mental illness as Petzer and others (1982) have done. It appears that the chronically mentally ill person is likely to be institutionalized for an extended period because his/her illness is likely to be a problem to him/herself as he/she can not meet daily necessary basic needs or in short can not take care of him/herself. Based on his definition of the chronically mentally ill, Goldman (1983) estimated the population of the chronically mentally ill to range in size from 1.7 to 2.4 million Americans, including 900,000 who are not in institutions. The above estimated number of the chronically mentally ill suggests that there are many persons with mental disorders inside and outside correctional institutions. The number of persons with nonserious mental disorders may even be more than the number of the chronically ill because most persons with no serious mental disorders do not come to the attention of the psychiatrists and they may not even seek professional help.

According to the Michigan Mental Health Code, mental illness refers to a substantial disorder of thought or mood which significantly impairs judgement, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. A person needing or requiring treatment according to the Code, is:

> a) A person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.
>
> b) A person who is mentally ill, and who as a result of that mental illness is unable to attend to those of his basic physical needs such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic needs.
>
> or
>
> c) A person who is mentally ill, whose judgement is so impaired that he is unable to understand his need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to himself or others. This person shall be hospitalized only under the provisions of sections 434 through 438 of this act. p.32.

For the Michigan Department of Corrections, inmates who fall in category c above can be involuntarily admitted to the Forensic Mental Care Unit after the MDOC has provided in writing to the court the need for such an inmate to be admitted in the unit.

According to the Michigan Department of Corrections Policy Directive (1982) on the subject of the mentally ill prisoners,

1. the mentally ill prisoner is "one suffering from a diagnosed or suspected psychiatric illness. This includes, with rare exceptions, patients suffering from psychoses or

major affective disorders, as described in the Diagnostic and Statistical Manual of Mental Disorders, DSM-III (p. 1)."

2. psychiatric illness being "a disorder in which both behavioral and physiological dysfunctions are manifest. Behavioral dysfunctions are characterized by a substantial disorder of thought or mood which significantly impairs judgement, capacity to recognize reality or the ability to cope with ordinary demands of life. In most instances, psychiatric illness is chronic in nature and is characterized by alternating periods of exacerbation and remission (p. 1)."

The definition by the MDOC of the mentally ill prisoner seems to be limited to only those inmates whose symptoms are identifiable and who eventually seek treatment or whom the mental health team can without any consent admit to an inpatient chronic care or acute care units. However those inmates who are sick but whose symptoms are not readily identifiable are excluded from the definition. Also excluded are those inmates who though their symptoms are identifiable (i.e., minor mental illness) do not seek treatment.

The Labeling of Female Offenders

Dobash and Dobash (1986) mention that women who enter the correctional system as prisoners during the 1960s were regarded as intellectually deficient and emotionally disturbed, therefore in need of "some form of medical, psychiatric or remedial treatment". This belief still holds

even today. Women have also been viewed as more mentally unstable than men and therefore by definition are mentally disordered or "acting out (of) (stereotypically female) character." Women prisoners according to Dobash and Dobash (1986) are therefore considered triply mad and in need of treatment (why else would they be in prison?). In prisons women, especially those with a previous record of psychiatric treatment, and those convicted of violent crimes including infanticide (these are crimes in which a woman must be "mad" to commit) have to see a psychiatrist. Schur (1983) concurring with Dobash and Dobash (1986) mentions that women are usually treated as being emotionally disturbed to dismiss what she says or does and "as a serious implicit threat should she seriously step out of line (p. 199)."

Dobash, Dobash and Gutteridge (1986) and Schur (1983) seem to concur that women are incorrectly viewed as mad. They do not however acknowledge that in reality there are mentally ill female inmates. It is therefore improper to designate <u>all</u> female inmates as being incorrectly labeled as "mad" as it is faulty to assume that <u>all</u> female inmates are correctly stigmatized. To be noted here again is that though some stereotypes about female inmates still hold, there is no observable line which demarcates a myth from reality. There is evidence that more and more women who enter the criminal justice system have a history of mental illness and that some mental illness is triggered by incarceration (i.e some female

inmates can not deal with incarceration, hence depression symptomatology appears).

Dimick (1979) says that nearly one in every seven women confined in prison can be legitimately considered functionally psychotic. Another twenty-five to thirty-five percent of the prison population demonstrate enough severe neurotic symptoms so as to be in need of psychiatric or psychological attention.

It appears from the above paragraphs that female offenders are regarded as mentally ill. However, the literature does not specify why, if there are a number of mentally ill female inmates, only a few volunteer for the in-patient psychiatric care.

Defining Mental Illness in This Study

The mentally ill prisoner in this research is one who scored low in the mental health scale by Golberg (1975) (suggesting that the inmate is mentally ill) (see appendix B), and therefore qualifies for treatment as it appears in the Michigan Mental Health Code above, paragraphs 330.1400a and 330.14001 subsections a and b or c. It therefore includes females who are mentally ill but who do not volunteer for treatment. This definition is adopted because it is broad. It encompasses both those people who are aware of their mental illness and therefore seek treatment and also those who are not aware of their illness, but who need treatment. The definition of the person needing treatment as defined by the

mental health code has the following features that make it more inclusive than other definitions:

1. a person with mental illness who within the near future can be expected to intentionally or unintentionally injure himself or others (in HVWF most inmates in CCU meet this criterion).

2. a person unable to attend to his/her daily basic physical needs such as food, clothing, or shelter.

3. a person who does not understand his/her need for treatment and therefore does not seek any.

The following section reviews the characteristics of women behind bars and suggests that it is likely that many female inmates enter the prison with mental illness as defined above or with the history of psychiatric hospitalization.

Reasons to Suspect a High Prevalence Of Mental Illness For Michigan Women in Prison

There are several reasons to suspect that a large number of the women in Michigan prisons experience mental illness, particularly depression as defined in this study. First, the number of females behind bars in Michigan has been increasing. Figueira-McDonough et al., (1981) conducted a study to determine the characteristics of the Michigan female inmates. They came to the conclusion that most women in prison are nonwhite or of minority status. However, the number of white females has been increasing too. They also found out that

very few inmates are married even though most of them are mothers, that some have a drug history and psychiatric history that more than half of all female inmates committed are below the age of thirty, that most of them come from poor families, have little education and have low status occupations. Given these characteristics and the fact that mental illness is mentioned by O'Connell and Mayo (1988) as being prevalent among black inmates and the fact that black females are overrepresented in prisons, we could therefore presume that the number of the mentally ill females behind bars is higher than the number of women who actually seek treatment.

Secondly, according to the Michigan Department of Corrections 1984 annual statistical report, there were 544 female commitments. Thirty two were 19 years old and under, 82 were between the ages 20-24, 163 between the ages 25-29, 216 between the ages 30-39, and only 51 were 40 and over. Three hundred and ninety two were nonwhite. These numbers show that most female inmates in Michigan's prisons are between the ages 30 and 39, followed by those between the ages of 25-29. According to Boyd and Weissman (as cited by O'Connell and Mayo, 1988) the average age for disorders for women is late 20s and to middle or late 30s. Therefore based on the statistics provided above from the MDOC it would be legitimate to project that many female inmates in Michigan prisons would be expected to have some mental problems.

Third, Boyd and Weissman as cited by O'Connell and Mayo (1988) mention that the risk of affective disorders is three times greater for women than for men and among working-class women with young children. Average age for disorders for women is late 20s and to middle or late 30s. According to Weissman (in Heckerman 1980) the peak ages for depression in women are 20-44. However, according to her depression decreases with age. Rates of depression when sex and social class are controlled for whites and blacks do not differ. However, O'Connell and Mayo (1988) mention that blacks are underdiagnosed because they express psychopathology differently than whites, and they do not enter the health care system as easily as whites but instead may be channeled into the criminal justice system or otherwise untreated. O'connell and Mayo (1988) therefore suggest that mental illness is higher among black inmates as many of them are channeled into the criminal justice system and that most of them do not seek treatment. This study found that mental illness affects both races. However, since blacks are overrepresented in prisons, black inmates do suffer some psychological problems if not psychiatric problems. That too can be explained by the societal and family environments in which they were raised in especially if they were subjected to physical and sexual abuse during their childhood.

Childhood experiences (especially the death of a parent or separation from a parent in early childhood) are said also

to be related to adult depression. Individuals who have experienced an excess of threatening event are more likely to be at risk than those who did not. Goldman (1983) summarizes the characteristics of the chronically mentally ill persons as being 87% white, 63% female, 59% married and living with spouse on a mean family income of $7,800. The population has slightly more nonwhites, more females and is less well educated and poorer than the nonmentally disabled (those whose disabilities are not mental).

Fourth, women are said to be disproportionately overrepresented as patients of depressive disorders i.e they outnumber men by roughly 2:1. Schrag (1978) says that twice as many females as males are hospitalized for depression, twice as many women as are men get electroshock treatments, and twice as many women as men are treated as outpatients many of them between the ages 35 and 50. This overrepresentativeness in depressive disorders of women is attributed to 1) the biological and chemical changes associated with menopause, 2) depression being typically an affliction of women who have lost their roles as mothers and housewives, and that the highest incidence among women occurs among "housewives with maternal role loss who have overprotective or overinvolved relationships with their children." Based on these arguements one would expect female prisoners to be overrepresented in the depressive disorder category because of their loss of roles as mothers or wives.

Weissman (in Hackerman 1980: 309) says that there are three meanings to the term depression: a mood, a symptom, or a syndrome. As a mood, depression is universal (i.e. at one point in time we all have experienced it) and is produced by a situation of loss. It "is a signal that something is wrong in our lives." As a symptom, it is not easy to draw a line between the normal and the pathological. As a symptom depression is prevalent among psychiatric patients who can not necessarily be regarded as primarily suffering from depression. As a syndrome, depression refers to "a cluster of symptoms and is the clinical depression..." Depressive symptomatology according to Rosenfield (1980:34) include: 1) "a change in mood, involving feelings of sadness, apathy, and or loneliness, 2) a negative self-concept with feelings of guilt, self-blame, self-reproach, 3) a loss of interest in usual activities and in sex - a general loss of energy, 4) problems with sleeping and eating (appetite can either be poor or increased), 5) trouble concentrating, and 6) psychomotor retardation or agitation." To these symptoms, Weissman (in Heckerman 1980) adds the following: feelings of helplessness, shame, pessimism and hopelessness, bodily complaints and thoughts of death. Lerner (1988) says that depression has been linked to avoidance of the awareness and expression of anger. Depression is regarded by Lerner (1988) as an indirect form of protest. According to Freudenberger and North (1985) most women with depression are unaware that they are

depressed (which may also explain the low number of female inmates using psychiatric services).

Fifth, depression is likely to be prevalent among female inmates due to their environment. Most often they would blame themselves for everything that has happened to them including incarceration. They may see themselves as helpless as if nobody cares about them (which may be true). Dimick (1979) mentions that there are periods when the female inmate looks at herself and her life and then completely loses control of her emotions. She (the female inmate) often wonders what is happening to her children if she has any. She worries herself as to what will happen to her since all that has happened in her life is her fault. Dimick (1979:73) says "some women live in a life style of depression. They surface in a while to feel undepressed... and then immediately dive back into sorrow and depression." The thinking according to Dimick (1979) includes the following: "look at me and what I do not have. How could anybody like me? My best guess is that no one does." A depressed inmate will then try to test that hypothesis by listening to clues and seeking direct feedback. In testing the hypothesis she finds that the responses she gets are exactly as she expected which exarcebate the feelings of hopelessness and helplessness and reinforce what she already thought herself to be.

Conclusion

For this study inmates who scored low on the mental health scale were the inmates regarded as mentally ill and needing in-patient psychiatric care. This determination of the mentally ill differed from the institutional determination of the mentally ill inmates because the psychologist relied basically on the MMPI.

Influences on Volunteering for Mental Health Care

The Attitudes of the Free Society Toward Mental Illness

The following section reviews the literature on the attitudes of the free society toward mental illness and how the ex-mentally ill and mentally ill respond to their mental illness given the attitudes of the free society towards them. This literature is included because it is the basis for generating hypotheses to explain why some individuals do and some do not volunteer for treatment.

General Attitudes Towards Mental Illness

It is the belief of this researcher that opinions about mental illness do not differ much from persons in the free community to persons behind bars because they are all exposed to similar stereotyping or nonstereotyping mass media with the exception that those behind bars have limited access to mass media especially newspapers, cable T.V. and maybe books. In

addition to reviewing literature as mentioned above, a brief review on the role of the mass media on changing or stereotyping the mentally ill will be mentioned because of the fact that inmates do have some access to the mass media.

Recent studies (e.g Link et al. 1987) as opposed to earlier studies (e.g. Susser and Watson 1962) seem to share the optimistic ideas that the attitudes of the free society towards the mentally ill is changing toward the better, depending on the severity of the behavior projected by the mentally ill. For example, the more bizarre the behavior is or more violent it is, the more negative are the attitudes and the higher is the social distance between the mentally ill and the public (Link, et al. 1987). However, Rosenfield (1982) on her study on the sex roles and societal reactions to mental illness found that both males and females recieve severe societal reaction if their mental illness or projected behavior deviates from their traditional sex role norms. For example, a male with neurotic and depressive behavior will be more strongly reacted to than a female with similar behavior. On the other hand, females who have been diagnosed as having personality disorder and substance abuse "provoke a more severe societal reaction" than males with the similar diagnoses.

Cumming and Cumming (1957) conducted an experimental study of opinions about mental illness in the Province of Saskatchewan. The results of the study indicated that those

persons sampled feared mental illness and therefore depending on the severity of the behavior manifested, wanted the mentally ill to be segregated from the rest of the community through hospitalization.

Nunnally (1961) conducted a six year survey to evaluate the public's knowledge and feelings about mental illness and treatment. Nunnally summarized his findings thus:

1. The mentally ill are regarded with fear, distrust and dislike by the public;
2. Old people and young people, highly educated people, and people with little formal training regard the mentally ill as relatively dangerous, dirty, unpredictable and worthless;
3. Bad attitudes were held because of lack of information rather than because of misinformation about mental illness;

Whatley (1958) conducted a study on the social attitudes toward discharged mental patients. His results showed that the public tend to distance themselves from former mental patients (especially in situations of closeness vs. impersonal situations), which encourage social isolation of the former mental patients which in turn contributes to problems of readjustment for them.

Most studies conducted prior to the year 1960 indicate that the public attitudes towards the mentally ill were negative, and the label mattered. The person labeled as

mentally ill was feared, isolated, rejected and stigmatized (Allen 1943).

The following studies conducted after 1960 tend to be more optimistic than studies cited above.

Ridenour (1961) reported that by the late 1950s there were improvements in attitudes of the public toward mental illness. She asserted that many concepts about mental illness have been positively reacted to as a result, many mentally ill patients were willing to admit that they were ill and therefore sought psychiatric help. Crocetti and Lemkau (1962-63) in their Baltimore study where they used the vignettes, found that the respondents identified the vignettes as indicative of mental illness, felt that each person described in the vignette should see the doctor, and mostly favored the community based treatment for each person. They concluded that the responses of the subjects did not support the concept of denial, rejection, and isolation of the mentally ill persons as have been suggested by earlier studies. Following this study, Lemkau (1962) studied the public aattitudes toward the mentally ill in Carroll County Maryland. He found that about eighty two percent of those interviewed disagreed with the idea that all mental patients are dangerous, and seventy nine percent disagreed with locked door system as the best way to handle the mentally ill patients. He too concluded that the attitudes of the free society towards the mentally ill is

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not as negative as portrayed in studies like those of the Cummings (1957), Star (1952) and Whatley (1958-59).

Crocetti, Spiro, and Siassi (1971) after their 1962 study conducted another study ten years later in Baltimore. The authors concluded that the subjects studied were optimistic in their view about mental illness and treatment and therefore were not extremely rejecting. They concluded that their findings do not therefore support the general view that psychiatric patients are stigmatized.

Mayer (1964) replicated Crocetti, et al.'s 1960 Baltimore study. His results were similar to those by Crocetti et al. He too concluded that the free society's opinion toward the mentally ill has changed toward the greater tolerance of the mentally ill.

Bentz and Edgerton (1971) interviewed a sample of 1,405 respondents to determine their attitudes toward mental illness and their extent of tolerance for the mentally ill in terms of their willingness to interact with ex-mental patients. They tested the generally accepted proposition that rejection results when a person is labeled as mentally ill. Their data did not support or refute the proposition, however the data indicated that there is a trend toward greater acceptance of mental illness and mentally ill by the free society.

Rahav (1987) conducted a study in Israel assessing the attitudes of the Israel public toward the mentally ill. He found that though some people still hold a negative view of

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the mentally ill, his results show a changing pattern of these negative stereotypes to more favorable views. He attributed the changing views of these people to mass media which according to him have recently been not negatively stereotyping the mentally ill.

Link et al. (1987) conducted a study where he sampled 240 Ohio residents. One hundred and fifty two individuals responded, 53 of those were women. The study was based on the vignette experiment to measure the social rejection of former mental patients and to assess why labels matter. They found that labeling shows little effect on a social distance scale, but when a measure of perceived dangerousness of mental patients was introduced labeling had strong effects. They say "specifically, the data reveal that the label of "previous hospitalization" fosters high social distance among those who percieve mental patients to be dangerous and low social distance among those who do not see patients as a threat." They concluded that labels do play an important role in how the free society percieves the former mental patients, and that the labeling theory should therefore not be discarded as a theoretical base for understanding social factors in mental illness.

The studies cited above take the optimistic view of the mental illness, i.e they see the public attitudes toward mental illness as being not so negative as portrayed in some earlier studies.

Based on the literature reviewed so far on the attitudes of the free society toward mental illness, it is clear that the public tend to react strongly to persons who exhibit severe and dangerous behavior and in personal situations. Rabkin (1974: 20) in support of this view says:

> "People respond differently to various kinds of symptoms. When deviant behavior includes violence as a major component, this symptom pattern is, understandably, quickly rejected, apart from any question of seriousness of the psychopathology."

Based on the literature reviewed, it seems that there are dissenting opinions as to whether the free society's attitudes toward mental illness is negative or positive, with earlier studies indicating negative views and recent studies showing a change in attitude. However, the sample sizes of these different studies can not be questioned since almost all studies cited above had more than 100 individuals in a sample. How each sample for each study was selected is rather problematic because most cited (above) studies do not mention how their samples were selected. With the exception of one study (by the Cummings), all studies used survey methods to collect data. Therefore the difference between earlier studies and recent studies may be attributed to the difference in time, and the changing image of the mentally ill as portrayed in the mass media. Most people are now informative

and well informed about mental illness and therefore their responses are based on what they themselves know about the illness.

The literature reviewed above encouraged the present researcher to assess the attitudes of the female inmates behind bars toward mental illness or the mentally ill.

Reactions of Those Labeled as Mentally Ill

This section addresses the reaction of the mentally ill to the label "mentally ill". This literature is reviewed because it is not clear what makes some but not all mentally ill persons volunteer for psychiatric treatment. The literature has suggested that most do not voluntarily seek professional help because of the stigma attached to mental illness and that most mentally ill persons have been reacted to negatively.

Farina, Gliha, Boudreau, Allen, and Sherman (1971) conducted two experimental studies (one a replication of the other) on hospitalized mental patients, to determine whether believing that others know about their mental illness will change their behavior toward others. They found that believing others know about their illness caused patients to feel less appreciated, to find tasks more difficult, to perform more poorly, and they were perceived as more tense, anxious, and poorly adjusted by an observer who did not know what the patients were told. Farina et al. (1971) concluded

that the results of their study suggest the possibility that the rejection stigmatized persons expect and fear is in part caused by themselves (i.e they are imagining rejection by the public).

Like Farina et al. (1971), Clausen (1981:287) mentions that former mental patients' feelings of stigmatization are not "so much a consequence of the response of others to their mental illness or labeled mentally ill as of self-doubts or chronic manifestations of mental illness." In other words the ex-mental patients feel as if they are isolated, as if other people think negatively of them when in fact they have no evidence that people are really isolating them or think negatively of them. They are therefore reacting to what they <u>believe and think</u> is happening rather than what is really happening.

To support his view, Clausen (1981) conducted a study of the ex-mental patients regarding their own experiences as patients and ex-mental patients. Clausen (1981:293) found that patients "were less likely to feel ashamed by the initial consultation with a physician but more likely to feel stigmatized as a result of entering the psychiatric treatment. Fearing stigmatization by close associates, nearly half of the patients concealed from neighbors and friends the fact of their treatment."

A majority of clients according to Clausen (1981) felt that their lives have been adversely affected by their mental

illness and their having sought psychiatric help, yet less than a third could give evidence of negative responses from others. Therefore their attitudes and feelings derive from what they think others feel and how they respond to them rather than actual responses from others.

Weinstein (1983) reviewed thirty five studies which dealt with: 1) hospitalized patients' attitudes toward the label of mental illness, and 2) ex-patients' attitudes toward the stigma or effects of hospitalization. His data were interpreted within the context of five propositions derived from labeling theory. The propositions are:

1. hospitalized patients tend to espouse unfavorable attitudes toward mental illness;
2. patients' attitudes toward mental illness become more unfavorable during the course of hospitalization;
3. patients are less favorable in attitude toward mental illness than nonpatients;
4. ex-patients tend to express unfavorable attitudes toward the stigma of mental hospitalization;
5. ex-patients' attitudes toward the stigma of mental hospitalization, compared to their pre-discharge attitudes, will be more unfavorable;

Proposition one according to Weinstein "was not supported by data, as patients summoned favorable images of mental illness labels slightly more often than unfavorable." Proposition 2

recieved no empirical support. Proposition 3 was not supported too and the author suggests that it be rejected because the labeling theory was correct in only about one-third of cases. Proposition 4 was also not supported by studies cited in Weinstein's study, and he concluded that the labeling theory appears to underestimate the positiveness of former patients in the community. For proposition 5, findings from three studies in his research which measured changes in ex-patients' attitudes indicated a weak support. He therefore concluded that mental patients are not affected by labeling process as much as the labeling theory presupposes. He further ascertained that societal reactions to the mentally ill are acutely understood, but not internalized by patients. Therefore the evidence in Weinstein's review of the 35 studies indicates that a psychiatric perspective explains the attitudes of mental patients better than the labeling theory.

The validity of the labeling theory behind bars was tested. This was done by testing the following hypotheses:

1. Negative stereotypes of mental illness interfere with volunteering for treatment among female inmates.
2. Female inmates who view the mental health program as being for people with bizarre behavior would not volunteer.
3. Inmates who view inmates in the Chronic Care Unit as dangerous will not volunteer.

4. Depressed women will less likely volunteer and those who do volunteer will have other sicknesses.
5. Previously treated female inmates will not volunteer for future treament.

The section that will address methodology will be addressed in Chapter Three.

It has been mentioned above that mass media has been cited as potraying the mentally ill more favorably than in previous times. It is the belief of this researcher again that if the attitudes of the free society toward mental illness are changing towards the better so are the attitudes of the females behind bars because they too have an access to newspapers, radios, T.Vs and magazines. Winick (in Gove 1982) mentions that the more negative the mass media potray the mentally ill, the more negative will the public's attitudes be. However, this researcher is not aware of any study that has been done to support Winick's assertation or hypothesis.

Based on the literature reviewed above, one can hypothesize that female inmates who are aware of the stigma attached to being mentally ill will not voulunteer for treatment. Still others will try to deny their illnesses either because they do not want to be stigmatized or they are not aware of their illnesses. Younger inmates will be more likely to volunteer for treatment because their cohort has been exposed to less stigmatization of the mentally ill.

Conclusion

We have seen that mental illness is defined differently by different scholars. Some definitions are narrow while others are broad. Therefore mental illness is a desease just like any desease except that mental illness involves behavior of the ill person. His or her behavior helps us to attach a name to his or her illness. If the behavior is extremely strange and does not seem to follow certain socially expected behavior, we (the observers) call that person ill even though we may not agree on what is wrong with him/her, or the person whose behavior seems to be strange may not be aware that his/her behavior is strange becuase he/she sees someone else who behaves like him/her and therefore to him/her the behavior is "normal". Since someone else exhibits behavior like his/hers, the person denies being ill and therefore makes no endeavor to find out what is wrong with him/her, hence we see people we think are "crazy" but who do not seek psychiatric help.

The researcher also tested whether stigmatization and volunteering for treatment are related and whether demographic characteristics play a role as to who volunteers and who does not. Also because so little is known about the female inmate and mental illness, this study did not only test hypotheses but also generated new ones to explain which women seek help and why.

CHAPTER 111

RESEARCH DESIGN

This study is explanatory and scientifically descriptive in nature. It is explanatory because it tests the theoretical hypotheses that negative stereotypes of the mental illness interefere with volunteering for treatment for female inmates, and that age and prior experience with mental hospitalization is related to the female inmate's volunteering for psychiatric treatment. It is descriptive because it also describes the characteristics of the female inmates who are mentally ill and who seek treatment, versus those who are mentally ill but who do not seek psychiatric treatment. The characteristics of the female general population will also be contrasted with those females in the mental health unit and protective environment unit. By identifying the mental health services that are most often used by those that need them within the CCU (Chronic Care Unit), it is hoped that the MDOC (Michigan Department of Corrections) will be able to expand the services to accommodate those mentally ill female inmates who do not volunteer for treatment. By determining characteristics of the female inmates likely to volunteer for treatment, the MDOC may be able to develop better procedures for recruiting appropriate patients. The study also generates hypotheses

explaining why some women who are not mentally ill volunteer for in patient mental health services.

This chapter describes the research methods used in the study. It includes the research site, historical development of the research site, target population, sampling, hypotheses, and research questions.

Research Site

The research was conducted in Huron Valley Women's Facility (HVWF). It is the first prison in Michigan to be designed solely for female offenders. It was opened in August 1977 to replace the Detroit House of Correction Women's Division. This institution is chosen because it is the only women's facility accessible to the researcher which has an inpatient mental health care unit and a protective environment unit. These two units are of major importance to and critical for the present proposed study. The institution is also chosen because of its population size, which suggests that it will be possible for this researcher to choose purposive samples with adequate sample sizes.

Huron Valley Women's Facility is located at 3511 Bemis Raod in Ypsilanti, Michigan. It is said that the facility provides more program space and a more humane environment than other prisons. Each permanent housing unit has its own dining room, special facilities for application of cosmetics and hairstyling, a study room, special activities room and laundry

facility. The capacity of the facility as of September 1988 was 326. By June 1990 the inmate population fluctuated between 575 and 580. The age limits for inmates in the institution is 17 and up. The institution is a closed medium and minimum security. It also acts as the Reception and Guidance Center for all female inmates who enter the Michigan Department of Corrections. Therefore all levels of custody are housed in the facility until prisoners are classified. It also houses the administrative segregation cases and the mentally ill. Approximately 10% of the facility's population is serving a life sentence. According to the Prisoner Guide Book most women within this insitution are serving sentences for larceny from a building (this is a single most common offense).

When committed to the facility, each prisoner is interviewed, given a complete medical examination and a battery of psychological tests. She recieves employment counseling and is then classified to a security level, housing unit and program assignment. An inmate who qualifies after classification may be transferred to a facility with lesser custody level. Educational programs include Adult Basic Education, GED preparation and remedial education. About 60 to 80 prisoners take college classes through Jackson Community College and Spring Arbor College. Through this institution women can earn an associate's degree. Vocational training

programs are offered in food services, business occupations, horticulture, building maintenance and graphic reproductions.

All programs offered are sanctioned by the U.S. Department of Labor's Bureau of Apprenticeship and Training. Women have to be involved in either an education, vocational or work programs. Also, the vocational assessment and evaluation program, and the counseling services allow women prisoners to explore non-traditional areas of skills and employment.

Support services rendered in this facility include counseling for chemical dependencies, and also religious and psychological counseling. Out-Patient health care is provided by a full-time medical staff at the institution, and the in-patient care is provided by the Huron Valley medical complex housed at the adjascent Huron Valley Men's Facility.

Several volunteer groups are active. These groups include the Holiday Project, Salvation Army, Women's Issues Advisory Board, Alcoholic Anonymous, American Association of Black Business Women and Professional Women's Clubs Inc., and a special program, Children's Visitation Program which is a joint effort by volunteers and institutional staff to provide constructive visits between the female prisoner and her child. This program is separate from regular visits.

For leisure time, there is a library, gymnassium (however at present it is used as a housing unit because of lack of bed spaces in other units), and the services of two full-time

recreation directors with activities supplemented by the Michigan University Project Community and Ann Arbor Parks and Recreation, and by other local colleges.

The facility has three major responsibilities which are

1. to protect "the citizens of Michigan by keeping all prisoners secure within an institution;

2. to provide programs for prisoner self-improvement;

3. to provide a safe and clean environment." (HVWF Prisoner Guidebook p. 1)

The activities that take place within HVWF are described in an inmate guidebook, which is the facility's prisoner guidebook. The guidebook highlights some major activities and programs which the inmates can take advantage of, it also explains rules and principles of the facility.

As of December 1988 the institution had a total of 264 employees, including 129 minority employees, 148 correctional officers, including 99 female correctional officers, 98 minority correctional officers and 2 ex-offender officers. (Since 1988 the number of employees has increased.) Therefore as in all institutions, HVWF correctional officers are outnumbered by inmates.

Research Population

The research population consisted of the female inmates at Huron Valley Women's Facility. This population was selected because it provided wide differences in terms of

demographic variables which were critical for the present study. Within this population were female inmates with mental illness problems. By comparing the general inmate population's characteristics with the characteristics of the female inmates within the CCU and the PE, the researcher was able to identify inmates who were likely to need psychiatric treatment and also identified those inmates who were likely to volunteer for such treatment vis-a-vis those who though considered (by the treatment team) to need services, would not volunteer for treatment.

To get information for this project, the following steps took place.

Research Sample

The research sample consisted of 100 female inmates who were subgrouped into five samples. The subsamples included the following:

1. Ten inmates were currently serving time in the CCU. Two inmates from this population had been in this unit before.
2. Eighteen inmates who were ex-CCU patients. Some of these inmates were serving time in then PE Unit, and some were in the GP units.
3. Five inmates who had volunteered for treatment but were not admitted in the CCU.
4. Twelve inmates considered to need inpatient

psychiatric services by staff members but who refuse inpatient treatment.

5. Fifty five inmates from the general inmate population who were neither in unit 3 nor treated for mental problems in the insitution.

Before the interviews, the inmates had to agree to participate in the study by signing the consent form. Of the eleven inmates in the Chronic Care Unit only one refused to be interviewed. With the signed consent for releasing medical and institutional records to this researcher (by sampled inmates), this researcher was able to review their records after the interviews to check on the validity of the information provided (see Appendix D). Procedures which pertained to the inmates' daily activities were also reviewed to determine whether there were certain daily routine activities which were not appealing to other inmates not in the unit which therefore would discourage them from volunteering for treatment.

The scale used to measure the institutional environment where inmates were currently serving time was borrowed from Moos (1975). This scale was chosen because Moos (1975) mentioned it to be useful in predicting which inmates will not participate in correctional programs. To measure the reliability of the scale a reliability test for all sub environment scales was done. This resulted in certain items

being omitted from the final quantitative analysis of the institutional environment.

The inmates who were eliminated from the PE unit were those few who were there for medical reasons rather than psychiatric reasons. Out of 26 inmates in the PE unit twenty three inmates agreed to be interviewed.

The psychiatrist and the clinical nurse helped the researcher identify inmates who had volunteered for treatment but were refused admission to the mental health unit because they did not qualify for the inpatient treatment, and they also helped with the identification of the inmates that, according to their professional judgement, needed inpatient treatment but who refused to volunteer. Most inmates who failed to volunteer were in the PE unit and several in Unit 6 which is the segregation unit for the inmates considered violent, and dangerous to other inmates and staff members.

Inmates who were in Unit 3 CCU but who had been released to the general population were also interviewed to assess how they were treated by other inmates and how they in turn reacted to other inmates after their release from the unit. These inmates were selected from the institutional list. All those who were still in the institution were interviewed. Purposive samples from all units were selected from the institutional list, and one hundred inmates who were willing to participate in the study were interviewed.

Inmates from the general population who were excluded from the study were those who had been in prison for less than a month, and inmates who were still being classified because HVWF acts as a classification center for all Michigan incoming female offenders. These inmates were excluded because they might have been transferred to other institutions before the completion of the interviews. The inmates who had served less than a month were excluded because the researcher thought there might differ markedly from others in responses to the environmental scale since they might still had been confused and trying to adjust to their surroundings and prison environment or have not been subjected to similar experiences which other inmates had been subjected to.

Data Collection

This study used field research techniques to 1) describe the influences which encourage or discourage inmates to volunteer for psychiatric treatment (included here was the determination of the characteristics of the mentally ill inmates), and 2) to explain why some inmates volunteer for treatment while others do not.

Field research offers the advantage of probing social life in its natural habitat and is especially appropriate for studying attitudes and behaviors (Barbie, 1983). Interviews were thus conducted, for all subjects who consented, in the prison.

The interview format concentrated on soliciting information on the inmates' attitudes toward mental illness, their demographic characteristics, experiences which inmates may have had or observed which discouraged or encouraged them to volunteer for inpatient mental care, and on verifying the existence of depression and other mental illness in the various groups. Ten indepth interviews were also conducted to supplement data. The purpose of these was to solicit in depth information on the factors the inmates considered to influence them to volunteer or not to volunteer for CCU. Five staff members were also interviewed to gather information pertaining to their attitudes towards mental illness and CCU.

Interviews were conducted between eight in the morning and one in the afternoon. Each interview took between twenty minutes and forty minutes, except for the indepth interviews which took approximately an hour and a half. The interviews were conducted in different locations depending on the targeted population that day. For example all CCU subjects were interviewed in the unit. Inmates in PE were conducted in that unit. Interviews for the general population were conducted in the clinic.

The questions consisted of both open-ended and closed-ended items. Open-ended questions were used because they allowed the respondent to provide her answer to the question thus giving her an opportunity to express her feelings about the phenomenon being considered. Closed-ended questions on

the other hand were used to provide a greater uniformity of responses, and because they are easily processed. All interviews were conducted by the researcher. The questions for the ten inmate in depth interviews and five staff members were open ended. For the rest of the interviews, the researcher read questions to the subjects and recorded the answers on the interview format. The non-indepth interviews were conducted first. This was done so that the researcher could identify the extroverted inmates who later may provide more information on mental illness. Data was hand recorded.

All subjects were asked similar questions so that the researcher would be able to assess the attitudes of all inmates (including those in CCU and PE) interviewed toward mental illness (Appendix B). No personal identification of the interviewees were used and all responses were confidential. Questions focused on the objectives of the study. Participation in the study was completely voluntary.

Specific Research Objectives:

1. to investigate the relationship between negative stereotyping of mental illness and volunteering for psychiatric treatment.
2. to determine whether prior experience with hospitalization interferes with inmate volunteering.
3. to determine the characteristics of the people who are not mentally ill but who do volunteer for treatment.

4. to determine the characteristics of the mentally ill female inmates who do not volunteer for treatment or who refuse treatment.

Hypotheses

There are several research hypotheses generated from the literature review.

Hypothesis One:

Negative stereotypes of mental illness interfere with volunteering.

Hypothesis Two:

Prior experience with hospitalization results in negative attitudes towards self and mental illness and therefore stands in the way of volunteering.

Hypothesis Three

Inmate age is related to volunteering for the CCU

Hypothesis Four

Unit environment is an influence on volunteering.

Scales Used to Test the Hypotheses

In order to test the hypotheses mentioned above and to test the assumptions of the labeling theory, and answer research questions about the inmates who volunteer versus those who would not volunteer, and to determine which

predictors strongly predict in which category each inmate will fall in terms of the four subgroups studied, different scales were used.

I. Link's Social Distance Scale

To measure the social distance of female inmates from the mentally ill, Link's (1988) social distance scale was used. This scale was adjusted to accommodate inmates. It consisted of four items (see Appendix B). This scale was used because it consisted of the items this researcher considered to be important to measure social distance. Because Link (1988) did not mention the reliability of the items used, a reliability analysis of the items was done by this researcher.

II. Moos's Unit Environment Scale and Unit Perception Scale

Moos's (1975) scale to measure unit environment was used. This scale was used because Moos (1975) did the item analysis for all the items and had used the scale on several inmate populations, and found significant results. However this researcher also did the item analysis for those items used. Also Moos's perception scale was used to measure the inmate perception of the mental health unit. Item analysis was also done for all the items.

III. Golberg's Mental Health Scale

This scale was adopted because Golberg (1972) did the item analysis, and therefore provided limitations and advantages of his scale. He also tested the reliability of this scale by administering it to different patients and non patients and found that the results were comparable. Some adjustments were made in this scale. Instead of using Golberg's choices for responses, ordinal categories of choice were used i.e "strongly agree, agree, disagree, and strongly disagree. The item analysis was also done by this researcher.

For the full description of the above mentioned scales, see chapter VI.

Research Variables

Conceptual and Operational Definitions

This section gives the conceptual and operational definitions of the variables used (see an interview guide in Appendix B for a listing of items).

Mental illness: Mental illness refers to a substantial disorder of thought or mood which significantly impairs judgement, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. Consistent with the conclusion drawn from the review of the literature in Chapter 2, questions to indicate depression (Golberg 1972)

were used to indicate mental health. The use of this scale is based on the assumptions that females inmates are disproportionally overrepresented as patients of depression. However through doing the factor analysis, this researcher discovered that this scale did not only measure depression, but nervousness and the level of affection of inmates towards others.

Person needing psychiatric treatment: Mental Health staff were asked to indicate the mentally ill inmate following these guidelines:

1. inmates who have reported hearing voices;
2. inmates who frequently talk to themselves;
3. inmates with uncontrollable crying;
4. suicidal inmates;
5. inmates who do not get along with other inmates;
6. inmates incapable of making decisions about things;
7. inmates who feel they can not overcome their difficulties;
8. inmates who consider themselves worthless;
9. Unhappy inmates;
10. inmates easily distracted from what they are doing.

Therefore an inmate who is mentally ill is one a) who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure her/himself or another person, and who has engaged in an act or acts or made significant

threats that are substantially supportive of the expectation; b) a person who is mentally ill, and who as a result of that mental illness is unable to attend basic physical needs such as food, clothing, or shelter and this might do serious harm to self in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs; or c) a person who is mentally ill, whose judgement is so impaired that he/she is unable to understand the need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to self or others. (Definition taken from the Mental health Code). An inmate with all the above symptoms but who do not volunteer for treatment will be regarded as mentally ill in the eyes of the staff in this research.

Volunteer: A person who of her own accord without coercion from her friends and staff members seeks psychiatric treatment will be referred to as volunteering for treatment.

Hospitalization: It will refer to any ex-mental patient or mental patient who had been admitted to a psychiatric hospital in the free community or is admitted in the in-patient CCU within any correctional institution.

Negative stereotypes: will refer to the use of such words as "crazy", "lunatic", "violent", "worthless", "useless" and "not normal".

Labeling: To attach a name (i.e., to stigmatize) to an inmate's sickness or refering to the sick inmate as "crazy".

Methods used for Data Analysis

In analyzing data both qualitative and quantitative measures were used. Anecdotal responses were used for qualitative data analysis. As recommended by Schatzman and Strauss (1973), data were grouped according to events, classes and properties which characterize them. This categorization helped the researcher to link events with others. The descriptive statistics such as the mean, mode, and standard deviation were used to desrcibe the sample.

To analyze quantitative data obtained from the inmates and to measure the relationships between variables, Chi-square, a nonparametric inferential statistical test and a Contingency Coefficient were used. Usually chi-square test is used when research data are in the form of frequency counts and when the sample size is large. The Contingency Coefficient was used to determine the strength of association between categorical variables and because the Chi-square value is influenced by the sample size (i.e with a large sample a small difference between the independent and dependent variables may be statistically significant). After the scales were computed (i.e the scale to measure inmate social distance from the ex-CCU inmates, the scale to measure unit

environment, the scale to measure inmate perception of CCU, and the scale to measure inmate mental health), Anova and the t-test were used to compare the subgroup differences in means and to test whether inmates who volunteer were significantly different from those who do not volunteer.

The propability was $p < .05$ where the null hypothesis was rejected if the Chi-square (test statistic) was greater than its critical value at .05 alpha level. The probability for Anova was .05. A multivariate analysis was computed to determine which independent variables significantly predicted volunteering and the different subgroups in which each inmate would fall, when controlling for other independent variables.

Ethical Consideration

A major consideration for this study was obtaining the informed consent from the inmates themselves and the consent to authorize the researcher to review their medical and institutional records. A consent form (see Appendix C) describing the purpose of the study was read to the inmates. Those who could read, read the consent form themselves after the researcher had explained the study and its purpose to them, and what was expected of them. The consent form was used to ascertain that the purpose of the study was understood and that participation in the study by inmates was strictly

voluntary and was done without any coercion from the researcher and the prison staff members.

The second ethical and legal consideration involved using inmates' medical and institutional records to validate the information given during interviews. This was done by asking the respondents whether they had any objections to letting the researcher review their medical and insitutional records. If the inmate had no objection, she signed the Authorization to Release Medical Records Form (see Appendix D). The third ethical issue involved the protection of respondents against any physical and psychological harm. For example, respondents were not subjected to any verbal or physical abuse if they did not answer the question asked (i.e., when they gave answers to unrelated questions). When this situation occurred the researcher tried to listen patiently to whatever the respondent was saying and when the respondent seemed to have finished talking, the researcher would ask the question again.

The fourth consideration concerned the protection of the respondents' identity. This was done by not using any identification on the interview forms which could link the respondent to the answers. Finally the respondents were told that if they wanted the results of the study they should request that in writting so that one could be mailed to them. They were also promised that a copy of the bound finished study would be sent to the institution's library for their use.

CHAPTER IV

DESCRIPTION OF UNIT THREE

Introduction

Unit three is located between the Activities Building and Unit nine. It is the first building on the left you see after leaving the Administration Building. The unit is divided into two subunits. One subunit is called the Protective Environment unit (PE) and the other is known as the Comprehensive (or Chronic) Care Unit (CCU). These units are separated from each other by a wall. However there is a door which leads from one unit to the other. This door is always locked. It is only opened by staff members when they have to go from unit to unit or when they let the PE inmates go to the dining room which is located in the CCU section.

The structure of the units is very similar. CCU has about 20 beds but only 10 were occupied at the time of this interview. Some of the vacant cells are used as offices basically because there are few inmates in the unit, and one as a music room where only one inmate is allowed to be in the room at a time. This is done because of the space of this room and for security reasons. In this room there is a big stereo which can play cassettes. To listen to the music, inmates have to use earphones so that other people in the unit can not be disturbed. Exiting through the door on the right when

facing North is the dining room which unit three inmates share with some of unit nine inmates. On the right of the dining hall when facing East across it, is the Day Room which has a big screen Television set hanging nicely on the wall in view of all inmates in the room. This room has glass walls so that the staff members can have a full view of the inmates within it. It can hold up to fifty inmates at the same time. Inmates also use this room as the ironing room or for doing their hair. The floor in this room is shining, it is like nobody ever walks on it. It has colorful comfortable armchairs. Watching inmates in this room make them seem different than inmates in other parts of the prison. They differ in that they look happy or they giggle a lot in this room, they play cards and joke with one another. The unit also has two bathrooms on each corridor. There is also one bathroom for staff members. Only one inmate is allowed to use a bathroom at a time. During count hours since all inmates at this time are locked in their cells, inmates have to ask to go use a bathroom. Mostly when the count is on inmates in this unit are refused permission to use bathrooms at least until the count is cleared.

The PE unit has the same structure as the CCU. The difference is that the PE has many more inmates than CCU, i.e., all of its twenty six cells are occupied by inmates. Also the lighting in the units seems to be different. In CCU the lights are dim which therefore makes the unit darker.

In the PE, lights are bright therefore making the unit brighter than the CCU. The CCU is more quiet than PE. Inmates in the PE are always talking to one another and they seem to be lively, whereas inmates in the CCU seem to keep to themselves a lot. At least during the period this researcher was in the unit (about four weeks) she rarely observed any verbal exchange between residents. The only time she observed verbal exchange was when one inmate was delivering laundry to one inmate, and the other inmate whose laundry was being delivered was expressing her discontent with the way the other inmate was handling her clothes. Inmates in CCU also seem to be in no hurry to go anywhere, meaning that almost all of them walk very slowly with their faces looking gloomy. Of course this should be expected because most of them take psychometric drugs which have different side effects. When one staff member was asked whether the inmates in this unit are always like this, she said, "No, usually after working hours (3:45) they are very lively they even run around because at that time they can leave their cells and go to the day room to be with their friends."

Inmates who refuse to work or to go to school are locked in their cells between 8:30 am and 3:45 pm, and allowed to leave their cells only for the bathroom, meals and medication. Also inmates in CCU are always locked up when other inmates from other units (e.g. PE and unit nine) come for their meals. This, according to one staff member, is done so that inmates

in CCU will not be distracted or hear any negative remarks from other inmates which may make them seek discharge from the unit.

History of the Unit

Unit three was initially used as a custody unit just like any other unit at HVWF. At that time unit three was known as the PE unit because at that time there was no CCU. All inmates who had some mental illness, whether severe or not, whether mentally retarded or bordeline, or who needed any medication were in this unit. The staff members who were working in this unit were custodial staff, not Correctional Medical Aides (CMAs) or clinical and psychiatric staff members. CCU came about as a result of the U.S.A. v. The State of Michigan (see Chapter I). Staff members in HVWF were not informed that the institution itself was also supposed to have an inpatient mental health care unit. According to one of the staff members the institution was only given one day's notice that an inpatient mental health care unit was needed and that it had to open the following day. The unit therefore was opened in December of 1986. At that time the unit was run by the custody staff. Though they were CMAs, they were required to perform custody functions rather than what they were trained for. Health care personnel had no say about the running of the unit and had no say about who qualifies to be a correctional medical aide. Only the Department of

Corrections Administration located in Lansing had a say. As a result, any correctional officer could be trained as a CMA. Most of these correctional officers trained had no psychiatric background nor interest. Their training was limited to forty hours classroom training in basic psychology and twenty four hours on the job with supervision from the nurse. However at that time there were only two nurses, suggesting that supervision of these CMAs was limited.

CCU begun functioning under the psychiatric health direction in April 1987. When the Psychiatric Health Personnel took over, a formal CMA training curriculum was established.

The current CMA training Curriculum can be divided into three components, which include the following:

Part I Basic Psychiatric Course ..... 4 weeks

Part II Advanced Psychiatric Course...3 weeks

Part III Annual CMA Training Update...1-3 days

Curriculum Topics were:

Part I - Basic Psychiatric Course (4 weeks)

Module I : Basic Introduction to MDOC Mental Health Licensure and Accreditation Process

Module II : Roles and Responsibilities of the CMA

Module III: Patient Rights and Restrictions Documentation

Module IV : Confidentiality

Module V : Environment/Milieu

Module VI : Basic Intervention and Communication Skills

Module VII: Nursing Procedures
Infection Control/Universal Precautions

Part II - Advanced Psychiatric Training (3 weeks)

Module VIII: Non Physical/Physical Intervention Skills

Module IX : Medication/Side Effects

Module X : Psychodynamics of Mental Health/Illness

Module XI : Therapeutic Relatiotionships

Module XII : Group Dynamics

Module XIII: Treatment Plan Process
Prisoner Disciplinary Process

Part III - Annual Training Update (1-3 days)

A. Non Physical/Physical Intervention Skills Update four hours

B. Reinforcement/Modification of Mental Health Issues.

After training, the CMAs must be working all the time (alternating in shifts). Presently there are fifteen CMAs who work on three shifts. There are six CMAs who work during the day (not all six CMAs are present during the day, and each shift can not have less than two CMAs). There are five CMAs who work during the afternoon shift, and there are four who work during the night shift (CCU is a 24 hour inpatient care unit).

There are two certified nurses (One level II and the other level IV) who work during days and the other two work during the night shift.

When the unit started functioning, inmates could not leave their cells without staff escorts. They were also not supposed to talk to other inmates not in the unit i.e they were totally isolated from other inmates. This has changed. Inmates who are not in Status C or B within the unit can leave their cells without staff escorts.

CCU Prisoner Status Levels

The Procedure OP-HVH 80.01 outlines the prisoner status within the CCU. The objective of this procedure is to provide a uniform procedure for determining the status level of CCU prisoners based on their psychological condition and adjustment within the unit.

Status Levels:

"C" Status Level : Inmates in this status are those who have impaired reality contact and/or need supervision and high structure. Inmates in this status are not allowed to attend off-unit activities. They are only allowed to be in the CCU yard. (Each unit has its own yard and then there is a general prisoner yard where all inmates can go). These inmates are escorted to and from visits by CCU staff.

"B" Satus Level : Inmates in this Status level are those who are in a partial state of remission and who possess only limited responsibility for their behavior, thus requiring some structure and supervision. These inmates can be escorted to general inmate population yard. They are escorted by CCU staff to and from

visits. They are allowed to attend off-unit activities, but must be escorted by the CCU staff.

"A" Status Level : These inmates are chronically ill but able to function independently and assume responsibility for their behavior. However, they must not be an escape risk and their present illness must be in a state of substantial remission. These inmates are allowed to leave the unit unescorted. They can go to the general population yard and to visits unescorted. They can attend group activities with PE inmates at the discretion of the treatment team. They are allowed to have a personal room key.

All newly admitted inmates to CCU are considered "C" status. The levels and priveleges of each level are determined by and at the discretion of the Treatment Team (TT). The treatment team can modify the established categories and the privileges to fit the individual treatment plan. Following are chronological duties of people responsible for the functioning of the CCU.

TT 1. reviews inmate health records

2. evaluates inmate prisoner mental status

3. determines inmate status level based on the inmate's psychiatric condition

4. informs CCU staff of prisoner Status Level

5. records the inmate's level in the treatment plan file

Therapist/Case Manager: 6. discuss with the inmate any behavior indicative of an inability to accept responsibilities of assigned level or any behavior indicative of the ability to handle the responsibilities of a level higher than the one the inmate is currently assigned.

Treatment Team: 7. evaluates the inmate's progress and status on an ongoing basis at least weekly. Makes necessary changes in the status level

8. notifies the prisoner of any status level changes

9. notifies CCU staff of any status level changes

10. records status level changes on the treatment plan

Case Manager: 11. delivers weekly and updated status level reports to the control center (see Appendix I for admission review and continued stay review of CCU patients).

Psychological Testing Referrals Procedure

The objective of this procedure is to establish an efficient method of referring and completing psychological testing evaluations for CCU inmates.

The psychologist, as part of the intake procedure, screens all incoming inmates for possible referral to the psychiatrist using the following scales:

1. M.M.P.I.
2. Bender Gestalt
3. Draw a person
4. Incomplete sentences
5. SAT-STEA - ec. Screening and Level Tests.

These tests are reviewed by the psychologist in the Reception and Guidance Center (R & G C). If additional testing is necessary, the R & G C psychologist may administer additional tests, such as Weschler Scale, or Rorschach Scale. Inmates who voluntarily admit themselves to the CCU may at times, need additional testing. When the CCU TT feels additional psychological testing is required, a referral to the psychologist is made.

Who	Does What
Psychiatrist	1. determines that a CCU prisoner is in need of a psychological evaluation.
	2. makes a referral in the form of a memorandum to one of the HVW psychologist.
Psychologist	3. schedules session and completes the psychological testing.
	4. scores and interpretes test results.

	5. reports findings to the psychiatrist.
Psychiatrist	6. reports findings to the treatment Team
TT	7. incorporates findings of the evaluation in the prisoner's treatment plan.
CCU nursing staff	8. files testing results in prisoner's health record.

An inmate who has been determined by the TT to be mentally ill and in need of specialized intensive treatment can be transferred voluntarily or involuntarily with the court order to the Center for Forensic Psychiatry which is operated by Department of Mental Health not MDOC (see Appendix E).

Admission to CCU

Admission to CCU is voluntary, i.e. the inmate has to give voluntary consent to being admitted to the unit. Upon admission to the unit, inmates are suppose to be introduced to the CCU staff, given information related to individual rights and responsibilities, and given a tour of the unit. This researcher did observe one inmate who was newly admitted to the unit who was not being introduced to the staff members nor was she given information pertaining to her rights and responsibilities. On arrival this inmate was escorted by one of the CCU staff members and was taken by this CMA straight to her room. She stayed there until lunch time.

A nurse has to interview the newly admitted inmate to the unit about her previous health history. A complete physical review and necessary blood and urine workup are conducted shortly after admission to the unit by the health care staff. Within two weeks of the inmate's admission to the unit a formal introduction to the CCU TT is held. The Treatment Team includes the following:

1. The Psychiatrist: who is a doctor in charge of the inmate's psychiatric treatment.
2. Nurses: who are responsible for initial health assessments, passing medications, counseling and day to day activity of the CCU.
3. Correctional Medical Aides (CMAs): who are unit officers with special health care training.
4. Case Manager: who acts as the Residence Unit Manager (RUM).
5. Activity Therapist: Conducts planned individual and group activities involving art, music, drama and recreational activities.
6. Therapists: These include a clinical nurse specialist, psychologist, social worker who are all available for individual and group psychotherapy.

CCU Rules and Regulations

CCU has rules and regulations which are similar to the rules of other units perhaps with slight moderation.

The following are rules and regulations in the CCU taken from the MDOC Inmate Rules and Regulations Bulletin:

The following areas are out of bounds:

1. Any corridor or wing other than the one on which the inmate lives.
2. Laundry, study, recreation, and dining room except during scheduled hours.
3. Loitering on window ledges, unit doorsways, corridors or CMA's desk.
4. No prisoner is allowed to sit in the CMA's chair or CMA's desk.
5. The prisoners are not allowed to enter other prisoners' rooms.
6. CCU offices are out of bounds unless prior approval by staff members is given before entering.

Recreation Room and Study Room Rules

1. No screaming, dancing, horseplay, etc., allowed.
2. Only drinks are permitted in these rooms but not food.
3. Radios and tape players with earphones can be used in the recreation room.
4. Furniture is to be arranged so that prisoners are in full view of staff. No sitting in window ledges or feet on radiators.
5. Inmates are not allowed to lie down on the couch, or any body contact.

6. Prisoners must not wear any of the following in these rooms, robes, lounge ware and pajamas.
7. Lights must remain on until 10:20.

Telephones

1. Telephone hours Monday through Friday are:

   3:30 p.m. - 6.00 p.m.

   Saturday and Sunday & holidays are:

   8:00 a.m. 6:00 p.m.

2. When the count is on no calls can be placed. Calls in progress should end when the count is on.
3. Only one person to a phone call, no sharing of conversations.
4. There is a ten minute limit on calls when others are waiting to use the phone. When no one is waiting to use the phone, conversations may be extended to no longer than fifteen minutes.

General Regulations

CCU prisoners are not allowed to have personal sewing supplies nor allowed to keep medication of any type in their rooms. All inmates are not allowed to leave their units without an I.D card plus a pass from staff or detail. All prisoners classified as unemployable are confined to their rooms except for meals and bathroom privileges and unit therapeutic activities from 8:30 a.m. to 3:30 p.m. Prisoners

who are unassigned due to irresponsible behavior, poor performance or disciplinary reasons are confined to their rooms as unemployable (For more rules and regulations for CCU inmates see Appendix F).

The treatment team reviews misconducts by CCU inmates. The team also decides whether the inmate should be charged with the major rule violation or minor rule violation by completing the form on Appendix G. Though all rule violations fully apply on these inmates like those in other units, staff members in CCU are more lenient and tolerant than staff members in other units. They write up a misconduct ticket only if it is the major rule violation which cannot be ignored (this is informal).

Inmates in CCU can sign out anytime if they want to (i.e they can demand to be discharged from the unit anytime) even if they are not ready for GP (general population). However, staff members in this unit can sometimes use manipulative mechanisms to discourage those who want to be discharged from the unit even if not ready. They use such language as this: "we can discharge you from this unit but we do not know in which unit the classification center will put you in. It may be unit 6 (a segregation unit for the violent inmates) or any other unit you may not want to be in". According to one of the staff members this always works because most inmates would want to be released from the unit to be with their friends in other units. However, if they will not be discharged to the

unit with their friends they reconsider staying in at least until they can function in the general population units. However, that does not mean that if they stay in the unit until they get better they will be transferred to the units they want to be. Usually it depends on their custody security level. For example, there are levels 1, II, III, and IV. These levels are determined by the confinement level plus management level (see Appendix H).

Admission Axis for CCU Patients from April 1987 to April 1990:

The following section provides the pattern of diagnoses of CCU patients since April 1987 to April 1990. This section is included to show what type of mental illness female inmates have been diagnosed to be suffering from.

LOS[1]	Admis. Axis[2]
under 50 days	1 None
	II "Mixed Personality D/O with severe explosive and manipulative behavior
100-199 days	I Dysthymic D/O II Borderline Personality D/O with passive-aggressive feature, frequent self mutilating behavior and suicidal gestures, substance abuse and frquent manipulative behavior
200-299 days	I Organic Personality D/O with poor pulse control and severe temperamental

[1]Length of stay in the Unit; ranges are given to protect confidentiality.

[2]Admission Axis.

	behavior without psychosis. II Explosive Personality D/O.
under 50 days	I Schizoaffevtive D/O, recurrent II Antisocial Personality D/O with atypical psychotic episodes
100-199 days	I Questionable Schizophrenia, Catatonic type, withdrawn, chronic II Schizotypical Personality
100-199 days	I Atypical Affective D/O Possible borderline or mild Retardation II Boderline Personality
50-99 days	I Atypical Psychosis, Schizophrenia, chronic undifferentiated type, II Schizoid Personality D/O
over 300 days	Schizoaffective D/O with postpartum exacerbation II Schizoid Personality D/O
50-99 days	I Agoraphobia without current panic D/O, alcohol abuse, chronic.
over 300 days	I Atypical Psychosis vs. manipulation II Mental retardation, mild
50-99 days	I Adolescent Conduct D/O Socialized aggressive, substance abuse, multiple, Possible organic Personality Syndrome with poor impulse control II Potential of Antisocial Personality Trait.
50-99 days	I Borderline intellectual functioning with Conduct D/O. II Immature Personality, severe with poor impulse control.
over 300 days	I Schizophrenia, undifferentiated type, chronic substance abuse
50-99 days	I Hallucinosis, substance abuse. II Personality D/O
100-199 days	I Organic Personality syndrome. II Antisocial Personality D/O
under 50 days	I Schizophrenia, Paranoid

	type, chronic with acute exacerbation. II Antisocial Personality D/O.
over 300 days	I Mental retardation, mild with oppositional behavior D/O with recurrent major depression associated with auditory hallucination of derogatory comments. II Personality D/O, passive aggressive type
200-299 days	I Schizoaffective D/O II Personalty D/O with explosive features.
100-199 days	I Schizoaffective D/O, History of chronic alcohol abuse. II Personality D/O with dependent tendency.
over 300 days	I Bipolar D/O II Personality D/O
under 50 days	I Schizoaffective D/O
200-299 days	I An episode of paranoid psychosis, polysubastance abuse II Personality D/O with antisocial features.
under 50 days	I Organic Personality D/O mild mental retardation. II Adult Antisocial behaviors.
over 300 days	I Bipolar D/O Sociopathic Pesornality D/O
over 300 days	I Schizophrenia, undifferentiated, chronic
over 300 days	I Schizophrenia undifferentiated
under 50 days	I Schizoaffective D/O II Explosive Personality.
over 300 days	I Schizophrenia, undifferentiated, chronic
over 300 days	I Schizophreina, undifferentiated II Antisocial Personality D/O
100-199 days	I Atypical Bipolar D/O
100-199 days	I Major depression, Adjustment behavior with depressive mood II Passive Aggressive Personality.
100-199 days	I Alcoholic Hallucinations II Personality D/O

over 300 days	I Schizophrenia, Paranoid type, chronic
100-199 days	I Atypical Psychosis II Schizotypical Personality D/O.
100-199 days	I Atypical Depression II Borderline Personality, severe.
over 500 days	I Schizophrenia, undifferentiated type, chronic with acute psychotic decompensation
over 300 days	I Schizoaffective D/O, Bipolar type with the history of multiple substance abuse
50-100 days	I Atypical psychosis & recurrent, multiple substance abuse
50-100 days	II Borderline personality D/O, severe.
50-100 days	I Schizoaffective D/O vs. Schizophrenia.

To be noted in the above admission data is that some inmates who were discharged from this unit usually regress and come back to the unit. However, this researcher omitted the data where the same individual was readmitted. Contrary to the literature that most women suffer from manic depression, the data presented above shows that most inmates were diagnozed as having schizophrenia, and personality disorders. Only two persons in this data were diagnozed as having severe depression. Most of the inmates in this unit have a history of substance abuse. The inmates dates of birth ranged from 1962 to 1944 with the 1960s overrepresenting the year of birth. Some of the inmates who were discharged from this unit when the admission list was compiled, are back in the unit again. Most inmates discharged from this unit are

those who seek discharge or who violated the major institutional rules, and thus they had to be sent to unit 6 which is a segregation unit for the inmates considered too violent and dangerous to other inmates and staff members. Most of the inmates discharged from the mental health unit are unable to adjust in the general population and they regress and if not, they violate major institutional rules and end up in segregation. This implies that inmates discharged from the mental health unit need more time to adjust to the non mental health units so that they will be able to relate to other inmates and staff members without violating institutional rules.

The psychiatrist decides where the inmate from CCU should be discharged to, the general population or to the PE.

Protective Environment Unit

According to procedure number OP-HVW 42.02, the objective of the PE unit is to provide a supportive specialized transitional housing environment for female prisoners who are unable to be managed in the general population without special support but who do not need inpatient care. Therefore the PE consist of the inmates who have been diagnosed as having mental illness but currently in remission or which has been stabilized, and those inmates who have been identified as having "serious impaired adaptive behavior deficits."

The PE is considered to be a general population unit which differs from other units in that it houses special inmates who need specialized programs which are supposed to assist them in their reintegration with other inmates. The PE facilitates the provision of therapeutic programming which includes individual and group counseling and therapy, medication, activity, occupational and recreational therapy, and assignments such as work, and school. The PE staff consist of a combination of Bureau of Correctional Facility (BCF) and Bureau of Health Care (BHC) employees. Basically, the treatment team that functions within CCU also functions in the PE. The difference is that CCU has a licensed RN nurse (Level IV) who is in charge of the unit, and the PE has a counselor as the Assistant Residence Unit Manager (ARUM) in charge. The Shift Commander visits the PE daily, and these visits are recorded in the unit log book. Anyone not assigned to this unit must have the prior approval of the Shift Commander or higher authority to enter the unit. All doors leading into the unit are kept locked. Prisoners assigned to this unit eat their meals in the dining room and visit during the visiting hours like all other inmates in the institution. In-unit recreation is available according to a schedule developed by the ARUM and is similar to that available in the general population.

Admissions and Group Classifications of PE Inmates

I Admissions:

Prisoners admitted to the PE must first be accepted by the PE psychiatrist (who is the psychiatrist for CCU inmates too), and when necessary, have the approval of the Assistant Deputy Director, for the Bureau of Correctional Facilities (BCF). Incoming inmates who are identified by the psychologist as requiring PE are sent directly to it from the Reception Center (inmates do not have to volunteer for this unit). Inmates are transferred to PE in accordance with PD-BCF-42.03, which is the procedure for the treatment of the mentally ill and mentally retarded offenders. Inmates can also be transferred to the PE by order of the psychiatrist or placed temporarily by the physician-on-call with approval for placement by the Assistant Deputy Warden-Housing. Within two business days following admission, the inmate is interviewed by the Treatment Team (TT). At the end of the interview, the TT develops a written treatment plan and submit it to the psychiatrist for approval within ten business days. Following the approval, the ARUM (Assistant Resident Unit Manager) is responsible for coordinating the implementation of the plan. The inmate's treatment plan may only be altered with the approval of the supervising psychiatrist.

II Group Classification:

For the purpose of program identification and implementation, inmates in this unit are assigned to either Group I or Group II Group I: Group I inmates are:

1) Those who have been identified to have severe impaired adaptative behavior deficits. Areas of deficits are self care, receptive/expressive language, learning, mobility, self-direction, capacity for independent living, economic self-suffiency, and personal/social responsibility.

2) Inmates who are unable to manage in the general population units without the special support available in the unit.

3) inmates in need of assistance to improve in life competence abilities and basic living and work skills.

4) inmates who will benefit from the specialized program of scheduled groups and activities designed to increase social integration, thus enabling release to nonspecialized housing units.

Group II: In this group are inmates:

1) who have been diagnosed with mental illness currently in remission or stabilized and continue under the care of the psychiatrist.

2) inmates who are unable to be managed in general population housing units without the special support available in this unit.

3) Inmates who are in need of special and/or increased monitoring of psychiatric and psychological symptoms and progress.

4) inmates who will benefit from enriched program of scheduled group and activities designed to assist them in the understanding of and adjustment to mental health.

It is important to realise the distinction between these two groups is only on paper. When this researcher asked the ARUM to see the inmates who fall in group II she was told that there are no inmates in either group because the unit includes all kinds of inmates who really do not fit clearly in either group. This resulted in this researcher interviewing all inmates in the unit except the inmates who were there for medical reasons rather than psychiatric problems.

PE has a "Quiet Room". This room is used by inmates who are subject to moods and behavioral changes. These changes can range from high to low, from passive to aggressive. It is not unusual for an inmate in PE to hear voices, hallucinate, or exhibit immature and self defeating behaviors. When staff recognize the change in the inmate behavior such that she may require confinement to protect the troubled prisoner, other prisoners and/or staff, she
is placed in the confinement room, the "Quiet Room". This quiet room is furnished only with a mattress which limits movements and contacts for a temporary period of time. The

maximum hours an inmate can spend in this room is eight (PE Directives, 1990).

Inmate Discharge from the PE

Inmates can be discharged from this unit if they are unmanageable or no longer require the PE level of treatment and can mantain an acceptable level of functioning with mental health services provided by the outpatient treatment. If the inmate needs more intensive psychiatric care, she may be transferred to an acute psychiatric inpatient hospital, CCU, or to the Center for Forensic Psychiatry.

Inmate tranfers from the PE are initiated in two ways.

1) by the Security Classification Committee because of a change in security level
2) by Health Services because of a change in the inmate's abilities, mental status or for other medical reasons:

a. Inmates diagnosed as acutely mentally ill and who can not be treated in the PE.
b. Prisoners who are stabilized and can handle nonspecialized general population with the approval of the psychiatrist.
c. Inmates who have completed a consecutive 6 month placement in this unit (however most of the time reason number 3 is violated, i.e there are inmates who have been in PE ever since they came in prison

meaning that they have been in the unit for more than 6 consecutive months).

d. Prisoners requiring more extensive medical care services which can not be provided at the PE.

Again the TT recommends any discharge of the inmate to the psychiatrist.

Conclusion

Unit three is the unit where inmates who need specialized services are housed. However the rules which apply to other inmates also apply to inmates in this unit. When inmates from this unit violate major institutional rules they are subjected to discipline just like other inmates in the general population. The inmates from this unit who are not controllable can be transferred to unit 6 which is a segregation unit with a high security level. Inmates in the PE do not have to volunteer for the unit whereas to be committed in CCU inmates have to voluntarily seek admission. Most of the time decisions by inmates to volunteer for CCU are made because the staff members have somehow convinced the inmate to volunteer.

CHAPTER V

QUANTITATIVE ANALYSIS

This chapter presents the findings on the sample and inmate subgroup background information. The background information includes the following: race, sentence length, previous criminal records, age, marital status, type of crime committed, time served, educational level, units where time was being served at the time of the interview, socio-economic status, previous mental illness treatment, and whether or not they had children. The chapter also describes the scales used in the analysis, compares sample subgroups on possible predictors of volunteering for inpatient mental health treatment for the purpose of generating hypotheses, and it also compares those who would and would not volunteer in terms of the independent variables to provide an initial test of hypotheses about volunteering. Finally multivariate analysis is used to identify the predictors of volunteering after controlling for other independent variables.

There are two indicators of volunteering. The first indicator is the use of the four subgroups as identified by staff members. The second indicator is the answer to the question, "would you volunteer for CCU if you needed help?" It is recognized that both indicators have some problems, for example, the staff members may not have accurately defined the

subgroups, also an inmate's positive answer to the question on volunteering does not guarantee that that inmate would really volunteer for CCU. Therefore, the researcher compared subgroups as well as the volunteer and no volunteer groups. If the same independent variables predict both dependent variables, the researcher accumulates evidence to suggest valid predictors of volunteering versus not volunteering.

Description of the Sample

The sample is described below because the researcher relied on the institutional staff to identify inmates falling in three of the four groups described in the section on 'Description of the Subsamples'. Therefore all inmates who were identified by staff members as falling in the three groups who consented were interviewed. Inmates in the inmate general population who were not candidates for the in-patient psychiatric care unit were selected non randomly from the institutional list. Only those inmates consenting were interviewed. Because of selecting the sample this way, inmates interviewed in comparason with the Michigan's female inmates were slightly different in certain characteristics. For example, the sample consisted of somewhat more educated inmates, in that the majority of the inmates in the sample had a high school diploma or its equivalent (GED) and some years in college. The sample also overrepresented nonwhite inmates.

Demographic Variables

Race: There were one hundred inmates interviewed. Thirty eight were white, fifty six were black, four were American Indians and two were Mexican-American. Race was recoded as "white" and "nonwhite" combining the four American-Indian and two Mexican-American inmates with fifty six black inmates.

Age: The minimum age was 19 and maximum age 47. The average age was 31.

Religion: Most inmates in the sample were Baptist (46% or 46). Nineteen inmates were Catholic, 2 were Moslem, 19 were Protestant, 6 were either Jewish or Jehovah Witness (born again), only 8 had no specific religion.

Marital Status and Children

Of the one hundred inmates interviewed, seven were married, thirty six divorced, fourty six never married, eight widowed, and three separated. For the purpose of analyzing data, divorced and separated categories were collapsed and married and widowed were combined thus forming three categories: divorced, never married, and married. Though more than fifty percent of the inmates reported being single (never married), the majority had children. This is consistant with the literature (Figuierra-McDonough 1978) that most of Michigan's female inmates are single i.e never married yet more than half have children.

Education and Work History

There was only one inmate who had a seventh grade or less education, 5 had completed the eigth grade, 9 the 9th grade, 6 the 10th grade, 2 the 11th grade, 34 the 12th grade, 14 had a GED, 16 had some college, and three had no education at all. The level of education for the sample shows that the majority of the female inmates interviewed had a high school diploma. The nine categories were collapsed to four categories (see table 2 under level of education). The three inmates with no education could read and write and they were in the school program.

Most inmates (71%) versus 29% were not employed at the time of their arrest. The majority (38%) had their major source of income from the wage of another person, and only 15% had their own wages as the the major source of income. Thirty two percent were on welfare and fifteen percent were on Social Security Income. For the few who were employed before incarceration, the majority worked as waitresses and clerks earning minimum wages.

Prior Record and Type of Crime

There were 51 inmates with previous criminal records and 49 with no previous records. There were fifty three inmates convicted for committing violent crimes, and fourty seven for nonviolent crimes. The violent crimes category consisted of the crimes such as the following: armed robbery, assault with

the intent to do grivious bodily harm, murder, and arson. The nonviolent crime category included crimes of child sexual abuse, dealing and possession of drugs, larceny, breaking and entering, uttering and publishing, and driving under the influence of alcohol. The largest number of inmates were serving time for murder.

Sentence Length and Time Served

There were eight inmates serving time between 12 and 24 months, 11 between 25 and 36 months, 53 were serving more than 36 months and 28 were serving life. The sentence length categories were collapsed to 3 categories combining "between 12 and 24 months" with between 25 and 36 months".

Time already served: Twelve inmates had served less than 6 months, 22 had served more than 6 months but less than 12 months, 32 had served served more than twelve months but less than 36 months, and 34 had served more than 36 months.

Type of Unit

There are 8 units at Huron Valley Women's Facility. Of the 100 inmates interviewed, 11 were serving time in Unit 1, 13 in Unit 2, 10 in Unit three CCU, 23 in Unit three PE, 11 in Unit 8, 9 in Unit 6, 12 in Unit 9, and 11 in the Gym, which was used as a dormatory due to overcrowding. In order to be able to analyze data, these 8 units were collapsed into three categories according to the security level of each unit.

Inmates who were serving time in units 1, 2, 6, and 8 were combined to the unit for closed custody, units three CCU and PE were combined to the units for the Mental Health, and unit 9 and the gym were collapsed to the minimum custody unit.

Conclusion

The sample consisted of the inmates who were generally nonwhite, generally educated, had children, were not employed at the time of imprisonment. Their main source of income was the wage of another. They had committed crimes 'reserved' for males (e.g murder, armed robbery, etc.). They were serving longer sentences than typical female inmates. The inmates in this sample did not differ very much from each except in terms of whether or not they considered themselves mentally ill. Inmates interviewed were similar to women in Michigan prisons in that:

(1) the majority had children though most of them were not married (or never married).

(2) At the time of imprisonment they were not employed and they depended on other peoples' wages.

(3) Most inmates were nonwhite.

They were different from Women in Michigan's prisons in that:

(1) They had a high school diploma or its equivalency and some college.

(2) They had committed violent crimes our society "reserved" for males.

(3) They were serving longer sentences.

Development of Scales

Social Distance Scale

There were four items which were designed to measure inmate social distance from the mentally ill inmates. This scale was borrowed from Link (1988). The four items used were modified to suit people serving time behind bars. The subjects had to use this key to respond to the items: definitely willing, not sure and definitely unwilling. The items were:

(1) How would you feel about sharing a cell with an ex-mental patient?

(2) How about as a worker i.e being on the same job?

(3) How would you feel about an ex mental patient as the caretaker of your children?

(4) Would you make friends with an ex-mental patient?

A reliability test for all the items was done. In order to increase the scale alpha from .51 to .66, item three was dropped.

Perception[1]

The scale used to measure inmates' perception of unit three (mental health unit) consisted of five items taken from Moos (1975). The scale key to items was strongly agree, no opinion, and strongly agree. The items were:

(1) Unit three is mostly for people who are violent.

(2) Unit three is for people whose behavior is bizarre.

(3) Unit three is for people who are dangerous.

(4) Unit three is for people with drug related problems.

(5) Unit three is for people who are unable to take care of themselves.

The factor analysis was done on all the items. The loadings for the one factor appear in Table 1 below.

Table 1

Loadings From a Factor Analysis to Determine Female Inmate Perception Of The Mental Health Unit (N=100)

	Perception
Dangerous	.83
Violent	.80
Bizarre behavior	.73
Unable to take care of themselves	.67

According to Golberg (1972) people who consider the units for mental illness to be violent, dangerous, and consisting

[1]The highest mean among groups indicates a more negative perception of the mental health unit.

of people whose behavior is strange, would tend to keep away from those units. According to Table 8 above, Moos's items loaded very high on perception. The results of the reliability test on the above items was .76 after the deletion of the fourth item.

The Unit Environment Scale

The environment scale for the unit where the inmate currently lived was borrowed from Moos (1975). The scale consisted of subscales: involvement, support, expressiveness, autonomy, and staff control.

Subscale: Involvement[2]

This unit environment subscale consisted of seven items. The items were:

(1) The residents are proud of this unit.

(2) Residents here really try to improve and get better.

(3) Residents in this unit care about each other.

(4) The unit has very few social activities.

(5) Very few things around here ever get people excited.

(6) Residents do not do anything around here unless the staff ask them to.

(7) This is a friendly unit.

A reliability test of all the items was done. Three items

[2]The higher the scale group mean the less of involvement the units have and the less involved are the subgroups.

were deleted in order to increase the alpha level. Items excluded were "the unit has very few social activities", "very few things around here ever get people excited", "and residents do not do anything unless the staff ask them to." The subscale alpha was .84.

Subscale: Support[3]

The subscale support consisted of four items namely:

(1) The staff help new residents get acquainted on the unit.

(2) Staff go out of their way to help residents.

(3) Staff are involve in resident activities.

(4) Counselors have little time to encourage residents.

A reliability test of all the four items was done leading to the deletion of two items: counselors have little time to encourage residents and the staff help new residents get acquainted. The scale alpha was .55.

Subscale Expressiveness[4]

Expressiveness as the unit environment subscale had seven items. The items were:

(1) Residents are encouraged to show their feelings.

---

[3]The higher the mean the lower the levels of support

[4] The lower the mean the higher is expressiveness

(2) Residents tend to hide their feelings from staff.

(3) Staff and residents say what they feel about each other.

(4) People say what they really think around here.

(5) Residents are careful about what they say when staff are around.

(6) It is hard to tell how residents are feeling on this unit.

(7) On this unit staff think it is a healthy thing to argue.

After running the reliability test for all the subscale items, four items were excluded. The excluded items were:

(2) Residents tend to hide their feelings from staff.

(5) Residents are careful about what they say when staff are around.

(6) It is hard to tell how residents are feeling on this unit

(7) On this unit staff think it is a healthy thing to argue.

The resulting alpha was .67.

Subscale: Autonomy[5]

This environment subscale consisted of five items. The items were:

---

[5]The lower the mean the higher is the level of autonomy

(1) The staff act on residents' suggestions.

(2) Residents are expected to take leadership on the unit.

(3) Residents have a say about what goes on here.

(4) The staff discourage criticism.

(5) Residents are encouraged to make their own decisions.

Three items computed the final autonomy subscale with the alpha .74. The items were:

(1) Staff act on inmates suggestions.

(2) Inmates take leadership in the unit.

(3) Inmates have a say about what goes on here.

Subscale: Staff Control

Subscale staff control consisted of five items, namely

(1) Once a schedule is arranged for a resident, she must follow it.

(2) Residents will be tranferred from this unit if they do not obey the rules.

(3) All decisions about the unit are made by the staff and not by the resident.

(4) Staff do not order residents around.

(5) The unit staff regularly check up on the residents.

Two items were finally used for computing this subscale. The items used were: "staff make decisions not inmates" and "staff do not order inmates around." The alpha for the subscale was .84.

The Mental Health Scale[6]

The mental health scale was borrowed from Golberg (1972). The scale consisted of 23 items. The items were:

I am able to concetrate on what ever I am doing.
I lose much sleep over worry.
I have been having resless and depressed nights.
I have been managing to keep myself busy and occupied.
I feel on the whole that I am doing things well
I am able to feel warmth and affection for those near to me.
I am finding it easy to get on with other people.
I feel cabable of making decisions about things.
I feel constantly under strain.
I feel I could not overcome my difficulties.
I feel life a struggle all the time.
I am able to enjoy my normal day-to-day activities.
I have been getting scared or panicky for no good reason.
I am able to face up to my problems.
I find everything getting on top of me.
I have been feeling unhappy and depressed.
I am losing confidence in myself.
I have been thinking of myself as a worthless person.
I have been feeling life is entirely hopeless.
I have been feeling hopeful about my own future.
I have been feeling reasonably happy all things considered.
I have been feeling nervous and strung up all the time.
I feel that life is not worth living.

The key used was: 1. strongly agree 2. agree 3. disagree 4. strongly disagree. A factor analysis on all items was done resulting in three factors which were: Depression, Nervousness, and Affection. The loadings of the factor analysis follows:

[6]the lower the subgroup mean the higher the level of depression, nervousness, and affection.

Table 2

Factor Loadings on Inmate Mental Health (n=100)

	Factors		
	1	2	3
	Depression	Nervousness	Affection
Worthless	0.88*		
Life hopeless	0.86*		
Life not worth living	0.78*		
Losing confidence	0.75*		
Overcome difficulties	0.68*		
Scared & panicky	0.65*	0.32	
Unhappy & depressed	0.63*	0.38	
Hopeful about future	-0.59*		
Face up to problems	-0.55*		
Make decisions	-0.54*		0.45
Reasonably Happy	-0.51*	-0.41	0.41
Nervous		0.78*	
Restless & dep. nights		0.68*	
Life a struggle		0.67*	
Enjoy day activities		-0.62*	
Lose sleep over worry		0.59*	
Getting on top of me	0.48	0.55*	
Under strain		0.53*	
Get along with people			0.79*
Affection for others			0.79*
Doing things well	-0.40		0.63*
Busy and occupied		-0.50	0.51*

* High loadings which characterise the factor.

The reliability tests for each factor were done. The items whose loadings were high (.50 or above) but negative on the factor were recoded. For depression, nine items (with .50 or above) were used to produce the alpha .88. For nervousness six items produced alpha .78. For affection the alpha was .78 with five items.

Description and Comparison of Subgroups

This section describes the background information for the sample subgroups. There were four subgroups which were: inmates who were chronic care unit candidates and who volunteered for the unit, chronic care unit candidates who did not volunteer for the unit, general population inmates who are not chronic care unit candidates, and lastly inmates who are not chronic care candidates but who volunteer for the unit. The following is the table showing the frequency of the inmates in each subgroup.

Table 3

Subgroups Frequencies

Subgroups	Frequency	Percentage
CCU Candidate/vol	28	28.0
CCU Candidate/notvol	12	12.0
GP Inmates not Candidate	55	55.0
NonCCU Candidate/vol	5	5.0
Total	100	100.0

According to Table 1 above the sample included few inmates (5% or 5) who were not CCU candidates but who

volunteered, twenty eight percent of the inmates were CCU candidates and did seek in-patient psychiatric treatment, and only 12% (12) inmates were CCU candidates who refused in-patient treatment. The small percentages in groups 2 and 4 resulted from staff inability to identify people in these groups.

I. Demographic Differences

Table 4 below summarizes subgroup differences on demographic variables.

Table 4

Subgroups' Demographic Variables

	CCUCan/vol		CCUCan/notvol		GPnotcan.		NonCCUcan/vol.	
Race	%	n	%	n	%	n	%	n
White	35.7	10	33.3	4	49.1	27	20.0	1
N.white	64.3	18	66.7	8	50.9	28	80.0	4
chi-square=2.95			df=3		significance=.399			
S.length								
12-36m	10.7	3	33.3	4	23.6	13	00.0	0
GT 36m	57.1	16	33.3	4	54.5	30	60.0	3
Life	32.1	9	33.3	4	21.8	12	40.0	2
chi-square=.83			df=6		significance=.442			

Prior Criminal Record								
Yes	42.9	12	58.3	7	50.9	28	80.0	4
No	57.1	16	41.7	5	49.1	27	20.0	1
chi-square=2.68			df=3		significance=.443			
Age								
19-27	17.8	5	33.3	4	40.0	22	60.0	3
28-34	42.9	12	41.7	5	41.8	23	20.0	1
35-47	39.3	11	25.0	3	18.2	10	20.0	1
chi-square=7.65			df=6		significance=.264			
Marital Status								
Div.	32.1	9	50.0	6	41.8	23	20.6	1
N.marr.	42.9	12	41.7	5	47.3	26	60.0	3
Marr.	42.9	7	8.3	1	10.9	6	20.0	1
chi-square=4.55			df=6		significance=.603			
Type of Crime								
Violent	75.0	21	58.3	7	40.0	22	60.0	3
N.viol.	25.0	7	41.7	5	60.0	33	40.0	2
chi-square=9.41			df=3		significance=.024			
Employed Before Incarceration?								
Yes	28.6	8	25.0	3	30.9	17	20.0	1
No	71.4	20	75.0	9	69.1	38	80.0	4
chi-square=.39			df=3		significance=.942			

Source of Income								
Wage of Another	32.1	9	33.3	4	45.5	25	00.0	0
My own Wages	21.4	6	8.3	1	12.7	7	20.0	1
Welf.	25.0	7	41.7	5	29.1	16	80.0	4
SS	21.4	6	16.7	2	12.7	7	00.0	0
chi-square=10.68		df=9			significance=.29			
Have Children?								
No	35.7	10	25.0	3	41.8	23	20.0	1
Yes	64.3	18	75.0	9	58.2	32	80.0	4
chi-square=6.29		df=3			significance=.391			
Educational Level								
< 8th	17.8	5	8.3	1	3.6	2	20.0	1
9-11	28.6	8	33.3	4	25.5	14	20.0	1
12th	28.6	8	41.7	5	32.7	18	60.0	3
Ged-Col	25.0	7	16.7	2	38.2	21	00.0	0
chi-square=10.36		df=9			significance=.322			

Note: Columns may not sum to 100% because of rounding.

From the above table (Table 4) it appears that the only significant difference between subgroups is in the type of crime. Namely, CCU candidates who volunteer are most likely

to have committed a violent crime and CCU candidates who do not volunteer are least likely to have committed a violent crime.

11. Hypothesized Predictors of Volunteering for In-Patient Psychiatric Treatment

General Attitudes and Experiences Related to Mental Health Treatment and Mental Health Patients

When the subgroups were compared on the hypothesized predictors of volunteering for mental health treament, they were not different on whether or not they could be friends with inmates from CCU, or on how they think other inmates would react to inmates discharged from the mental health unit. Table 3 below shows that although the difference was not significant at .05 level all subgroups tended to report that they would be negatively reacted to, for example, of the 28 inmates who were CCU candidates and had volunteered 21 mentioned negative reactions, 10 of the 12 inmates who were CCU candidates but did not volunteer mentioned negative reactions, 43 of the 55 general population inmates not CCU candidates mentioned negative reactions. Breaking this pattern, only 2 of the 5 non CCU candidates who volunteered mentioned negative reactions. The subgroups also did not differ in terms of how (if they were inmates from CCU) they would react to general population inmates after discharge from

the unit, in terms of whether or not they would inform prospective employers about previous mental illness, and in terms of whether or not they would tell anyone (friend, boyfriend) about their mental illness (i.e if any) (see Table 5 below).

Table 5

Non-Significant Differences Among the Subgroups

	CCUC/VOL		CCUC/NVOL		GPINCCUC		NCCUC/VOL	
be friends with exCCU inmate	%	n	%	n	%	n	%	n
Yes	89.3	25	100.0	12	92.7	51	100.0	5
No	10.7	3	00.0	0	7.3	4	00.0	0
chi-square=1.89	df=3		significance=.598					
ExCCU inmates' reaction to general inmate pop.								
Ignore them	25.0	7	75.0	9	41.8	23	20.0	1
Keep to myself	39.3	11	16.7	2	21.8	12	20.0	1
Socialize with them	35.7	10	8.3	1	36.4	20	60.0	3
chi-square=11.97	df=6		significance=.062					

Inform employer of prev. mental problems								
Yes	57.1	16	41.7	5	56.4	31	100.0	5
No	42.9	12	58.3	7	43.6	24	00.0	0
chi-square=4.93		df=3		significance=.177				
Inform boyfriend or friend								
Yes	67.9	19	83.3	10	87.3	48	100.0	5
No	32.1	9	16.7	2	12.7	7	00.0	0
chi-square=5.94		df=3		significance=.115				

Note: Columns may not sum to 100% because of rounding.

Though the subgroups did not differ significantly on how they thought inmates discharged from CCU react to general inmate population, the difference was near significance (.06). The majority of the inmates who were CCU candidates but did not volunteer (75% or 9) tended to report that exCCU inmates ignore the reactions of the general population toward them, whereas inmates who were not CCU candidates but who volunteered reported that the exCCU inmates keep to themselves.

The subgroups did differ in terms of whether or not they have had mental illness before coming to prison. As Table 6 shows below, a very high proportion of women who are

candidates but who did not volunteer (92% or 11), and those women who are CCU candidates (82% or 23) had previous mental health treatment. The findings suggest that inmates who are candidates for the inpatient mental health care unit, irrespective of whether they volunteer or do not volunteer, have been previously treated for mental illness.

Table 6

Inmate Subgroups By Previous Mental Illness Treatment

	CCUC/VOL		CCUC/NVOL		GPINCCUC		NCCUC/VOL	
	n	%	n	%	n	%	n	%
Yes	23	82.1	11	91.7	17	30.9	1	20.0
No	5	17.9	1	8.3	38	69.1	4	80.0
Total	28	100.0	12	100.0	55	100.0	5	100.0

chi-square=29.61 df=3 significance=.000

The subgroups differed also in terms of the units in which they were serving time. According to Table 7 below 80% (4) of the five inmates who were not CCU candidates but who volunteered were serving time in the closed custody[7] whereas

[7]this was a very small group therefore this interpretation must be viewed with caution.

only 36% (10) of the inmates who were CCU candidates who did volunteer were serving time in the closed custody unit. This findings suggest that the majority of the inmates who were not CCU candidates but who volunteered serve were serving their time in closed custody units. This may explain why these inmates volunteer for treatment (they are closely watched since they are in this level of custody, and their movements are monitored).

Table 7

Unit Where Time Was Being Served by Inmate CCU Status

	CCUC/VOL		CCUC/NVOL		GPINCCUC		NCCUC/VOL	
	n	%	n	%	n	%	n	%
Closed custody	10	35.7	6	50.0	24	43.6	4	80.0
Mental Health Unit	16	57.1	1	8.3	15	27.3	1	20.0
Minimum custody	2	7.1	5	41.7	16	29.1	0	00.0
Total	28	100.0	12	100.0	55	100.0	5	100.0

chi-square=16.89 df=6 significance=.01

Note: columns may not add up to 100% because of rounding.

Seventy four of the inmates interviewed had experiences that discouraged or encouraged them to volunteer for in-patient mental health care.

To determine whether the subgroups differed in terms of the type of experiences which discourage or encourage them from volunteering, the subgroups were crosstabulated by type of experiences. In this analysis, 26 inmates who had no experiences encouaraging or discouraging them from volunteering for the CCU were excluded. Table 8 below shows that all five inmates who were not CCU candidates who volunteered for the unit mentioned personal psychiatric problems as a type of experience encouraging them to volunteer. The majority (68% or 8) of inmates who were CCU candidates who did not volunteer cited having observed that the CCU inmate movements are restricted. Most (58% or 19) inmates in the general population mentioned labeling experiences as discouraging them from volunteering. The findings suggest that non CCU inmates who volunteer and CCU inmates who volunteer would cite personal psychiatric problems as experiences encouraging them to volunteer, whereas CCU candidates who did not volunteer will cite movement restrictions on CCU inmates as observed experiences discouraging them from volunteering. On the other hand, inmates in the general population not labeled mentally ill

will mention labeling experiences as discouraging them from volunteering.

Table 8

Type of Experience By Inmate Subgroups

	CCUC/VOL		CCUC/NVOL		GPINCCUC		NCCUC/VOL	
	n	%	n	%	n	%	n	%
Psychiatric problems	12	52.2	0	00.0	5	15.2	5	100.0
Movements restricted	1	4.3	8	66.7	9	27.3	0	00.0
Labeling experiences	10	43.5	4	33.3	19	57.6	0	00.0
Total	23	100.0	12	100.0	55	100.0	5	100.0

chi-square=35.4 df=6 significance=.000

Note: Columns may not add up to 100% because of rounding.

After developing the scale with alpha .66, to test whether the four subsamples differed in terms of the social distance, Oneway Anova was done. The subsamples means were not significantly different at the .01 level of significance.

This finding suggest that the subsamples were not different in terms of the social distance scale.

A breakdown of the sample by subgroups' level of perception indicates that the mean level of perception of the mental health unit by those who are not CCU candidates but volunteer is 4.40 (suggesting a more positive perception of the unit), for CCU candidates who do volunteer is 7.29, for general population inmates not CCU candidates is 8.04, and for CCU candidates who do not volunteer is 9.58 (suggesting a more negative perception of the mental health unit). Table 9 below shows the oneway ANOVA used to obtain the differences between the four groups. Because the oneway ANOVA was significant a Tukey-B multiple test of significance was used to identify groups whose means were significantly different. A Tukey-B test indicates that the inmates who were not CCU candidates but who volunteered for the inpatient psychiatric treatment and the CCU candidates who volunteer were significantly different from the CCU candidate inmate who does not volunteer, and that the general population inmates not CCU candidates, and CCU candidates who volunteer significantly differed from the non CCU candidate inmate who volunteer. These findings suggest that the perception of the mental health units by the subgroups is related to whether an inmate would be in a subgroup that is considered mentally ill but would not volunteer for the inpatient care (mean = 9.58) or

in a group that is not considered mentally ill but volunteer (mean = 4.40).

Table 9

Analysis of Variance of the Level of Inmate Perception of the Mental Health Unit By Inmate Subsamples

Variable	Source	DF	SS	MS	F
Subgroups	Between	3	106.35	35.45	5.6
	Within	96	607.76	6.33	
	Total	99	714.11		

*p< .05 level

Tukey-B Test Of Significance

Mean	Group	nCCUc/vol	CCUc/vol	GPinCCUc	CCUc/nvol.
4.40	nCCUc/vol				
7.29	CCUc/vol	*			
8.04	GPinCCUc	*			
9.58	CCUc/nvol	*	*		

*p< .05 level

Inmates who are not CCU candidates but who volunteer significantly differed from inmates who are CCU candidates who volunteer for the inpatient psychiatric treatment (Table 10). Inmates who are not CCU candidates but volunteer did not differ from CCU candidates who do not volunteer and from the general inmate population not labeled mentally ill. CCU candidates who do not volunteer also did not differ from general inmate population not CCU candidates. The findings suggest that inmates who are CCU candidates and who volunteer are less controlled by staff (mean=3.18) and that those inmates who are not CCU candidates but who seek in-patient care are more controlled by staff (mean=2.6).

Table 10

Oneway ANOVA of the Subscale Staff Control by Subsamples

Variable	Source	DF	SS	MS	F
People	Between	3	1.55	.52	2.71*
	Within	96	18.29	.19	
	Total	99	19.84		

*p< .05

Tukey-B Test of Significance

Mean	Group	NCCUC/VOL	CCUC/NVOL	GPINCCUC	CCUI/VOL
2.60	NCCU/VOL				
3.00	CCUC/NVOL				
3.02	GPINCCUC				
3.18	CCUI/VOL	*			

*p< .05 level

Experienced Differences in Unit Atmosphere

The above section compared the sample subgroups to identify factors that are associated with inmates being in a particular subgroup. This section compares the percieved atmosphere of the different living units that inmates were currently in at the time of the interviews in an effort to suggest reasons why some inmates would or would not volunteer for the in-patient psychiatric care unit. For example, inmates may percieve that they are not involved in their units which may then encourage them to volunteer for the in-patient psychiatric care where the inmates are more involved.

In order to determine whether units differ in how involved inmates were, one way ANOVA was performed. A breakdown of units by the level of involvement indicates that the mean level of ivolvement for inmates who were serving time in the closed custody units was 6.27 (suggesting low

involvement), in the mental health unit 4.55, and in the minimum custody units 4.78. Table 10 below show oneway ANOVA used to determine the difference between the three units. A Tukey-B test was computed because the F ratio was significant.

Tukey-B indicates that the level of involvement in closed custody units differed significantly from the level of involvement in both the mental health units and the minimum custody units. No significant difference was found between the mental health unit and the minimum custody units. This finding suggests that the closed custody units have a lower level of involvement than a mental health unit and the minimum custody units.

Table 11

Analysis of Variance of the Level of inmate Involvement by Units

Variable	Source	DF	SS	MS	F
People	Between	2	66.22	33.11	18.16*
	Within	97	176.82	1.82	
	Total	99	243.04		

*p< .01

**p< .05

Tukey-B Test of Significance

Mean	Group	MHU	MCU	CCU
4.55	Mental Health Unit			
4.78	Minimum Custody Unit			
6.27	Closed Custody Unit	*	*	

*p< .05 level

Oneway Anova was performed to determine whether the units differ in terms of the level of support accorded inmates. According to Table 12 below, the units differ in the level of support staff accord inmates. The multiple test of significance was done to determine which groups were significantly different at .05 level of significance. The mean level of support for the mental health units was 2.76, 3.61 for the minimum custody units, and 3.95 for the closed custody. The findings suggest that the mental health unit differ in the level of support from the minimum custody level units, and that the level of support for the closed custody units differ from both the mental health and the minimum custody unit. The mental health unit (mean = 2.76) had a higher level of support from staff members.

Table 12

Oneway ANOVA of the Level of Support by Inmate Units

Variable	Source	DF	SS	MS	F
People	Between	2	27.51	13.77	52.43*
	Within	97	25.45	.26	
	Total	99	52.96		

*p< .01 level

**p< .05 level

Tukey-B Test of Significance

Mean	Group	MHU	MCU	CCU
2.76	Mental Health Unit			
3.61	Minimum Custody Unit	*		
3.95	Closed Custody Unit	*	*	

*p< .05 level

Units differed in terms of expressiveness (Table 13). The closed custody units were different from both minimum and mental health units but the mental health units did not significantly differ from the minimum custody units. The findings suggest that closed custody units had a lower level

of expressiveness (mean = 5.12) than the minimum custody units (mean = 4.39) and the mental health units (mean = 4.48).

Table 13

Oneway Analysis of Variance of Inmate Level of Expressivenessby Units

Variable	Source	DF	SS	MS	F
People	Between	2	13.44	6.72	5.91*
	Within	97	110.27	1.14	
	Total	99	123.71		

*p< .01 level

**p< .05 level

Tukey-B Test of Significance

Mean	Group	MHU	MHU
CCU			
4.39	Minimum Custody Unit		
4.48	Mental Health Unit		
5.18	Closed Custody Unit	*	*

*p< .05 level

Units differed significantly in the autonomy scale (Table 13). The test of significance shows that the closed custody units differed from the mental health units and the minimum custody units. The mental health units and the minmum custody units did not differ from each other. The findings suggest that the closed custody units (mean=5.55) are less autonomous versus the minimum custody units (mean=4.65) and the mental health units (mean=4.61).

Table 14

Oneway Analysis of Variance for the Autonomy Scale by Inmate Units

Variable	Source	DF	SS	MS	F
People	Between	2	20.90	10.45	9.39*
	Within	97	108.00	1.11	
	Total	99	128.90		

*p< .05

Tukey-B Test of Significance

Mean	Group	MHU	MCU
CCU			
4.61	Mental Health Unit		
4.65	Minimum Custody Unit		
5.55	Closed Custody Unit	*	*

*p< .05 level

The units did not differ in terms of staff control (Table 15).

Table 15

Oneway ANOVA of the Subscale Staff Control by Units

Variable	Source	DF	SS	MS	F
People	Between	2	.1048	.0524	.2576
	Within	97	19.7352	.2035	
	Total	99	19.8400		

p>.05 level

Differences in Mental Health and Self Assessment of Mental Health

To determine whether the subgroups differed in terms of depression, nervousness, and affection, Oneway ANOVA was computed.

Level Of Depression

Shifting from the comparison of units to the comparison of sample subgroups, the subgroups were significantly different at the .01 level of significance (F=17.89 Table 16). Tukey-B shows that the group level of depression mean for inmates who were regarded as CCU candidates but who did not volunteer was 14.92, 21.04 for inmates who were CCU candidates who volunteered, 22.00 for inmates not CCU candidates but who volunteer, and 23.45 for general population inmates not CCU. Inmates who were CCU candidates but did not volunteer differed from the inmates who were CCU candidates and volunteered, non CCU candidates who volunteered, and from the general population inmates not regarded as CCU candidates. CCU candidates who volunteer also differed from from GP inmates not CCU candidates. Non CCU candidates who volunteer did not differ from general population inmates who are not candidates for CCU, from CCU candidates who do not volunteer and from the CCU candidate who volunteer. The CCU candidate who volunteer did not differ from the CCU candidate who does not volunteer, from the non CCU candidate who volunteer, and

from the general population inmate who is not labeled mentally ill. The findings suggest that inmates who were CCU candidates but did not volunteer, had a highest level of depression (mean=14.92) than the other three subgroups, and that inmates who were CCU candidates who volunteered had a higher level of depression (21.04) than those inmates in the GP population not considered CCU candidates (23.45). The difference in depression between the inmates who were CCU candidates and had volunteered, and those who were candidates but did not volunteer may be due to the fact that inmates in the CCU were already getting help they needed whereas those who did not volunteer were not getting any help they needed to deal with their depression (i.e can not be given anti depressant medication without their consent).

Table 16

Oneway ANOVA: Level of Depression By Sample Subgroups

Variable	Source	DF	SS	MS	F
People	Between	3	734.24	244.75	17.89*
	Within	96	1313.52	13.68	
	Total	99	2047.76		

*p< .05

**p< .01

Tukey-B Test Of Significance

Mean	Group	CCUc/nvol	CCUc/vol	nCCUc/vol
GPinCCUc				
14.92	CCUc/nvol			
21.04	CCUc/vol	*		
22.00	nCCUc/vol	*		
23.45	GPinCCUc	*	*	

*p< .05

Level Of Nervousness

The subsamples also differed in terms of the level of nervousness. Because Oneway Anova was significant at .05

level of significance, Tukey-B was computed. Tukey-B (Table 17) below shows that only two subgroups were significantly different at .05 level. The subgroups that were significantly different were the inmates considered CCU candidates but who do not volunteer and inmates from the general population considered not CCU candidates. The findings suggest that inmates who are CCU candidates who do not volunteer rank low on the nervousness scale (mean=11.08) suggesting that they have a high level of nervousness than inmates in the general population not considered CCU candidates (mean=14.29).

Table 17

Oneway Anova: Level of Nervousness by Sample Subgroups

Variable	Source	DF	SS	MS	F
Nervousness	Between	3	109.13	36.38	3.33*
	Within	96	1047.78	10.91	
	Total	99	1156.91		

*p< .05

Tukey-B Test Of Significance

Mean	Group	CCUc/nvol	NCCUc/vol	CCUc/vol GPinCCUc
11.08	CCUc/nvol			
12.80	NCCUc/vol			
13.21	CCUc/vol			
14.29	GPinCCUc	*		

*p< .05

Level Of Affection

This subscale measured whether or not an inmate was able to feel warmth and affection for other people, or whether an inmate is able to get along with other people. Therefore the lower the mean the more affectionate an inmate is towards others. Firstly the group means were compared in terms of the level of affection. Oneway Anova (Table 18) reveals that the subgroups were significantly different from each other. Inmates not CCU candidates but who volunteer differed from CCU candidates who do not volunteer. General population inmates not CCU candidates differed significantly from both CCU candidates who volunteer and and those who do not. Inmates who are CCU candidates and volunteer were also different from those who are candidates but did not volunteer. The findings suggest that inmates who are CCU candidates who did not

volunteer has the lowest level of affection (14.08) than the three other sabsamples and that CCU candidates who volunteer have a lower level of affection (11.96) than general population inmates not considered CCU candidates (10.35). Inmates who are not CCU candidates but who volunteer had a higher level of affection than CCU candidates who do not volunteer.

Table 18

Oneway ANOVA: Inmate Level of Affection by Sample Subsamples

Variable	Source	DF	SS	MS	F
People	Between	3	163.39	54.46	9.04*
	Within	96	578.32	6.02	
	Tota	99	741.71		

*p< .01

Tukey-B Test of Significance

Mean	Group	NCCUc/vol	GPinCCUc	CCUc/vol	CCUc/nvol
10.00	NCCUc/vol				
10.35	GPinCCUc				
11.96	CCUc/vol		*		
14.03	CCUc/nvol	*	*	*	

*p< .05 Level

To determine whether being in the subgroups is affected by an inmates state of mind i.e whether or not she considers herself mentally ill or not, and therefore is a volunteer or not volunteer, the four subgroups were crosstabulated by an inmate's mental state and by whether or not an inmate would volunteer. Table 18 below shows that non CCU candidates who volunteer (100% or 5) consider themselves not mentally ill but would volunteer, and that CCU candidates who do not volunteer (75% or 9) considered themselves mentally ill but still would not volunteer. There was no difference in proportion of general population inmates not labeled mentally ill who considered themselves not mentally ill in terms of whether or not they would volunteer. As would be expected, the majority of the inmates who were CCU candidates and had volunteered considered themselves mentally ill. The findings suggest that

inmates who are mentally ill but do not volunteer for inpatient care assessed themselves as being mentally ill but still would not volunteer for the in-patient mental care unit, and that inmates who are not CCU candidates but who volunteer also assessed themselves as not mentally ill. We can therefore reject the assumption that inmates may not volunteer for in-patient care because they do not know that they are mentally ill.

Table 19

Contingency Table: Inmate Subgroups by Inmate Mental State by Volunteering or not Volunteering for the In-patient Psychiatric Care

Subgroups	Would Volunteer				Would Not Volunteer				Total
	M.N.Ill		M.Ill		M.N.Ill		M.Ill		Total
	n	%	n	%	n	%	n	%	n %
CCuc/vol	8	28.6	9	32.1	7	25.0	4	14.3	28 100.0
GPnCCUc	26	47.3	1	1.8	26	47.3	2	3.6	55 100.0
CCUc/nvo	0	0.0	0	0.0	3	1.5	9	25.0	12 100.0
NCCUc/vo	5	100.0	0	0.0	0	0.0	0	0.0	5 100.0

chi-square=35.95 df=9 significance=.000

111. Dependent Variables by Subgroups

Table 20 below shows that subgroups differ in terms of whether or not they would seek psychiatric treatment in the institution if they felt a need for it. As would be expected, the inmates who had volunteered but were not considered to be candidates (100% or 5), and those who had volunteered and who had been accepted (82% or 23) were most likely to say they would seek treatment. The inmates in the general population who were not candidates were in the middle, with 64% (35) saying they would seek treatment. The non volunteers in mental health treatment were least likely to say they would seek help. The subgroups were significantly different on whether or not they would seek psychiatric treatment.

Table 20

Inmate CCU Status By Seeking Treatment in the Institution

	Yes		No		Total	
	n	%	n	%	n	%
CCUc/vol.	23	82.1	5	17.9	28	100.0
CCUc/nvol.	3	25.0	9	75.0	12	100.0
GPinotca.	35	63.6	20	36.4	55	100.0
NCCUc/vol.	5	100.0	0	00.0	5	100.0

chi-square=15.0 df=3 significance=.01

Note: Columns may not add up to 100% because of rounding.

Summary for the Description and Comparison of Subgroups

The section on the description and comparison of subgroups compared the four subgroups namely

1. CCU candidates who volunteer
2. CCU candidates who do not volunteer
3. General population inmates not labeled mentally ill, and
4. non CCU inmates who volunteer.

The groups did not significantly differ on the demographic variables such as race, though nonwhite inmates tended to be overrepresented in all subgroups. The subgroups also did not differ significantly on age, prior criminal records, marital status, source of income, whether they had children, whether they were employed before imprisonment, and on the level of education. However they did significantly differ on the type of crime they were inmprisoned for. The majority of the CCU candidates who volunteered were in prison for violent crimes.

On hypothesized predictors of volunteering for treatment, subgroups were not significantly different on a social distance scale, on whether or not they could be friends with inmates from CCU, or on how they think other inmates would react to inmates discharged from the mental health unit, and in terms of how they would react to general population inmates if they were CCU inmates discharged from the unit. They did differ on whether or not they have had mental health treatment before coming to prison. They also differed in terms of the units they were serving time in (i.e mental health unit, closed custody or minimum security), in terms of their perception of the chronic care unit, and on mental health subscales.

Conclusions about the subgroups in terms of the variables they significantly differed on:

(1) Inmates who volunteer for the in-patient psychiatric

care unit had committed violent crimes.

(2) Inmates who do not volunteer reported that the inmates discharged from CCU will tend to ignore general inmate population.

(3) Inmates who volunteer but were not mentally ill serve time in the closed custody units.

(4) Inmates who negatively percieve CCU would not volunteer for the unit.

(5) units where there is less support and less autonomy and less expressiveness of inmates will tend to have inmates who would not volunteer for CCU.

(6) Subgroups differed in their self assessment as mentally ill. Although the mental health staff's label of who is mentally ill and who is not is not hundred percent accurate, the staff were able to put inmates in five categories (i.e subgroups). The majority of the inmates who had assessed themselves as mentally ill did fall in the subgroups that were labeled by staff as mentally ill.

(7) The subgroups also differed in terms of whether they would seek treatment in the institution. Inmates who did seek treatment in the institution are also those who said they would volunteer for the in-patient psychiatric care unit.

Relationship of Independent Variables to Willingness to Volunteer

In order to determine whether the independent variables were related to the sample's willingness to volunteer for the in-patient psychiatric care unit, all categorical independent variables were crosstabulated by volunteering or not volunteering, and means for interval and ratio variables were compared for the volunteer and would not volunteer groups.

In order to determine whether inmates who reported that they would volunteer for the inpatient psychiatric care versus those who would not were different on their perception of the CCU, a t-test for independent groups was done. The two groups did differ in terms of how they perceived the unit (Table 21). The inmates who would not volunteer had a mean of 8.98 suggesting a more negative perception of the unit. The inmates who would volunteer had a mean of 6.63, suggesting a more positive perception of the unit.

Table 21

A t-Test: Inmate Volunteering or not Volunteering by InmatePerception of CCU

Variable	Group	N	Mean	SD	DF	t
Perception	Would Vol.	49	6.63	2.33	98	-4.85*
	Would not Vol.	51	8.98	2.52		

*p<.01

To determine whether the unit environment where the inmate currently lives is related to volunteering or not volunteering, a t-test on each of the subscales was computed using the two groups "the inmates who would volunteer" and "the inmates who would not volunteer"

According to Table 22 below, inmates who would volunteer for the inpatient psychiatric care are significantly different from those who would not on the subscale "support". The inmates who would not volunteer had a mean of 3.73 suggesting a high score in the support scale indicating the low level of support from staff members. The mean for the inmates who would volunteer is 3.22 indicating a high level of support from the staff members. The findings suggest that innmates with a low level of support from the staff members would not volunteer for the inpatient psychiatric care. The inmates who

would not volunteer did not differ from the inmates who would volunteer in terms of the involvement scale.

Table 22

Environment Subscales By Volunteering or Not Volunteering: A t-test

Variable	Group	N	Mean	SD	DF	t
Support	Would Vo	49	3.22	.85	76	3.59*
	Would not Vol.	51	3.73	.49		

*p< .01

The two groups (inmates who would volunteer and inmates who would not volunteer) were not significantly different on the expressiveness scale, staff control scale and the social distance scale. However they did significantly (at .05 level) differ in terms of the autonomous scale (Table 23). The inmates who would volunteer had a mean of 4.80, and the inmates who would not volunteer had a mean of 5.25. The findings suggest that inmates who would volunteer were more autonomous in their units than those who would not volunteer.

Table 23

A t-test: Level of Inmate Autonomy in the Unit By Volunteering or Not Volunteering

Variable	Group	N	Mean	SD	DF	t
Autonomy	Would Vol.	49	4.80	1.15	97	-2.04*
	Would not Vol.	51	5.25	1.09		

*p< .05

To determine whether some demographic variables are related to volunteering or not volunteering, inmate age, sentence length, previous criminal records, inmate race, inmate marital status, inmate type of crime, and inmate source of income were crosstabulated by volunteering or not volunteering. The demographic variables were not significantly related to volunteering or not volunteering (Table 24).

Table 24

Non significant Demographic Variables to Volunteering and Not Volunteering

	Would Volunteer		Would Not Volunteer	
Age	%	n	%	n
19-27	36.7	18	31.4	16
28-34	38.8	19	43.1	22
35-47	24.5	12	25.5	13
chi-square=.337	df=2		significance=.845	
Sentence Length				
Between 12 & 36	18.4	9	19.6	10
More than 36	55.1	27	51.0	26
Life	26.5	13	29.4	15
chi-auare=.174	df=2		significance=.916	
Prior Records				
Yes	40.8	20	60.8	31
No	59.2	29	39.2	20
chi-square=3.99	df=1		significance=.045	
Race				
White	44.9	22	39.2	20
Nonwhite	55.1	31	60.8	31
chi-square=.331	df=1		significance=.565	

Inmate Marital Status				
Divorced	38.8	19	39.2	20
Married	12.2	6	17.6	9
N> Married	49.0	24	43.1	22
chi-square=.673		df=2		
significance=.714				
Type of Crime				
Violent	61.2	30	45.1	23
Non Violent	38.8	19	54.9	28
chi-square=2.61		df=1		
significance=.106				
Source of Income				
Wage of Another	38.7	19	37.2	19
My Wages	18.4	9	11.8	6
Welfare	32.7	16	31.4	16
Social Security	10.2	5	19.6	10
chis-quare=2.228		df=3		
significance=.527				

Volunteering or not volunteering was also not related to whether inmates could be friends with a CCU inmate, to whether they could inform anyone about their mental illness, on whether they were previously treated for mental illness before coming to prison and on whether or not they consider themselves mentally ill.

Inmates' percieved reaction to the ex CCU inmates is

significantly related to whether an inmate will volunteer for treatment. Table 25 below shows that the majority of the inmates (86% or 44) who would not volunteer are those who think that the general population inmates react negatively to inmates discharged from CCU, and the majority of those inmates (35% or 17) who would volunteer think the ex CCU inmates are positively reacted to. Therefore inmates who think ex-CCU inmates are negatively reacted to will tend to mention that they wuold not volunteer for CCU.

Table 25

Inmate Reaction to Ex CCU Inmate by Volunteering or not Volunteering for the CCU

	Would volunteer		Would not volunteer	
	n	%	n	%
Negative Reaction	32	65.3	44	86.3
Positive Reaction	17	34.7	7	13.7
Total	49	100.0	51	100.0

chi-square=6.02 df=1 significance=.01

Inmates who would volunteer differed significantly from those who would not volunteer on whether they would inform the

employer about their previous mental illness if any. The majority of the inmates who would volunteer (67% or 33) would tell the employer about mental illness whereas those inmates who would not volunteer (53% or 27) would not tell the employer about their previous mental illness (Table 26).

Table 26

Volunteering For CCU by Whether an Inmate would Inform the Employer about Her Previous mental illness

	Would Volunteer		Would not Volunteer	
	n	%	n	%
Yes	33	67.3	24	47.1
No	16	32.7	27	52.9
Total	49	100.0	51	100.0

chi-square=4.19 df=1 significance=.04

Inmates who would seek treatment in the institution are inmates who would also volunteer for the in-patient psychiatric care unit (92% or 45). Inmates who would not volunteer would not seek treatment in the institution (Table 27). The finding suggests that volunteering or not

volunteering is significantly related to whether an inmate would seek treatment in the institution.

Table 27

Inmate Volunteering by Whether an Inmate Would Seek Treatment in the Institution

	Would Volunteer		Would not Volunteer	
	n	%	n	%
Yes	45	91.8	21	41.2
No	4	8.2	30	58.8
Total	49	100.0	51	100.0

chi-square=28.6 df=1 significance=.00

To determine whether ex CCU inmate reaction to general inmate population is related to volunteering, the reactions mentioned by inmates were crosstabulated by inmate responses on whether they would volunteer or not volunteer. Table 28 below shows that the majority (55% or 27) of the inmates who would volunteer would socialize with general population inmates. Inmates who would not volunteer for CCU would tend to ignore inmates from the general inmate population (58% or 30).

Table 28

ExCCU Inmates' Reaction to General Inmate Population by Volunteering and not volunteering

	Would Volunteer		Would not Volunteer	
	n	%	n	%
Ignore them	10	20.4	30	58.8
Keep to Myself	12	24.5	14	27.5
Socialize with them	27	55.1	7	13.7
Total	49	100.0	51	100.0

chi-square=21.89 df=2 Significance=.000

In summary, factors associated with volunteering or not volunteering for CCU are:

1. Support: inmates receiving less support from staff members will not volunteer.
2. Autonomy: inmates who are more autonomous in their units will volunteer.
3. General inmate population percieved reaction to inmates discharged from the CCU: Inmates who think ex CCU inmates are negatively reacted to by the general inmate population will not volunteer.
4. Telling the prospective employer about previous mental

illness: inmates who would not volunteer would also not tell the employers about their previous mental illness if any.

5. Inmates who would seek treatment in the insitution are also those inmates who would volunteer.
6. Inmates if they were ex CCU inmates who would socialize with general population inmates are also those who would volunteer for in-patient psychiatric treatment.
7. Perception: Inmates who have a negative perception of the unit would not volunteer.

Multivariate Analysis: Relationship of Independent Variables to Willingness to Volunteer

To determine which independent variables affect volunteering while controlling for other independent variables, a discriminant analysis was performed. All significant predictor variables in the bivariate analyses were included. The discriminant function was most characterized by whether an inmate would seek treatment in the institution (.72), by ex CCU inmates reaction to general inmate population (-.60), by inmates' perception of the CCU (.56), and by the unit environment "support" (.42). Though perceived general inmate reaction to ex-CCU inmates (-.29), informing employer of previous mental health treatment (.24), unit environment "autonomous" (.24), and inmate previous criminal record

(-.23) were significantly related to volunteering (bivariate analysis), they did not help predict volunteering or not volunteering of the inmates for the in-patient psychiatric care unit. The eigenvalue for this function was .75, chi-square=52.87 with the df=8. The percentage of the grouped cases correctly classified was 77%.

Independent Variables by Subgroups

To determine whether independent variables could predict in which subgroups inmates would fall, a discriminant analysis was computed. All independent variables which were significant in bivariate analysis were used to compute the descriminant functions. Two functions were extracted. Variables which highly characterized function 1 were: depression (-.71), self assessment of being mentally ill (.70), affectionate (.51), and nervousness (-.31). Function 2 was highly characterized by inmates' perception of CCU (-.57), by type of crime inmates had committed (-.55), and by the unit where the inmates were serving time (-.21). The percentage of variance was 85% for function 1, 15% for function 2 (chi-square=78.43 for function 1 with df=14, for function 2 chi-square= 14.96 and df=6). Seventy two percent of the grouped cases were correctly classified. Therefore the findings suggest that we can correctly predict in which subgroup an inmate will fall by knowing their level of

depression, affectionate, nervousness and whether they consider themselves mentally ill. We also could predict in which group the inmates will fall by knowing their perception of the CCU and by the type of crime they were imprisoned for. However, knowing the unit where the inmate is serving time will not help us much in prediction.

Relationship of Depression, Nervousness and Affection to Self-Identification as Mentally ill and Willingness to Volunteer for The In-patient Psychiatric Care Unit.

To determine whether inmates who considered themselves to be mentally ill or not mentally ill had a high level of depression a t-test was computed. According to Table 29 below, inmates who considered themselves not mentally ill also had a low level of depression (mean=23.13) versus those inmates who considered themselves to be mentally ill (mean=17.32). The findings suggest that inmates who ranked high on the depression (suggesting low level of depression) scale considered themselves not mentally ill and those who ranked low considered themselves to be mentally ill. Inmate level of depression for inmates who would or would not volunteer did not differ, suggesting that knowing that an inmate has a high level of depression does not necessarily mean that she would volunteer for treatment.

Table 29

A t-Test: Inmate Level of Depression By The Inmates' Mental State

Variable	Group	N	Mean	SD	DF	t
Depression	Not Ill	75	23.13	3.49	33	5.78*
	Mentally ill	25	17.32	4.61		

*p< .001

To determine whether inmates with a high level of nervousness considered themselves mentally ill or not, a t-test was computed. The inmates who had a high level of nervousness (mean=10.84) considered themselves mentally ill, while those who had a low level of nervousness (mean=14.43) considered themselves not mentally ill. The difference was significant at .01 level of significance (Table 30). However, the level of nervousness was not significantly related to volunteering or not volunteering. The findings suggest that knowing ones mental state does not necessarily mean that one would volunteer for an inpatient psychiatric care.

Table 30

t-Test: Inmate Nervoussess by Whether an Inmate Considers Herself Mentally Ill

Variable	Group	N	Mean	SD	DF	t
Nervousness	Not Ill	75	3.24	.374	98	5.88*
	Mentally ill	25	2.41	.482		

*p<.01

The t-test also reveals a significant difference between the inmates who considered themselves not mentally ill (had a high level of Affection (mean=10.68) and those who considered themselves mentally ill (had a low level of affection (mean=12.88)) (Table 31). The inmates with low level of affection were the inmates who considered themselves mentally ill. However, capacity for affection does not affect volunteering or not volunteering, the means were not significantly different at .05 level of significance.

Table 31

Level of Affection by Inmate Mental Status

Variable	Group	N	Mean	SD	DF	F
Affection	Not Ill	75	10.68	2.31	98	-3.70*
	Mentally Ill	25	12.88			

*p<.01

Summary

The factors which are strongly related to whether an inmate would volunteer for the in-patient psychiatric care are(see summary table):

1. type of experience an inmate has had or observed about the Chronic Care Unit. Inmates who experienced psychiatric problems versus those who did not would tend to volunteer for treatment, and those who encountered labeling experiences would not.

2. Inmates' perception of how inmates react to the mental health unit also interferes with whether an inmate will volunteer or not. For example inmates who percieve that inmates from the mental health unit are negatively reacted to would tend not to volunteer.

3. Inmates with previous mental illness treatment would not necessarily be discouaraged by their previous mental

illness to volunteer again for in-patient care. However their future volunteering is influenced by their experiences while they were institutionalized. For example if they were treated badly (yelled at, called by names, etc) they would tend not to volunteer for in-patient psychiatric care again.

4. Negative perception of the mental health unit by inmates is related to whether inmates would volunteer or not volunteer.

5. Inmates who would or would not volunteer are not different in terms of the level of support within their units, but the level of support did have an effect on whether or not an inmate would seek treatment in the institution.

Summary Table

Variable	Comparison of sample subgroups	Volunteer/Not Volunteer Groups
Social Distance	No difference	No difference
Involvement	Closed custody less involved	No difference
Support	No difference	Low level of support does not volunteer
Expressiveness	Closed custody least expressive	No difference
Autonomy	Closed custody least autonomous	More autonomous would volunteer
Staff Control	No difference	No difference

Depression	CCUC/NVOL more depressed	No difference
Nervousness	CCUC/NVOL more nervous	No difference
Affection	CCUC/NVOL low affection	No difference
Perception perception	CCUC/NVOL negative	Positive
	perception	Would volunteer
Race	No difference	No differecne
Sentence length	No difference	No difference
Prior record	No difference	Prior record would not volunteer
Age	No difference	No difference
Married	No difference	No difference
Type of crime	CCUC/VOL violent crimes	No difference
Employed?	No difference	No difference
Source of Income	No difference	No difference
Friends with CCU inmate	No difference	No difference
GP inmates reaction to CCU inmate	No difference	Negative reaction would not
volunteer		
Ex CCU inmates reaction to GP inmates	No difference	Those who would socialize would volunteer

Inform employer about mental not illness	No difference	Those who would inform employer would not volunteer
Tell anyone about mental illness	No difference	No difference
Prior Mental treatment	CCUC/VOL and CCUC/NVOL had prior treatment	No difference
Discouraging experiences	CCUC/NVOL movement restriction	Those who have had labeling expe. would not volunteer
Self identification as mentally ill	CCUC/NVOL consider themselves mentally ill. NCCUC/V consider themselves not mentally ill	No difference

There are two variables which are best predictors of volunteering for CCU. These variables are: inmate perception of the CCU, and the labeling experiences inmates have had. These two variables are predictors in both multivariate analyses.

CHAPTER VI

QUALITATIVE ANALYSIS

This chapter presents responses given by twelve inmates who were especially extroverted in the first interviews, and selected staff members. All questions were open ended and questions for the inmates were more or less similar to the questions they were asked during the first interview but worded differently. These inmates had been in the institution for more than two years. Some of them were CCU patients before but were now serving time in other general population units. This group of twelve inmates included two inmates who were in CCU before, two inmates in CCU, two inmates considered mentally ill but who refuse inpatient mental health care, two inmates who do not meet the criteria for inpatient admission in CCU but who had volunteered for such treatment, and four inmates from the general population who have never been CCU patients before.

Also, information collected from the full sample but that is not quantitative is presented. Finally, the results of a small number of interviews with staff are presented.

Inmate Attitudes Towards The Mentally Ill and CCU

Responses presented in this section were those given by the twelve inmates interviewed in depth. The questions asked

were geared toward soliciting information that would help to determine the factors which may discourage future volunteering for those inmates who have been in the unit before, information pertaining to the reasons why those inmates who are not CCU candidates volunteer, and what were the factors which encouaraged the inmates in CCU to volunteer for the unit, and lastly to determine the factors which would encourage or discourage the general population inmates from volunteering for the unit

Inmates' responses were more indepth than responses from the staff members and were more geared towards understanding their knowledge about unit three and their attitudes towards that unit especially CCU. As has been mentioned in the introduction of this chapter, the inmates interviewed in depth consisted of selected inmates in several groups: /those who were once in CCU, those who wanted to be admitted in the unit, those who did not want admission to CCU, general population inmates, and inmates who were currently serving time in the unit. The inmates who were once in CCU before were asked the following questions:

1. What are the things you liked or hated about CCU?
2. If you were an administrator or in charge of the unit which things would you change or encourage? and why?
3. How was your relationship with other inmates in CCU?
4. If you were to get sick again, would you voluntarily admit yourself in the unit? why?

5. Did counselors in the unit seem to have enough time to help you with your problems?

6. When you were discharged from the unit, how did you feel i.e. did you feel happy or sad?

7. How did the inmates in the unit you were transferred to treat you? How do they treat you now? What about staff members?

8. How did you treat inmates in that unit?

9. When you leave this institution and seek employment would you mention to the prospective employer that you were once treated for mental illness? and why?

In response to question number one about things they liked or hated about the unit, the following were responses:

A. Mostly I liked quietness of the place and nobody bothering you about nitty gritty things. You were left alone and given time to think and to keep your life together. I also liked the round o'clock attention we got. There was also some privacy because we were few which means that you really did not share a bathroom with many inmates like in the unit I am in right now. When also you had a detail staff members there always told you or reminded you so that you would not get a ticket for not doing your detail. I hated taking medication because it made me feel dizzy and tremble a lot.

* * *

A. I liked quietness but hated the way some CMAs were treating us, especially the male CMAs. They treated us very badly.

* * *

Basically according to the above responses, the best thing in CCU is its quietness. It is ironic that what

attracts other inmates in the unit is what repels most inmates from the unit i.e some inmates who would not volunteer mentioned the quietness of the unit as one of the reasons why they would not volunteer.

To question number two which asked what things an inmate would change or encourage in the unit, the following were responses.

A. Some inmates do not feel like they need help. Therefore I will make the unit more liberal i.e a patient who has no serious mental problems would occassionally be permitted to visit the unit, so that if she disintergrates she would not hesitate to volunteer for the unit. In other words I am saying by making the unit more open by allowing visitors rather than isolating the unit, I would permit some inmates who could benefit from the unit to come on regular bases just to know how the unit functions. I am saying this because most inmates do not come to the unit because they think inmates there are idle therefore bored and that is why the unit is so quiet. What they do not know though is that the unit is quiet because there are less people in it not because they are bored.

* * *

A. Inmates in CCU do not talk a lot with one another, instead each inmate keeps to herself which makes the unit more quiet than other units. So what I would encourage are more group meetings so that inmates would talk to one another. I would make them more involved in what ever is happening in the unit. I would also make sure that counselors give encouragement to the inmates because other people need that. I mean to talk to someone and tell her about things worth living for.

* * *

A. I would make sure that officers who become CMAs are those who could handle the job and who can sincerely help inmates when they need help. I would also encouarage more counselling sessions and then motivate girls for self improvement because they can not rely on the institution... they are pushing them back and forth from place to place (refering to discharging the inmates to GP units and then readmitting them back to the unit).

It looks like inmates who were in CCU before are aware that the unit is quiet and possibly this quietness which other inmates in the unit like, repels other inmates because they associate quietness with boredom rather than the number of inmates in the unit. They are also aware that inmates there keep to themselves a lot i.e they do not socialize among themselves, therefore the solution is to do more group work where inmates would talk to one another. The things these inmates would change or encourage in the unit include 1) making the unit more open than closed, 2) having more counselling sessions, and 3) improving the morale or attitudes of officers working in the unit.

Question four inquired about the inmate's relationship with CCU inmates while she was in the unit. These were responses:

A. I wouldn't say it was bad or good becuase we did not talk to one another that much. Each person seemed to mind her own business or trying to deal with medication side effects. You see, all my friends were in GP and I didn't see them that much.

I. What made you volunteer for CCU leaving your friends behind?

A. I knew something was wrong with me because I heard these voices talking to me telling me to kill myself. Sometimes the voices would say someone was trying to kill me. But I did not consider myself sick or mentally ill. I just convinced myself the voices would go away but they did not. You see I had been in mental institutions before therefore I was referred to the psychiatrist after intake. But for some reason I just did not consider myself sick or needing any treatment. Maybe that is because I do not trust staff members here. I had heard that they make you crazier here than you normally were. The psychiatrist convinced me that I needed inpatient care, so I signed the consent form.

I. If you were to have a relapse, would you voluntarily admit yourself in the unit?

A. No, I don't think so.

I. Why?

A. Because of the way some male CMAs treated me. They acted like they were doing you a favor by being there and that they didn't have to do anything for you. Their attitude was very bad. If you went off, instead of helping you you'll be given a handful of pills and the CMAs would just say "we will see you later" and not help you at all when you most really needed their help.

Another inmate responding to the question whether she could volunteer for CCU should she get sick again, said:

A. No way, I hate the way officers treat inmates there. Some are in fact physically aggressive with inmates.

I. Did counselors in the unit have enough time to help you with your problems?

A. Some counselors are really helpful and then there are those who just have no time for anything, who are always in a hurry.

I. When you were discharged from the unit how did you feel?

A. What do you mean?

I. I mean did you feel happy or relieved that you were leaving the unit or felt bad or sorry?

A. I felt really happy because I was gonna see my friends again but at the same time I was scared because I did not know to which unit I was going to be transferred too. The thing here is, they never seem to transfer you back to the unit you were in before admission to CCU.

It appears that inmates who were in CCU before would not want another admission in the unit because they did not like the way officers treated them in the unit. However though this may not be the only reason (see quantitative analysis), some inmates who are in the subcategory for those who are sick but not volunteer had been in CCU before. The researcher while she was in the process of asking the help from one member of the Treatment Team, to identify the inmates who are CCU candidates but who do not volunteer was told by this member that "most inmates who are in my unit who are really CCU candidates but who do not want to be admitted in the unit are those who have been in CCU before, frankly we have a difficult time convincing them that they will benefit from the inpatient care there." It is also interesting to note the difference in responses of the inmates who have been in the unit before but who do not want to volunteer from those who are CCU candidates but had never been in the unit before. Five of six inmates who were in CCU before cited officers as the reason why they would not voluntarily admit themselves in the unit again, while those who have never been there cited

restricted movements as the major reason. The following are the responses from those inmates who have never been in CCU before but who are candidates:

A. CCU is too close an observation. I do not want to be observed or supervised all the time. Inmates in that unit seem to be too slow and unhappy, they look like they can use some fresh air. Beside inmates in other units think all inmates in unit three are thorizine [a major tranquilizer drug most used in CCU] bitches.

* * *

A. I need my freedom a little bit. Inmates in that unit do not get to go to the yard by themselves. I want no officer tugging along behind me every time I go to the yard. I am too old for the babysitter don't you think? I don't think I am too sick anyways.

* * *

A. Inmates there are always in their cells. I'm not gonna be locked in no cell ... I need to move around and do things, they don't do things there but sleep and eat them drugs they are given. Besides I am not that crazy. CCU is for inmates who are really crazy who can stay or survive without drugs. As you can see I can perfectly function without thorizine.

* * *

A. I don't want to be locked in no cell all the time. God I will suffocate, I need fresh air now and then.

The above responses suggest that inmates who are CCU candidates but who do not volunteer are discouraged from volunteering because they think inmates in CCU are locked in their cells most of the time and they do not get to go out without an escort. To be escorted everytime an inmate goes out was cited by one inmate as degrading and as the ground

for ridicule by other GP inmates. What these inmates do not know or pretend not to know is that Level A (see chapter IV -- CCU Status Levels) inmates do go to the yard unescorted, and that Level B can only go out with an escort but Level C can not go to the GP yard all together but to the CCU yard with an escort. Also almost all inmates in the unit (at least when the researcher was there) were Level A status.

To the question on how inmates in GP treated them when they were discharged from the unit, the following were responses:

A. Some inmates laughed and made derogatory statements, like for example if you do something they do not like there may say "why don't you go back to the crazy house." That hurts a lot, though physically you do not show that you are hurting but spiritually and emotionally you are deeply hurt. But then there also those inmates who care who always try to be on your side when other inmates try to take advantage of you, or who console you if some asshole tried to be cute by getting in your nerves.

* * *

A. Basically inmates are not informed about mental illness. To them if you were in unit three you are crazy even when you are no longer crazy. Everything you do or do not do is attributed to your prior admission to unit three. Therefore unit three inmates are considered different from other inmates. In fact they call us thorizine queens.

* * *

A. Like people in any society, people themselves single those in unit three as a source of active mental gossip and confused ostracism.

* * *

A. Lot of them did not want to have anything to do with me. Well that is O.K. because I like to be by myself any way. I like the unit I am at right now unlike the unit I was transferred to after discharge from CCU.

It appears that inmates who were Unit three patients are subjects of ridicule. In other words they are labeled as crazy. Therefore the stigma of having been in Unit Three stays with the inmate forever. One inmate from GP who was a CCU candidate before, said: "sometimes inmates in my unit if ever one does something considered not normal they will laugh and say 'she ought to be in unit three'." The other one said "GP thinks everyone from unit three is crazy, they do not understand what goes on in these units, they are ignorant." To support what the above responses seem to suggest, one inmate who was in PE for medical reasons but was then in GP said: Before I was admitted to PE I had thought that unit three was for the crazy, and I was very angry and sad when the doctor told me he will put me in unit three. When I was finally admitted to the unit I realized that the unit is not as the way other inmates in GP potray and consider it. I loved that unit, should the doctor suggest the unit again, I don't think I will be mad or sad as I was before."

To the question about how the staff members treated them outside of the mental health unit, the majority felt that staff members treated them better, that is better than other inmates, and that of course there were some "assholes who

always passed some negative remarks whenever you did something wrong like 'So and So are you losing it again?'"

To the question about how the ex-CCU patients reacted to other inmates in GP several felt that they ignored the remarks and they tried to do their time. Some said they kept to themselves a lot, and still others socialized with other inmates. One inmate particularly pointed out that it is very hard to isolate yourself if you are serving years and years in prison. Another inmate said: "I treat people according to how they deal with me I am not biased by locational conceptions or others' opinions about people. I judge people through my own eyes." This inmate was suggesting that she treats people the way they treat her, if they are bad to her she will be bad to them.

The responses to the question "Is it right to mention to the prospective employer that one was a psychiatric patient before?" appear below.

A. No

I. Why?

A. Because mental problems are within all of us, why should a person have to place a "black ball" on themselves because theirs was treated?

Another inmate said:

A. Everybody is crazy here only some are crazier than some of us, therefore I don't see why one should mention any prior mental illness unless asked. Why supply the information not requested. In fact some counselors tell us not to provide that information because you may kiss the job good bye, they (employers) will not hire you. Don't tell them about imprisonment too.

* * *

A. Personally I wouldn't tell the employer because even if he or she does employ me I will always be a scapegoat for everything that goes wrong. Just like when you tell them about imprisonment, when something gets misplaced and they can't find it or gets lost you are the first suspect.

Basically the above responses suggest that inmates with past mental illness will not tell or provide the information not asked. However if asked directly they would not lie because they believe honesty is better than dishonesty especially after you lie and later the employer finds out.

As has been mentioned in the previous chapter, some inmates in CCU have been in GP before but had relapsed and most of them accumulated many misconduct tickets which they did not have in CCU. They feel that inmates in GP looked at them like they were still crazy and talked or whispered behind their backs. One inmate in particular who was serving time in CCU at the time of the interview said: "whenever you did something which deviated from what is expected of you they attributed that to abnormality when in fact if the inmate who had never been in unit three or CCU in particular did the same thing, her behavior would not be attributed to abnormality.

One inmate in CCU pointed out to the researcher that she did not like to be in the unit nor did she volunteer without coercion. She said the doctor gave her no choice, it was either CCU or Forensic unit. When asked why she did not want

to be admitted in CCU she replied "because inmates in the GP regard us as really luneys, and as people who can not function without drugs." She also mentioned that the place is "so damn quiet and quietness gets into my nerves. I need to be in a place where I can get my problems out of the way, that is, where I will not get a chance to think about my problems." For this inmate, prior hospitalization in a mental institution[1] discourages her from seeking inpatient treatment, but not because of the way she was treated while insitutionalized but because of the stigma associated with institutionalization and the lack of distraction from her problems.

One inmate who seems to have different views from the inmate whose responses are mentioned above, who also had some prior hospitalization in the mental institution before imprisonment, said she hated GP that she relapsed back and was readmitted in CCU. She said "I love it here; its quiet and staff members are great they really try to help me get

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[1]Among the ten CCU patients interviewed, only two had no prior mental hospitalization (this was double checked through the records). This therefore suggests that (consistent with the literature, e.g., Kalinich et. al 1988; Briar 1983) most inmates enter the criminal justice system already with serious mental problems. Instead of being diverted to some alternatives, they are directly sent to prison because they had committed a crime which they may not have committed if they had not been released from mental institutions to begin with. Most of these inmates share the same background e.g., grew up in broken homes because of divorce or desertation by one of the parents, they did drugs, were alcoholics or both, they are repeat offenders, have been sexually or physically abused by their parents as childre.

better. I do not want to go to the GP. Some inmates there call you names. But I don't think they mean it. It is because they do not understand." Another inmate in CCU (with prior mental institutionalization) who was once discharged from CCU to the GP but now is back in CCU, said, "CCU is okay if you need to be alone or need quietness. I don't mind being in the unit; when I was in GP inmates treated me like any human being and I mingled with them."

One inmate who had been a CCU patient before but now was serving time in PE, mentioned that CCU "is a good unit. I feel that if I hadn't been there for two years, I wouldn't have been able to cope (in fact this inmate has never served any of her time in any of the GP units but PE and CCU). CCU helped me adjust in prison. It was a nice unit and I enjoyed its quietness." Asked why there are few inmates in the unit she said "some people do not feel like they need help nor do they consider themselves sick, and others know they are sick but are not prepared to seek help for reasons known to themselves, but I suspect because unit three is known to the GP inmates as the unit for the crazy and therefore they do not want to be called crazy."

What this inmate was indirectly suggesting was that, inmates are not well informed (educated) about mental illness that they regard the mentally ill as abnormal, thus distancing themselves from anything associated with mental illness let alone admit to the whole institution that they are "crazy".

Two inmates who were serving time in the CCU[2] felt that counselors are not spending much time with them to encourage them to keep going and be hopeful about their future. They did mention that they hate medication they are given because it makes them feel terrible. For example, headaches, they tremble, have shaky hands, have insomnia and lose appetite.

Two inmates in PE not considered CCU candidates but who so badly wanted to be admitted in the unit, when asked why they want to go there one of them said: "I have never been admitted in the unit but whenever I go to the dining hall I always look inside the unit. It is quiet and it looks like staff members there care about inmates. I tried to get in there for quietness and its private one to one communication. I can't stand the noise." She also mentioned how much she hated lesbianism she said: "There are many lesbians in here and I have observed several times rapes and stebbings in showers and on the grounds; as a result I do not feel safe anywhere where there are many people and I do not go where I will be by myself without staff members around." She said whenever she is on grounds in the tennis courts or yard she never goes outside the courts because the staff members would not see her. When she was asked about her social history before imprisonment and about her parents, she became emotional (she started crying). She mentioned that when she

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[2]Also other inmates who were serving time in the CCU felt the same way.

was born her parents were already old (in their 50s) and they were very overprotective of her. According to her she lived a sheltered life because her parents did not allow her to mix with other children nor visit her relatives (cousins, uncles and aunts). She said: "my father was very demanding. He never saw good in me but negative criticism. Sometimes I would ask him to help me with math, he would say I am a stupid, idiot child, I must find my own answers. He never helped me with anything, He never even said 'thank you', 'very good', 'try again' or 'I love you'. As a result, I became very scared or frightened of him. In fact I hated him..."

After listening to her life history (and later verified it), the researcher came to realize that she wants to go to CCU for two main reasons:

1) CCU does not have many people ans is therefore quiet just like her childhood home. In CCU she will not have to mix with many people.

2) She is scared of the inmates in GP. She thinks they may do something to her e.g. rape or stab her. Therefore chances of being victimized in CCU are very slim. In CCU she can be by herself without fearing anything because staff members are in the unit 24 hours a day.

The other inmate who wanted admission to CCU like the above inmate, cited quietness and security as the major reason she wants to go there, not her illness.

Summary of Findings on Inmate In-depth Interviews

The responses above by inmates suggest the following factors as discouraging them (those who have never been admitted in the unit) from seeking inpatient care in CCU:

1) The place is very quiet.

2) They think that inmates there are pinned down all the time i.e they are always in their cells doing nothing.

3) They consider inmates there to be too "crazy" and do not consider themselves that "crazy".

4) They think that inmates in the unit do not go out to the yard without staff escorts.

5) They think that the unit does not have many activities.

6) They think that other inmates will call them names (ridicule them).

Basically, these factors suggest that many inmates are not well informed about CCU, though each inmate on arrival i.e during intake is given the prisoner guidebook with information about CCU. They really do not know what it is going on other than what they hear from other inmates.

The inmates who have been in the unit but who do not want to volunteer again, cite:

1) Officers' negative attitudes in the unit, and

2) Quietness

Those serving time in the unit they like it because:

1) the unit is quiet

2) Staff members care about them, i.e they want them to get better.

3) The unit provides semi-privacy because they do not share cells, they can use bathrooms by themselves (not many people in the bathroom at the same time) and

4) One to one verbal communication with staff members.

Results of General Interviews with Hundred Inmates

This section provides the responses of the hundred inmates interviewed without sample stratification according to four groups mentioned in chapter three. The questions asked concentrated on the factors associated with volunteering or not volunteering for the in-patient psychiatric unit (CCU). These responses were analyzed using frequencies, rather than anecdotal responses.

When the inmates were asked whether they would seek treatment in the institution if they thought they needed ite, sixty six inmates reported that they would. The reasons cited by the thirty four inmates who would not seek treatment in the institution were the following:

1) Others will make fun of me

2) Staff make you more crazy

3) I do not want to be called "crazy"

4) I do not trust staff members (meaning medical, and psychiatric staff) in here.

On the question " are there experiences you have had or observed which may make you volunteer or not volunteer for the CCU", depending on the nature of the sample being interviewed, this question was rephrased to fit the individual who was being interviewed. For example, an inmate who was already serving time in CCU and the one who wanted to be admitted to CCU but not chronically ill, the question read "were there experiences you have had or observed which made you volunteer?" and for the inmate who had been in the unit (CCU) before the question was "are there any experiences you have had or observed which may make you decide not to volunteer again?" For inmates in GP not CCU candidates, and those who were CCU candidates but did not volunteer the question read "are there experiences you have had or observed which may make you not volunteer?" Seventy four percent had had experiences which either discouraged or encouraged them. Responses such as the following were given by inmates who were at the unit (CCU) at the time of the interview:

1) hysterical crying

2) voices talked to me

The following were experiences discouraging inmates who were in CCU before from future volunteering:

1) officers' attitude in the unit

2) quitness.

The following are the responses given by those inmates considered mentally ill by staff members but who did not

volunteer and by the GP inmates not CCU candidates.

1) inmates are locked in most of the time

2) CCU inmates do not leave their cells without the staff member tugging along

3) the place is too quiet

4) the unit is for the crazy and I am not (that) crazy.

5) scared to be in the unit.

Below are the responses given by those inmates who were not considered mentally ill but who volunteered:

1) quietness of the place

2) availability of staff members 24 hours a day.

On the question about how each inmate thinks she would be or was treated by other inmates after being discharged from unit three, the following were responses:

1) alienate(d) me

2) make fun of me

3) say things behind my back

4) treat me bad

5) look at me like I am still crazy

6) call me names

7) treat me right

On the question on how they think staff members would treat them after discharge from the mental health unit, twenty seven percent felt that they would negatively react to them, and seventy three percent felt that the staff reaction would be positive.

The inmates were also asked how they would react to inmates in the general population (GP) considering the fact that they have been discharged from the mental health unit. The following were responses given by inmates:

1) ignore them (fourty inmates)

2) keep to myself (23 inmates)

3) try to mingle with them (34 inmates)

4) react with anger (3 inmates)

Ninety three percent inmates did not mind being friends with an inmate who has just been discharged from CCU. When inmates were asked whether one (if applying applying for a job) should mention one's previous mental problems, fifty seven inmates said "yes" citing the reason that honesty is best, rather than lying then later the employer finds out. The reason given by the fourty three inmates who would not tell the employer of any psychiatric problems, was "he/she may not hire me". Asked whether they would mention to anyone including a friend their previous mental illness, the majority (eighty two) would inform the persons close to them. Those who would not mention it cited "may want to have nothing to do with me" as the major reason why they would not tell anyone about their mental illness.

Summary of Findings for the Hundred Inmates Interviewed

Inmates interviewed who would not volunteer for CCU mentioned stigma (e.g. others will make fun of me), labeling

reasons (e.g. I do not want to be called "crazy"), and movement restrictions (e.g., inmates are locked in most of the time). Those who volunteered had psychiatric problems (e.g hysterical crying and voices talk to me).

The inmates also would inform employers of previous mental illness if any. Those who would not, fear that they may not be hired.

Results of Staff Interviews

This section provides responses given by a few staff members who were informally interviewed about CCU including those members who at the time of the interview were working in the CCU, and those who had most of CCU ex-patients in their units or who have some inmates they thought should be admitted in CCU. Answers to questions by staff members were recorded during the interview. These informal interviews were conducted to solicit information on the attitudes of staff members towards mental illness and CCU. Responses to questions which were similar were later recorded together under one category, for example, "social distance from the mentally ill" for the questions which asked whether the staff members could offer accommodation to ex mentally ill

patients, so that it would be easier for the researcher to report anecdotal responses to questions.

A staff member who was not working in CCU was asked what

her opinion about CCU is. She mentioned that CCU is for inmates who are mentally ill who need an around the clock supervision because of their problems. Asked whether she would like to one day work in this unit as a CMA (Correctional Medical Aide), she said "well I haven't thought of that before, but I do know that I do not want to become crazy too. If you stay too much with the crazy you end up being a little crazy yourself." Asked why she thinks so, she said, "look at the officers working there they definately are not doing much like we do on grounds. I think they are kind of bored and once you are bored and staying with the crazy, you definately loose it too."

The following were questions asked by the researcher and the responses she got from one other staff member who worked on the grounds.

I. Can you tell me something about Unit three

A. About what to be specific?

I. Anything you would like to share with me about the unit.

A. Well the unit is used for those inmates who are crazy (using her pointing finger at the same time showing the researcher what she means). However some inmates in the unit are not crazy they are there for medical reasons rather than psychiatric problems.

I. How would you feel about working in unit three CCU as a CMA?

A. I don't think I would like to work there because it does seem like the CMAs have nothing to occupy them during working hours because there are not many things which happen in that unit. In fact I think they are bored because they really do not do much except sit

down. I am a person who likes to be occupied.

I. If the CMAs had something to occupy them would you then work in the unit?

A. If I was assigned there I think I would, but against my will because you will never know when one of the inmates in there would completely loose it and begin to be violent.

I. Does that mean inmates in that unit are violent?

A. I would think some of them are.

I. Are there inmates in the unit you are assigned to right now who were CCU patients before?

A. Oh Ya! a number of them.

I. How do you react to them?

A. I think I am a little bit patiant with them because they are not like other inmates. I mean I sometimes overlook some minor institutional violations, violations which I do not overlook with other normal inmates.

These responses suggest that even staff members have stereotypes about the mentally ill. They think that working with the mentally ill makes a sane person insane, and that mentally ill people are violent and not normal. It appears that some staff members are also not informed well enough about the CCU because they think that officers working in the unit are not doing anything. One would think that more officers who think that CMAs do not do much in terms of their job should like to work there unless the officer wants to be working all the time. But in this case it is not like that. This makes one wonder whether there are other reasons other than officer idleness.

One officer pointed out that some inmates from CCU though most of them are ridiculed by other inmates, use their label "crazy"as a defense mechanism. Asked how, he said "to avoid confrontation or being molested by other inmates, these inmates begin to act crazy on purpose so that other inmates will keep away from them and say "well she is really crazy" and then leave her alone." The question than was: what kind of an inmate would want to be isolated from other inmates especially if she is serving a long sentence? The answer was: most of the inmates from Unit three are loners, they do not mingle a lot with other inmates possibly because they do not feel comfortable around other inmates, they always think that other inmates are laughing at them or something.

Observing the staff members working as CMAs in CCU, and listening when they talked to each other about some inmates in the unit, the researcher noted that these members often used phrases like "that one, she is really crazy" <u>not</u> phrases like "really sick." They often joked about themselves being crazy like the inmates in the unit.

To show how stereotyped mental illness is, one RN (a nurse) in the unit trying to explain to this researcher about how other staff members feel about mental illness, said: "One staff member in the Control Center (the prison administration center) said to me one day " Dr So and So is the only psychiatrist I know who is not crazy." I simply laughed because I didn't know what else to say. I know that he was

joking but that joke suggested something to me." In fact that comment was suggesting what other staff members assume happen when you work with the mentally ill: becoming crazy yourself.

Not all officers talked to had stereotypes about mental illness, however even these officers showed that, they tend to treat the mentally ill different from other inmates even though their illnesses may be in remission. Suggesting that they see these inmates as in no way like other inmates and therefore even though they are no longer sick they will always be seen as ill in the eyes of many (i.e the stigma which does not die).

The researcher also noted that officers working within CCU do not regard inmates there as violent or dangerous but just "crazy". The communication between the inmates and staff members (female staff members) appeared to be very good even though the inmates in CCU do not talk too much but when they were up to it they really conversed with staff members. Not even once did this researcher observe any impatience from any staff member in dealing with these inmates. They seemed to be very considerate even when some inmates were being a little bit impolite. They always asked "how are you feeling today So and So" and the inmate would reply "not so good" or "better than yesterday." The researcher observed one day an incident where an inmate who was working in the laundry room came crying from the room saying "Miss... I have been hit on my

head by the... and it hurts", the officer who was being addressed was very concerned she went to the laundry room and came back and she looked at the inmate's head (without touching the inmate's head though) and with the concerned voice said "Do not cry this much, I do not see any blood which means you did not hurt yourself that bad, you will be alright just sit down a little while you will feel better." The researcher then asked the officer how does she know that the inmate is not faking the whole thing so that she will take a rest? She said, "you can tell when an inmate is faking, but I did see what object hit her when I went to the room. Besides if she does not finish the laundry she won't have an opportunity to go to her room when other inmates return to their rooms for rest after their details." It was also interesting to note that officers in that unit (as in other units) addressed the inmates as "ladies" for example when they let them know about something like lunch time they will shout "ladies it's lunch time", and they also did not refer to the inmates' cells as "cells" but "rooms". For example when the count was on and some inmates were still in corridors they would say "ladies go to your rooms the count is not yet cleared." Some questions which were asked from the inmates were also asked from several staff members. The reason this was done was to determine whether staff members would distance themselves from the mentally ill. When some staff members were asked whether they could offer accommodation in their

homes to the ex-mentally ill patient and why. The following were some of the responses.

> A. Well it would depend on what kind of mental illness he/she previously had. If she/he really had severe mental illness involving violent behavior, I don't think I would be so generous as to offer her/him my home. How do I know she/he won't regress again? But on the other side if she was not seriously ill I may consider giving him/her accommodation, temporarily ofcourse until she/he finds his/her own place.
>
> * * *
>
> A. It is difficult to know whether I would be willing to share my home with the ex-mental patient. I may say yes I would be willing but when I 'm confronted by the real situation I may not say yes. Probably because I do not know that much about mental illness only what I hear other people say. Besides I 'm not sure whether my friends would want to be friends with me again. You know mental illness is always viewed negatively by the public, me included. It also depends on the type of illness that person may have had. Some illnesses are more severe than others even though a person may be considered cured. She may just go off like that and I wouldn't like that to happen in my house.
>
> * * *
>
> A. Offering a home to the previously mentally ill person is not easy. To begin with he may be a dangerous person in remission. What do I do when he gets crazy and kills everybody in my home? I guess the answer to your question is I wouldn't because I wouldn't feel safe in my own home nor would I trust him.
>
> * * *

The responses suggest that mental illness is the illness people do not want to hear about. The public still regard those who were mental patients as untrustworthy, as people

who can be violent any time because of their past illness. Therefore once a mental patient always a mental patient in the eyes of many. You can not do things differently than others because that will be attributed to your past psychiatric history.

Basically the way the ex-mental patient handles herself determines whether she will be regarded as cured or just "crazy" in remission waiting for the right moment to strike back. This therefore suggest that to gain acceptance ex-mental patients must always be aware of how they act or react in front of people especially in front of those who know about their past mental problems.

When these staff members were asked whether they would be willing to be on the same job (working together) with the ex-mental patients, most officers did not mind, for the simple reason that you only work with her or him but does not stay with him/her. Asked whether they would let an ex-mental patient take care of their children, almost all officers were not willing, citing the reason that they (the ex-mental patients) may "go off" while they are not there therefore endangering the children's lives. As above, this suggests that many of us do not trust people who were once mentally ill, let alone allowing them to stay with our children. Staff members were asked whether they were willing to make friends with ex-mental patients. The answers were

affirmative, suggesting that they can be friends with the ex-mentally ill patients.

Staff members were also asked whether they would see a psychiatrist if they became ill. A few felt that seeing a psychiatrist would be admitting that they were crazy while some thought that seeing a psychiatrist does not mean that one is crazy since there are different degrees of mental illness. Therefore they would see a psychiatrist.

Summary of Findings for Staff Responses

Staff members (especially those who were not working in the CCU) had a myth that working with the insane makes one insane.

The belief that CMAs (Correctional Medical Aides) are not doing much (i.e most of the time they are doing nothing) suggests that staff members working outside of the CCU are also not well informed about the unit and its personnel.

Staff members have stereotypes about the mentally ill, for example, believing that the mentally ill are not normal and cannot be trusted with anything.

Though the CMAs often joke about themselves as being "crazy" like the inmates in the unit (acknowledging the stereotype by other staff members, that the sane become insane when they work with the insane), they do care about the inmates in CCU.

Conclusion

The qualitative analysis reveals that inmates who have been in CCU before would not volunteer again for the CCU because of how they were treated by staff members in the unit. However, though they would not volunteer, they liked the quietness of the unit.

It is also evident from the above discussion that inmates (interviewed) who were candidates for CCU but who did not volunteer, mentioned movement restrictions of the inmates in the CCU, labeling and stigma related reasons as discouraging them from volunteering.

Inmates from the general population also gave similar reasons as the twelve inmates interviewed as to why they would or would not volunteer.

Staff members like the inmates, have stereotypes about mental illness. They would distance themselves from the ex-mentally ill, only if they had to live with them. However, they did not mind being friends with them. They admit that they tend to treat inmates from CCU differently because they are not "normal".

Based on the above discussion we can conclude that labeling does matter behind bars. Therefore inmates (interviewed) would tend not to volunteer if they fear stigmatization and labeling by other inmates. Also, both staff members and inmates are not well informed about CCU.

CHAPTER VII

SUMMARY AND CONCLUSIONS

This chapter gives a summary of the study, conclusions, implications for policy, and recommendations for future research. The conclusions in this chapter are based on findings derived from the four subgroups mentioned below, and from the inmates' responses on whether or not they would volunteer for CCU.

Summary of the Study

The major purpose of this study was to determine the difference between the four subgroups in a female prison population. The four subgroups were:

1. chronic care unit inmates who volunteer
2. chronic care inmates who do not volunteer
3. general population inmates who are not chronic care inmates
4. inmates who are not chronic care candidates but who volunteer.

These subgroups were compared in terms of a number of factors. The factors included:

1. the demographic variables
2. previous mental illness
3. units where they were serving time
4. seeking treatment in the institution

5. reasons why they would or would not seek treatment in the institution

6. whether or not the subgroups had had experiences which discourage (or encourage) them from volunteering

7. type of experiences they have had or observed about the CCU

8. social distance from the ex-mental patients

9. their perception of the mental health unit

10. unit environment (i.e how they consider units environment where they were serving time at the time of the interview)

11. scores on the mental health scale

The secondary purpose was to determine without stratifying the sample, whether the units where female inmates in general were serving time differed in terms of:

1. involvement
2. support accorded to inmates by staff members
3. expressiveness
4. autonomy and
5. staff control
6. whether unit environment is the factor in volunteering or not volunteering for CCU and
7. whether inmates who volunteer differ significantly from those who do not volunteer.

By determining whether the sample and the subsamples differed in terms of what is mentioned above, the following hypotheses generated from the labeling theory were being tested:

1. Negative stereotypes of mental illness interfere with volunteering for treatment among female inmates.

2. Female inmates who view the mental health unit as being for people with bizarre behavior would not volunteer.

3. Female inmates who view the mental health unit as being for people who are dangerous and violent would not volunteer.

4. Prior experience with mental hospitalization would discourage inmates from future volunteering for psychiatric treatment.

5. Inmates with depression symptomatology will less likely volunteer, and those who do, will have other mental illnesses.

In order to accomplish the task of testing the above hypotheses, all (33) inmates who were in the mental health unit (CCU and PE) with the exception of those inmates who were in the unit for medical reasons other than mental illness were interviewed. Some of the inmates in PE were identified by staff members as needing inpatient care but do not volunteer for the inpatient care in CCU. Others in the same unit (PE) were identified as not seriously mentally ill to warrant inpatient care. However, they had repeatedly volunteered for inpatient care. The total number of nonvolunteering inmates who were considered by mental health staff to be seriously mentally ill to warrant inpatient care was 12. The total number for those identified (by MH staff members) not

seriously mentally ill but who have repeatedly volunteered for treatment, was five, and the rest consisted of fifty five inmates from the general inmate population who were not sick nor considered sick by the mental health staff.

Major Findings on Subgroup Characteristics

To determine whether the subgroups differed significantly in terms of the demographic variables, previous mental illness, units where they were serving time, whether they would seek treatment in the institution, reasons why they would or would not seek treatment in the institution, experiences which they have observed discouranging (or encouraging) them from volunteering, a chi-square test of significance was computed.

The sample subgroups did not differ significantly at the .05 level of significance in terms of the demographic variables, a finding which runs contrary to the literature on other nonprison populations. This finding leads the researcher to conclude that inmate age and race (in particular) are not significantly related to staff labeling of mental illness or volunteering for treatment of mental illness among female inmates studied. The subsamples also did not significantly differ in terms of the other variables tested. These variables were:

1. the socio economic status;
2. whether or not they had children;

3. whether or not they could be friends with inmates from CCU;
4. how they think other inmates would react to inmates discharged from the mental health unit (in contrast to the literature which suggest that negative reactions from others would discourage seeking psychiatric treatment);
5. how they would react to general population inmates after discharge from CCU if they were inmates from CCU (contrary to the literature which also suggest that persons with mental illness tend to isolate themselves because they think others are ridiculing them);
6. whether or not they would inform prospective employers and friends or boyfriends about previous mental illness, if they had any. Inmates without mental illness tended to report that they would not tell employers about mental illness, however those who have had mental illness, tended to report that they would.

To determine whether the subgroups differed in terms of the social distance scale, unit environment scale, perception of the mental health unit scale, and on the mental health scale, oneway ANOVA was computed, and if the groups were significantly different, Tukey-B, a multiple test of significance was calculated.

Findings on Subgroups and their Scores on Measurement Scales

Subgroups and Social Distance

To test whether the subgroups differed in the social distance scale from the ex mentally ill inmates, oneway ANOVA was computed. The subgroups did not significantly differ from one another on the scale at the .05 level of significance. The researcher concluded that inmates studied would not distance themselves from the ex-mentally ill inmates.

Subgroups and the Unit Environment Scale

As mentioned above, to determine whether the units where the subgroups were serving time differed in terms of the environment scale, one way ANOVA was computed followed by Tukey-B if the F ratio was significant. The subgroups did not differ in terms of the environment subscales: support, involvement, expressiveness and autonomy. We can conclude that the four unit environment subscales are not a factor in determining who will fall in the four sample groups. However, the subgroups did differ in terms of the environment subscale, staff control. The inmates who were CCU candidates and who volunteered felt that they were less controlled by staff members than the inmates who were not CCU candidates but volunteers. The nonCCU inmates who volunteer regarded themselves as being more controlled by staff members.

Subgroups and Their Perception of the Mental Health Unit

The subgroups differed significantly in their perception of the Mental Health Unit. For example, to test the subgroups' perception of the mental health unit, Anova was computed. Inmates who were not CCU candidates but volunteered had a positive perception of the unit and inmates who were CCU candidates but did not volunteer perceived the unit negatively. We can conclude that inmates who would not volunteer for CCU would be inmates who negatively perceive the mental health unit, and that inmates who would volunteer even would be the inmates who positively perceive the mental health unit.

Subgroups and the Mental Health Scale

The mental health scale had three factors. These were: depression, nervousness, and affection. The subgroups differed significantly at .01 level of significance in the level of depression. Those with the highest level of depression were inmates considered to need inpatient psychiatric care who did not volunteer. These were followed by the inmates who were CCU candidates who volunteered.

The subsamples also differed in terms of the level of nervousness and affection. Inmates considered CCU candidates but who do not volunteer had a higher level of nervousness and the lowest level of affection than other subgroups.

The inmates who considered themselves not mentally ill had a high level of affection.

The subgroups also differed in terms of the other variables. These variables were:

1. whether or not they have had mental illness before coming to prison affected their diagnosis. The inmates who were not considered mentally ill (those in the general inmate population and those who volunteered but were not considered mentally ill by staff members) had no previous mental illness. On the other hand, candidates, whether they volunteered or not had previous mental illness. We can therefore conclude that inmates who are CCU candidates would be inmates who have been treated for mental illness before.

2. the unit they were serving time in also appears to have had an impact. Inmates who were not candidates for CCU but who volunteer were serving time in the closed custody. On the other hand, inmates who were candidates but did not volunteer were serving time in the minimum custody units.

3. seeking treatment in the institution also has an impact on volunteering. Inmates who seek treatment would be those who are not candidates for CCU who volunteer and those who are candidates for CCU and volunteer. On the other hand, inmates who are candidates but do not volunteer and the general inmate population not CCU candidates would not volunteer.

4. inmates who would not volunteer cited stigma related reasons, for example, being made fun of and disliking being called crazy. We can conclude that the inmates interviewed would not volunteer for treatment for fear of stigmatization by both the staff members and inmates.

5. inmates who were CCU candidates but did not volunteer had observed that movements are restricted for the CCU inmates. Inmates who did not volunteer are also discouraged from volunteering by labels attached to being a mental patient. Inmates more likely to volunteer would have experienced personal psychiatric problems. Inmates who would not volunteer would be those who cite restricted movements and labeling experiences as dicouraging them from volunteering.

The results also show that inmates with low levels of depression considered themselves not mentally ill and those with higher levels of depression and nervousness considered themselves to be mentally ill. Inmates with high level of affection considered themselves not mentally ill. Therefore we reject the hypothesis that inmates who are mentally ill do not know that they are mentally ill and therefore do not volunteer. Being affectionate was not a factor in volunteering or not volunteering.

Assessment of the Labeling Theory

The labeling theory was assessed by dividing inmates into two groups based on their responses to the question "would you

volunteer for CCU?" Those who responded affirmatively became the "would volunteer group", and those who said they would not, became the "would not volunteer group."

To determine whether negative or positive perception of the mental health unit is related to volunteering or not volunteering, a t-test was computed. The two groups differed significantly at the .05 level of significance. We conclude that among the inmates interviewed, those who negatively perceive the unit would not volunteer.

To test the hypothesis that negative stereotypes of mental illness interfere with volunteering for treatment among female inmates, type of experiences an inmate has had or observed (i.e how other inmates regard the mental health unit) about the inpatient unit was correlated with seeking treatment in the institution. The relationship was found to be significant at .05 level of significance. Therefore inmates who reported having observed or have had labeling experiences directed to them or others are discouraged from seeking treatment in the institution. Those inmates who have had no experiences (whether negative or positive) and those who had experienced personal psychiatric problems tended to be positively influenced towards seeking treatment. This finding suggested that inmates who considered themselves to be mentally ill and those who have not been exposed to negative experiences would not be discouraged from seeking treatment, but those who have been would be discouraged. Hypothesis

number one was found to be valid. The null hypothesis was then rejected at .05 level of significance in favor of the research hypothesis.

The view of the mental health unit as being for people with bizarre behavior, and the view of the mental health unit as being for people who are dangerous and violent were not factors in volunteering. However, inmates who were considered mentally ill but who did not volunteer had a negative perception of the unit. Therefore inmates' perception of the unit was found to be strongly related to volunteering for treatment.

To test hypothesis number four "prior experiences with mental hospitalization would discourage inmates from future volunteering for psychiatric treatment", inmates who have had prior mental hospitalization were asked whether they would seek treatment in the future should they get sick again. The majority of the inmates who were in the mental health unit had past mental hospitalization (suggesting that their past hospitalization did not discourage them from seeking future treatment). However, when controlling for the type of experiences, whether the experiences were positive or negative, prior hospitalization and seeking treatment were not significantly related. This therefore suggested that inmates who were treated very bad (had negative experiences) by staff members in the institution would tend not to seek future

psychiatric treatment especially the treatment which requires that the inmate be admitted to the inpatient care unit.

To understand whether inmates who have been discharged from the mental health unit to the inmate general population would be negatively or positively reacted to by the inmates, and therefore discourage or encourage those inmates from seeking future treatment, the responses by inmates on whether they think they would be positively or negatively reacted to by GP inmates were tested against future volunteering for treatment. The results showed that inmates who thought that they would be positively reacted to versus those who thought they would be negatively reacted to had no problem with future volunteering for treatment.

To the question about how inmates who have been discharged from the mental health unit would react to the negative reaction towards them by inmates in the general population, inmates with prior mental illness treatment (i.e hospitalized) versus those without prior mental illness treatment, would tend not to be offended by the negative reactions, in fact they would ignore the insults. However, this reaction was not significant at .05 level of significance.

This study (though the relationship was not significant) found that inmates with no previous mental illness treatment would tend to be more willing to do things with the former

mentally ill patients than those who have had previous mental illness treatment.

Inmates serving time in the mental health unit were also found to have no problem with future volunteering for treatment versus those who were serving time in either the closed custody units or minimum custody level units.

Findings on Inmate Unit Environments

The Difference in Unit Environments

To determine whether the environment differs in the units, a breakdown of units by the environment subscales was done. The inmates in closed custody units were found to be less involved, to have a low level of expressiveness, and to be less autonomous than inmates in other units. The units also differed in the level of support inmates are accorded by staff members. The mental health unit received a higher level of support from staff members than other units. The units did not differ according to the staff control scale.

To determine whether in general unit environment is related to volunteering or not volunteering, a t-test on each of the subscales was computed. The two groups "those who would volunteer and those who would not volunteer" significantly differed on the subscales "support" and "autonomy." Inmates reporting low levels of support from staff members would tend not to volunteer for treatment and

inmates who were more autonomous in their units would volunteer. The two groups did not differ in terms of the involvement, expressiveness, and staff control environment subscales nor did they differ on the social distance scale. Therefore the components of the unit environment which affect volunteering are: support, and autonomy. Units in which there is low support will have inmates who will not volunteer for CCU, while and in units where inmates are autonomous, inmates would tend to volunteer.

Summary

Characteristics of the Inmates who Volunteer

1) Inmates who consider themselves psychiatrically sick.
2) Inmates who are physically insecured.

Characteristics of the Inmates in the Mental Health Unit

Through reviewing the institutional records of these inmates, the majority of the inmates in this unit had:

1) prior mental illness hospitalization
2) come from broken homes because of divorce or desertation by one of the parents.
3) have used drugs or were alcoholics or both before coming to prison.
4) were abused physically or sexually as children.
5) have committed violent crimes.

Factors Associated with Not Volunteering

1) fear of being labeled "crazy".

2) fear of stigmatization.

3) perceived negative responses by the general inmate population to CCU inmates.

4) negative perception of the mental health unit.

5) staff support of inmates.

6) alleged movement restrictions of the inmates in CCU.

7) quietness of the CCU.

Attitudes of Inmates and Staff Members Toward Mental Illness

Both staff members and inmates have a negative attitude towards mental illness. They have stereotypes about the mentally ill. However, the inmates and the staff members would not distance themselves from the mentally ill. However, they would if they had to offer accommodation in their homes to the mentally ill.

The organization of the mental health unit is also problematic. Inmates and staff members associate the unit with psychotropic drugs (for example, thorizine). Inmates who could benefit from CCU may not volunteer for fear of being given psychotropic medication.

Psychiatric Services

Group and individual counseling are frequently used. The mental health treatment team monitors progress of the inmates

in CCU (see Appendix I). Psychotropic drugs are often prescribed by the psychiatrist. However, an inmate has to consent to taking medication (see Appendix K).

Findings based on the Multivariate Analysis

The Sample: The independent variables which affected volunteering of the sample while controlling for other independent variables were:

1) Whether an inmate would seek treatment in the institution;
2) Ex-CCU inmates reaction to GP inmates;
3) Inmates perception of the CCU;
4) Unit environment subscale "support."

The subgroups: The discriminant analysis showed that the following independent variables can 71% of the time correctly predict the subgroup in which inmates would fall.

1) Depression
2) Self assessment of being mentally ill
3) Affectionate
4) Nervousness
5) Perception of the CCU
6) Type of crime committed

Assumptions by the MDOC Psychologist

The MDOC psychologist assumed that 1) inmates who are not CCU candidates would volunteer because they want to be

near their victims, 2) that they would volunteer because they do not want to be assigned to laborous work, and 3) they would volunteer because they fear victimization by other inmates.

Only one assumption was validated by this study. Inmates who do volunteer for the in-patient psychiatric care though not mentally ill, are those, in this study, who fear victimization by other inmates.

Conclusions of the Study

The subgroups were not significantly different at .05 level of significance in terms of demographic variables, socio-economic status, whether or not they had children, on whether they could be friends with inmates from CCU, by how they think other inmates would react to inmates discharged from the mental health unit, by how they would react to general population inmates after discharge from the unit, or in terms of whether they would inform the employer about past mental illness if any.

Inmates who are CCU candidates and volunteered and inmates who are CCU candidates but who do not volunteer had previous mental illness. We conclude therefore that inmates who are candidates for CCU would be inmates who have had mental illness before.

Inmates who are CCU candidates who do not volunteer are serving time in the minimum custody units, and inmates who are

not CCU candidates but who volunteer are serving time in closed custody units. Therefore the unit where an inmate who is not considered by staff members to be mentally ill is serving time in, is related to whether or not she would seek treatment in the institution.

Inmates who would not seek treatment in the institution are those who do not want to be stigmatized by other inmates. Inmates who would volunteer for the unit would report having psychiatric problems and those who would not volunteer would mention labeling experiences as factors discouraging them from volunteering.

Sample subgroups do not differ in terms of the social distance scale from the ex-mentally ill inmates. Inmates who are not CCU candidates but who volunteer have a positive perception of the mental health unit, and those who are candidates but do not volunteer have a negative perception.

Closed custody units have a low level of support, involvement, autonomy, and expressiveness. The subsamples however did not differ in terms of the subscale, autonomy. The units did not differ in terms of the staff control, however the subgroups did differ in terms of whether or not they considered the units to be highly controled by staff members. Inmates who are not CCU candidates but who volunteer reported high staff control in their units, but those inmates who are CCU candidates and volunteer reported low staff control in their units.

Inmates who are CCU candidates and who do not volunteer have a high level of depression, high level of nervousness, and low affection. Inmates who are CCU candidates who volunteer also had a higher level of depression and nervousness than the two other susamples.

Inmates know about their mental states i.e whether they are sick or not. However that does not affect their volunteering. That is, inmates who are CCU candidates percieve themselves as mentally ill, but they still would not volunteer. Being affectionate is not related to whether an inmate would volunteer for inpatient psychiatric treatment.

The findings of the study have demonstrated that inmate demographic variables had no effect on whether or not an inmate would seek treatment in the institution and that the following is associated with volunteering:

1. Type of experiences an inmate have had or observed about the mental health unit (if the experiences are negative she will not volunteer). Inmates who experienced psychiatric problems versus those who did not would tend to volunteer for CCU.

2. Inmate general population reaction to the inmates discharged from the mental health unit. Inmates positively reacted to by GP inmates will volunteer.

3. Inmates serving time in the mental health unit will seek future psychiatric treatment.

4. Inmates who are less involved in their units will volunteer.

5. Inmates who recieve support from their unit staff members will volunteer for treatment.

6. Positive or negative perception of the mental health unit is related to whether an inmate will volunteer or not treatment.

The following is the summary of other variables which were found to be significantly related to one another.

1. Inmates with previous mental illness treatment also have a high level of depression, and nervousness.

2. Inmates in the minimum custody units are more involved in their units than inmates in closed custody units and mental health unit.

3. Inmates in the mental health unit have staff members who are more supportive than inmates in other units and are encouraged to express themselves more often than inmates in other units.

4. Inmates in the minimum custody units are more autonomous than inmates in other units.

5. Inmate demographic variables have no impact on how inmates percieve the mental health unit.

There were no identifiable inmate demographic characteristics which may enable us to predict the groups in

which each inmate will fall (i.e volunteer or not). However, inmates in CCU tended to have previous mental illness treatment.

Implications for Theory and Policy

Consistent with the labeling theory, the present study shows that negative stereotypes of mental illness interfere with volunteering for treatment among female inmates. Inmates who have encountered labeling experiences (for example, regarding CCU as the unit for the crazy) will not voluntarily admit themselves to the unit. Associating unit three (mental health unit) with thorizine is also problematic. It is true that most inmates in unit three - CCU are mostly treated with psychotropic drugs. However inmates in the general population do not know that drugs are not forced upon a patient, rather a patient has to consent for treatment with such drugs (see appendix K), and a patient who has consented may also refuse to take any more psychotropic medication without penalty from staff members.

Also inmates who negatively perceive the mental health unit (i.e view the unit as the unit for violent and dangerous inmates, for inmates with bizarre behavior, or for inmates who are unable to take care of themselves) will not volunteer suggesting that labeling of the unit plays a part on who volunteers and who does not.

There are also findings herein reported which are not consistent with the labeling theory. In particular, prior experience with mental hospitalization does not discourage an inmate from future volunteering. However this factor is influenced by the kind of an experience an inmate had while hospitalized. For example, if an inmate was not treated well by the staff members, that inmate will tend not to seek future treatment should she get sick again.

Evidenced too in this study is that inmates with high depression symptoms and nervousness are also those who have been treated for mental illness before. This suggests that inmates with previous mental illness are also the inmates with a high level of depression, implying that depression is associated with other mental illnesses (i.e the higher the level of depression the more likely that an inmate has also symptoms of other types of mental illnesses). Reported too in this study is that the unit environment does affect inmate's volunteering for treatment. For example, in units where inmates are less involved, inmates will volunteer and in units where staff members are not supportive of inmates in terms of programs and activities, inmates will tend not to volunteer for treatment. However staff control does not encourage or discourage inmates from volunteering because the level of staff control in all units is about the same. This

suggests that the unit environment is the important factor the institution personnel have to take into consideration when making policies.

Findings for this study have several implications for policy. Inmates should be educated about mental illness, suggesting that inmates be told about mental illness and be given an opportunity to visit the mental health unit.

Ignorance about the mental health unit on the part of the inmates suggests that they are not well informed about the unit by staff members. The only information the inmates have comes from other inmates, and that information about the unit is not favorable, hence inmates who really need psychiatric treatment refrain from seeking treatment because of what they have been told by other inmates (including the miscommunicated information about psychotropic drugs). In other words inmates can not make an informed decision as to whether or not to take the advantage of free mental health services provided to them by the institution, in part because they do not trust the staff members i.e they tend to believe what they hear from other inmates rather than what they read from the inmate guide book provided to them during an intake period or told by staff members. Therefore inmates need to be informed about the choices they have available to them should they become seriously mentally ill.

Because the reaction of inmates in the general inmate population to inmates from the mental health unit influences

whether or not an inmate will volunteer for treatment, inmates in the GP should also be prepared for dealing with the inmates recently discharged from the mental health unit.

The policy of locking up CCU inmates when other inmates from the PE, and unit 9 come for their meals is neither helpful nor harmful because some inmates in CCU do want to socialize with other inmates from other units. Others, however do prefer isolation from other inmates not in their unit.

Also some policies and procedures within the HVWF mental health unit are not followed. For example, the MDOC mental health delivery system is a continuum with five levels of service: outpatient services, protected environment unit, intermediate care program unit, inpatient chronic care unit, and the inpatient acute care unit. HVWF does not have level 3 (which is an intermediate care program unit). The disadvantage of not having this level is that inmates who would benefit from this level are discharged to the PE unit or to other units in the general inmate population when in fact are not yet ready to function within PE and general inmate population units (as a result most inmates discharged from unit three-CCU violate many insitutional rules which are symptomatological of their illnesses).

Inmates in PE are suppose to be in that unit for a period no longer than six months. This policy is not followed in HVWF. There are several inmates who have been in that unit

for a period over a year. The procedure is, if an inmate needs protective care for longer than a six month period, that inmate should be transferred to the intermidiate care unit (also a six month requirement in this unit is a policy). If the inmate requires care beyond a year then that inmate needs inpatient care in CCU or the Acute Care unit.

Also in the PE unit inmates are supposed to be classified according to groups, either group I or group II depending on their illnesses (see chapter IV under "Admissions and Group Classifications of PE Inmates"). This classification is nonexistent in HVWF. The classifications are necessary so that inmates who deteriorate from the current group classification could be transferred to appropriate units e.g CCU or intermediate care unit. Therefore inmates and staff members need to know about services rendered within unit three and the requirements for inmates to be in that unit. Inmates also need to be told about psychotropic medication andt hat an inmate has a right to refuse drugs. Since staff members who are not CMAs (Correctional Medical Aides) also have some stereotypes about unit three (especially CCU) they have to be educated about CCU because they are the members who are in contact with inmate general population most of the time. If they could be educated in how to encourage inmates who are seriously mentally ill, but who do not volunteer for CCU, most inmates with support from staff members could use in-patient psychiatric services.

Suggestions for Future Research

This study looked at the factors which encourage or discourage inmates from seeking institutional psychiatric treatment and determined the characteristics of the inmates likely to volunteer for treatment.

This study sampled only one hundred female inmates from but one institution. A study which will include a larger sample of the mentally ill inmates sampled from different prison institutions is necessary. A comparative study between institutions is also essential because the environmental factors are different in different institutions.

This study only concentrated on female inmates. In order to determine whether the factors associated with volunteering or not volunteering in female institutions are also factors which discourage male inmates from volunteering, a study which will be comparative is necessary. This way, the researcher may be able to determine the factors associated with volunteering across sexes, and across institutions.

The study of the intermediate care unit (as it exists in men's facilities) is also necessary to determine whether the intermediate care level does in fact help or alleviate some volunteering problems encountered within HVWF mental health unit.

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APPENDICES

APPENDIX A

Diagnostic Criteria For Schizophrenia

Diagnostic Criteria for Schizophrenia

A. Presence of Characteristic psychotic symptoms in the active phase: either (1), (2), or (3) for at least one week (unless the symptoms are successfully treated):

(1) two of the following:

(a) delusions
(b) prominent hallucinations (throughout the day for several weeks, each hallucinatory experience not being limited to a few brief moments)
(c) incoherence or marked loosening of associations
(d) catatonic behavior
(e) flat or grossly inappropriate affect

(2) bizarre delusions (i.e., involving a phenomenon that the person's culture would regard as totally implausible, e.g., thought broadcasting, being controlled by a dead person.

(3) prominent hallucinations [as defined in (1)(b) above] of a voice with content having no apparent relation to depression or elation, or a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other

B. During the course of the disturbance, functioning in such areas as work, social relations, and self-care is markedly below the highest level achieved before onset of the disturbance (or, when the onset is in childhood or adolescence, failure to achieve expected level of social development).

C. Schizoaffective Disorder and Mood Disorder with Psychotic features have been ruled out, i.e if a Major Depressive or Manic Syndrome has ever been present during an active phase of the disturbance, the total duration of all episodes of a mood syndrome has been brief relative to the total duration of the active and residual phases of the disturbance.

D. Continuous signs of the disturbance for at least six months. The six-month period must include an active phase (of at least one week, or less if symptoms have been successfully treated) during which there were psychotic symptoms characteristic of Schizophrenia (symptom in A), with or without a prodromal or residual phase, as defined below.

Prodromal phase: A clear deterioration in functioning before the active phase of the disturbance that is not due to a disturbance in mood or to a Psychoactive Substance Use Disorder and that involves at least two of the symptoms listed below.

Residual phase: Following the active phase of the disturbance, persistence of at least two smptoms noted below, these not being due to a disturbance in mood or to a Psychoactive Substance Use Disorder.

Prodromal or Residual Symptoms:

(1) marked social isolation or withdrawal
(2) marked impairment in role functioning as wage-earner, student, or home-maker
(3) markedly peculiar behavior (e.g., collecting garbage, talking to self in public, hoarding food)
(4) marked impairment in personal hygiene and grooming.
(5) blunted or inappropriate affect
(6) disgressive, vague, overelaborate, or circumstantial speech, or poverty of speech, or poverty of content of speech
(7) odd beliefs or magical thinking, influencing behavior and inconsistent with cultural norms, e.g., superstitiousness, belief in clairvoyance, telepathy, "sixth sense," "others can feel my feelings," overvalued ideas, ideas of reference
(8) unusual perceptual experiences, e.g., recurrent illusions, sensing the presence of a force or person not actually present
(9) marked lack of initiative, interests, or energy

E. It cannot be established that an organic factor initiated and maintained the disturbance

F. If there is a history of Autistic Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present.

APPENDIX B

Interview Format

Interview Format

The researcher read these questions to the respondents and recorded answers to avoid misinterpretation.

Background Information

1. Age.....

2. Which of the following best fits you?
   .....Married
   .....Divorced
   .....Single
   .....Widowed
   .....Separated

3. What level of education have you achieved?
   .....seventh grade and less
   .....eigth grade
   .....ninth grade
   .....tenth grade
   .....eleventh grade
   .....twelfth grade
   .....GED
   .....College
   .....Other

4. What type of crime are you imprisoned for?

5. How long is your sentence?
   .....Between 12 and 24 months
   .....Between 25 months and 36 months
   .....More than 36 months
   .....Life

6. How much time have you served so far?
   .....Less than 6 months
   .....more than 6 months but less than 12 months
   .....more than twelve months but less than 36mths
   .....more than 36 mths

7a. Have you ever had trouble with police before?
   .....Yes
   .....No

 b. If yes what was it for?

8. Which of the following best describes your race?
   .....White
   .....Black
   .....Hispanic
   .....Oriental
   .....Other, specify

9. What is your religion?
   .....Catholic
   .....Protestant
   .....Jewish
   .....Moslem
   .....Baptist
   .....Other, specify
   .....None

10. In which unit are you serving time?

Socio Economic Status

11. Before imprisonment were you employed?
    ....Yes
    ....No

12. If yes what kind of work did you do?

13a. What was your major source of income?
    ....Wage of another
    ....My own wages
    ....Welfare
    ....Social Security Income
    ....Other, specify

  b. Do you have children?
    ....No
    ....Yes, was caring for child(ren) born to me
    ....Yes, was caring for child(ren) adopted by me
    ....Yes, but child(ren) were being cared for by someone else
    ....Yes, sharing the care of stepchildren.

14. What was your monthly salary?

Social Distance Items[1]:

Use the following response format for questions 15-18.

0 = definitely willing
1 = not sure
2 = definitely unwilling

15. How would you feel about sharing a cell with an ex-mental patient?
16. How about as a worker i.e. being on the same job?
17. How would you feel about an ex-mental patient as the caretaker of your children?
18. Would you make friends with an ex-mental patient?

Stigma Items

19. Were you ever treated for mental illness?
    .....yes
    .....no

20. If you were sick and thought you needed psychiatric treatment would you seek one in the institution?
    .....yes
    .....no

21a if no why?

b i. Are there experiences you have had or observed which made you decide to volunteer/not to volunteer for CCU (for the subjects already in CCU and PE)?

ii. Are there experiences you have observed which may make you not to volunteer for CCU again (for those inmates who were in CCU before)?

iii. Are there experiences you have observed or had which may make you not to volunteer for CCU? (for the inmates in general population)?

c if yes which were those

22a. If you were discharged from Unit three to the general prison population, how do you think other inmates will react to you or treat you?

---

[1]this scale is borrowed from Link, et al (1987). It has been slightly modified to fit people in corrections.

b. What about the staff members?

c. How would you react to them?

23. Would you make friends with an inmate who has just been discharged from Unit three?

24. If one were to be paroled from this institution and apply for a job should one mention that one had psychiatric problems?
.....yes
.....no

25. If no why?

26. Should an ex mental patient mention to a friend, boyfriend or any other person that she was once a psychiatric patient?
.....yes
.....no

27. If no why?

The Institutional Environment Scale([2]):

28. For the following statements answer true or false. about the unit you are currently serving time in.

Involvement

The residents are proud of this unit.
Residents here really try to improve and get better.
Residents in this unit care about each other.
The unit has very few social activities.
Very few things around here ever get people excited.
Residents do not do anything around here unless the staff ask them to.
This is a friendly unit.

Support

The staff help new residents get acquainted on the unit.
Staff go out of their way to help residents.
Staff are involved in resident activities.
Counselors have very little time to encourage residents.

---

[2]This scale is adopted from Moos (1975) becuase it includes a number of items which are of interest to this researcher.

Expressiveness

Residents are encouraged to show their feelings.
Residents tend to hide their feelings from staff.
Staff and residents say what they feel about each other.
People say what they really think around here.
Residents are careful about what they say when staff are around.
It is hard to tell how residents are feeling in this unit.
On this unit staff think it is a healthy thing to argue.

Autonomy

The staff act on residents' suggestions.
Residents are expected to take leadership on the unit.
Residents have a say about what goes on here.
The staff discourage criticism.
Residents are encouraged to make their own decisions.

Staff Control

Once a schedule is arranged for a resident, he must follow it.
Residents will be tranferred from this unit if they do not obey the rules.
All decisions about the unit are made by the staff and not by the resident.
Staff do not order residents around.
The unit staff regularly check up on the residents.

Perception

29. For the following statements use:
    a. strongly disagree
    b. no opinion
    c. strongly agree

The Chronic Care Unit (CCU) is mostly for people who are violent.
The CCU is for people whose behavior is bizarre.
The CCU is for people who are dangerous.
The CCU is for people with drug related problems.
The CCU is people who are unable to take care of themselves.

The General Health Questions[1]:

29. For the following statements use:
    a. strongly agree
    b. agree
    c. disagree
    d. strongly disagree

I am able to concentrate on what ever I am doing.
I lose much sleep over worry.
I have been having restless and depressed nights.
I have been managing to keep myself busy and occupied.
I feel on the whole that I am doing things well.
I am able to feel warmth and affection for those near to me.
I am finding it easy to get along with other people.
I feel capable of making decisions about things.
I feel constantly under strain.
I feel I could not overcome my difficulties.
I feel life a struggle all the time.
I am able to enjoy my normal day-to-day activities.
I have been feeling scared or panicky for no good reason.
I am able to face up to my problems.
I find everything getting ontop of me.
I have been feeling unhappy and depressed.
I am losing confidence in myself.
I have been thinking of myself as a worthless person.
I have been feeling life is entirely hopeless.
I have been feeling hopeful about my own future.
I have been feeling reasonably happy, all things considered.
I have been feeling nervous and strung-up all the time.
I feel that life is not worth living.

What do you think of your mental health ?
    a. healthier and more stable than average
    b. about average
    c. fairly ill: would be helped by treatment
    d. very ill: need to be in hospital.

---

[1]This scale is adopted from Golberg (1972) becuase he did item analysis and have provided limitations and advantages of his scale. He also tested this scale's reliability by administering it to different patients and nonpatientsand found that the results are comparable.

APPENDIX C

Consent Form

Consent Form

1. I am conducting research for my PhD dissertation on factors associated with volunteering or not volunteering for psychiatric treatment within a female correctional institution. The study will enable the Department of Corrections to minimize those factors which discourage volunteering and increase those which facilitate volunteering.

2. The study only requires you to answer some questions on mental illness and some on the institutional environment as best as you can.

2. By signing below you are indicating that this study has been explained to you and that you understand what it is all about.

3. Your participation is strictly voluntary. You may choose not to participate at all, or not to answer certain questions or to stop your participation at any time without any penalty. Neither the Department of Corrections, nor the warden or any staff at this institution require or pressure you to participate.

4. By signing below you indicate that you are willing to volunteer for this study.

5. All results of the study will be confidential and no one will have access to them. Your responses to the questions will be presented in such a way that no one could figure out what your response was. With your request I can send you the general results of the study.

6. I do need your signature to make my study possible.

If you agree to participate and understand the above paragraphs, please sign below.

Signature_____

APPENDIX D

Patient's Authorization For Disclosure Of Health Records

MICHIGAN DEPARTMENT OF CORRECTIONS
PATIENT'S AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS CHJ-121 7/89

(PRINT FULL NAME OF PATIENT) (NUMBER) (DATE OF BIRTH)

Name and address of person(s) or organization(s) by whom disclosure is to be made.
RELEASED
FROM: Huron Valley Women's Facility

3511 Bemis Rd.

Ypsilanti, Michigan 48917

Name and address of person(s) or organization(s) to whom information is to be given.
RELEASED
TO: Nobuhle Chonco

Michigan State University

Criminal Justice Student

SPECIFIC INFORMATION TO BE DISCLOSED (Include dates of treatment):

Diagnosis, dates of admission into CCU, PE. Reviewing institutional files for prior conviction and social history.

PURPOSE AND NEED FOR SUCH DISCLOSURE: Research study to complete PhD. No identifying information will be used.

I understand that my records (including alcohol, drug abuse, mental status and serious infectious and communicable diseases including venereal diseases, tuberculosis, HIV, AIDS and ARC) are protected under the State and Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I may revoke this authorization at any time and that this authorization pertains to fulfillment of the above stated purpose(s) and will automatically expire after six months from date of signature.

I have read the above, and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I DO HEREBY CONSENT TO THE DISCLOSURE OF THE ABOVE DESCRIBED INFORMATION CONTAINED IN MY HEALTH RECORD.

DATE PATIENT'S SIGNATURE

DATE WITNESSED BY

Prohibition of redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal and State law. Federal regulations (42 CF Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Drug abuse office and treatment act of 1972 (21 USC 1175) comprehensive alcohol abuse alcoholism prevention, treatment and rehabilitation act of 1970 (42 USC 4582), federal register, Vol. 40, No. 127, Tuesday, July 1, 1975.

Requested by
Physician (Please Print)

APPENDIX E

Consent To Inpatient Psychiatric Treatment

MICHIGAN DEPARTMENT OF CORRECTIONS — Bureau of Health Care CHJ-156 4/86

RIGHTS INFORMATION

I have received the Guide Book containing a description of my rights and responsibilities and the names of persons to contact to discuss any complaints regarding possible violations of my rights as a patient.
This information is required by law and was explained to my satisfaction.

_____ _____
Date

☐ PATIENT'S SIGNATURE ☐ GUARDIAN'S SIGNATURE

NOTICE

CHAPTER 10 OF THE MICHIGAN MENTAL HEALTH CODE ALLOWS FOR THE TRANSFER OF PRISONERS TO THE DEPARTMENT OF MENTAL HEALTH'S CENTER FOR FORENSIC PSYCHIATRY. AT TIMES, A PROBATE COURT MUST CONDUCT A HEARING TO DETERMINE IF SUCH A TRANSFER IS TO BE MADE. DURING THIS HEARING, PSYCHIATRIC CENTER STAFF MAY HAVE TO TESTIFY AS TO YOUR BEHAVIOR. ALTHOUGH YOUR CONVERSTATIONS WITH STAFF IN FORMAL DIAGNOSTIC OR THERAPY SESSIONS ARE CONSIDERED CONFIDENTIAL, YOUR BEHAVIOR AND STATEMENTS MADE OUTSIDE OF THESE SESSIONS MAY SERVE AS THE BASIS OF TESTIMONY BY STAFF.

The above statement was read to _____ (patient's name) _____ (number) on _____ (date) at _____ (place)

_____ (PRISONER / PATIENT'S SIGNATURE) _____ (STAFF SIGNATURE)

CONSENT TO TREATMENT

In accordance with my rights, I consent to receive and accept routine diagnostic tests (laboratory, psychological, etc), medication and other treatments deemed appropriate by the medical, and psychiatric staff of the Bureau of Health Care Services of the MICHIGAN DEPARTMENT OF CORRECTIONS. I understand I have a right to receive a detailed explanation of expected benefits, risks, and possible side effects of any medication being considered in my treatment.
I understand this consent can be withdrawn and I may discontinue my participation in treatment at any time.

Comments: _____

_____ _____
Date

☐ PATIENT'S SIGNATURE ☐ GUARDIAN'S SIGNATURE

_____ _____
SIGNATURE OF STAFF WITNESS Date

PSYCHIATRIST'S REVIEW

I have reviewed the above consent to treatment. In my opinion, the patient:

_____ is able to give informed consent
_____ is not able to give informed consent for the following reason(s):

_____ _____
PSYCHIATRIST'S SIGNATURE DATE

PATIENT RIGHTS / CONSENT TO INPATIENT PSYCHIATRIC TREATMENT

PATIENT IDENTIFICATION

Name:
Number:
D.O.B.:

APPENDIX F

CCU Rules

PLEASE POST ON ALL BULLETIN BOARDS

CCU RULES

I. RULES AND REGULATIONS

The following areas are out of bounds:

1. Any corridor or wing other than the one on which you live. You should enter and exit the BR through the door on the hall in which you live.

2. Laundry, study, recreation, and dining room except during scheduled hours as posted.

3. No loitering on window ledges, unit doorways, corridors or CMA's desk.

4. No prisoner is allowed to sit in the CMA's chair or on CMA's desk.

5. No prisoner is to enter another prisoner's room for any purpose unless accompanied by an employee Employees are not allowed to permit a prisoner to enter another prisoner's room, except for maintenance reasons or to assist a prisoner in an emergency.

6. CCU offices are out-of-bounds unless prior staff approval is given before entering

II. DINING ROOM

1. No one other than dietary staff is allowed behind the food counter.

2. Prisoners must enter the dining room through the door by the telephones and exit through the door by the dishwasher as a group.

3. Nothing will be taken from the kitchen except one piece of fresh fruit which must be eaten the same day. Snacks are provided. Passing of food is not allowed.

4. Prisoners are not allowed to bring cups, containers or other items in the dining room.

5. Unit prisoners are not allowed in the dining room or to converse with those prisoners from other units who are entering, leaving, or eating.

6. Prisoners are to report to all meals in appropriate attire — sleeveless tops, lounge ware, curlers or slippers are not allowed at any time. Socks must be worn with open-toed shoes or sandals.

7. Prisoners are not permitted to use the kitchen facilities for personal food preparation.

8. Prisoners are to return to rooms if count is on when finished eating. No stopping for ice or hot water.

9. Prisoners on special diets details must eat at specified time in designated dining room.

10. Kitchen is open during meals only. Five minutes after the first call for meals is given, the doors are locked. Twenty minutes are allotted for the meal. Prisoners are expected to be on time.

11. Prisoners are to receive only their allotted portion of food on tray, and must receive all food the first time through the line. No cutting in the line. Prisoners are encouraged to eat but those electing not to eat will be locked in their rooms.

12. No smoking in dining rooms.

III. RECREATION ROOM AND STUDY ROOM

1. No screaming, dancing, horseplay, etc., allowed.

2. No eating of food allowed, drinks are permitted.

3. Radios and tape players with earplugs only in recreation room. Activity therapy equipment can only be used with activity therapy permission and in the presence of a staff person.

4. Furniture must be arranged so that prisoners are in full view of staff. No sitting in window ledges no feet on radiators.

5. No lying down on the couch. No body contact. No lying or sitting down on the floor or on the tables.

6. Prisoners must be properly dressed — robes, lounge ware and pajamas are not allowed. Slippers not allowed.

7. Lights must remain on until 2220 hours in the recreation and study room.

IV. TELEPHONES

1. Telephone hours:

Monday - Friday	1530 p.m. - 2100 p.m.
Sat. - Sun.	0800 a.m. - 2100 p.m.
Holidays	0800 a.m. - 2100 p.m.

2. No calls are to be placed when the count is on. All calls in process are to end when count comes on.

3. Only one person to a phone call, no sharing conversations.

4. There is a ten minute limit on calls when others are waiting to use the phone. When no one is waiting to use the phone, conversation may be extended to not more that fifteen (15) minutes.

V. LAUNDRY

1. Washers and dryers are to be used by classified laundry workers only. Personal hand wash must be done when laundry is completed.

2. Limit is one person in laundry room at a time. No loitering. No personal laundry will be done while classified laundry worker is on duty.

3. There is to be no food, drink or sound equipment in laundry room.

4. The laundry rooms are to be left clean after use including the dryer lint trap and drain.

IV. RESIDENT'S ROOM

1. All prisoners must be up at 0630 hours Monday through Saturday. Beds are to be made by 0700 hours, and rooms straightened before leaving for school or work assignments by 0730 hours (expect lay-ins). Prisoners, except medical lay-ins, should be dressed by 0730 hours. On Sunday and holidays, 0900 hours, wake up 0930 hours - beds made, 1000 hours - prisoners should be dressed, 2130 - close custody, 2230 - non close. Lock up time is 2230 hours, lights out at 2400 hours, midnight. Prisoners who do not have Saturday and Sunday off days will have their second off day treated as Sunday for wake up purposes.

2. All clothing, shoes and personal items, etc., are to be neatly stored in locker and desk. Only a radio, television and lamp are to be kept on desk tops.

3. Pictures etc., must be hung on bulletin boards or inside lockers only.

4. Furniture must be arranged according to regulation floor plan.

5. Door windows are not to be covered except for dressing or undressing. They must not be covered at count time. Window coverings may not be affixed to the door.

6. No items should hang from curtains, lights or ceiling.

7. Mirrors should not be removed from the wall.

8. All completed hobbycraft items are contraband in the unit. If you choose, they will be displayed in the unit for everyone's enjoyment.

9. Stuffed items and stuffed quilts of any sort are not permitted.

10. CCU prisoner who are medium or minimum custody (I, II, or III), and are/or "A" status may have a room and a locker key.

11. Rooms are to be maintained in a clean and orderly fashion at all times. Unit cleaning supplies will be available on Saturday for individual room cleaning.

12. Room vents are not to be plugged at any time. Prisoners are to clean room vents weekly.

13. Curtains must permit light to enter room and only one set may be hanging. Non-commissary curtains must be labeled flame retardant.

14. Ear plugs must be used with T.V.'s, radios, and tape players. Sound equipment, T.V.s and lights must be turned off when leaving rooms.

15. There are to be no flammable coverings on prisoner's toilets, desks, footlockers, or any flat surfaces in prisoner's rooms. Crocheted or knitted Afghans should not be on top of the beds.

VII. GENERAL REGULATIONS AND INFORMATION

1. Residents are to use only the front door of the wing where they live.

2. Saturday is general cleaning day for housing units and everyone who is not on work assignment on Saturday is to help clean the unit.

3. Prisoners may not leave the unit without an I.D., plus a pass from staff or detail.

4. Prisoners on medical lay-in will be required to remain in their area or rooms, except for meals and bathroom privileges, unless otherwise ordered by the physician.

5. All prisoners classified as unemployable are confined to their area or rooms except for meals and bathroom privileges and unit therapeutic activities from 0830 to 1545 hours. Prisoners who are unassigned due to irresponsible behavior, poor performance or disciplinary reasons will be confined to their rooms as unemployable.

6. Smoking is allowed in the CCU.

7. CCU prisoners will not be allowed to have personal sewing supplies. They will be allowed to check out sewing supplies through housing staff.

8. Prisoners in the CCU will not be allowed to keep medication of any type (including over the counter medications) in their rooms. All medications will be issued by the nurse.

APPENDIX G

Psychiatric Team Misconduct Review

HURON VALLEY WOMEN'S FACILITY COMPREHENSIVE CARE UNIT

PSYCHIATRIC TREATMENT TEAM MISCONDUCT REVIEW

Prisoner Name:_____ Number:_____

Date of Alleged Misconduct:_____

Nature of Alleged Misconduct:

Reviewed by:_____ Date:_____
(Unit Treatment Team)

Findings/Recommendations: (Check one of the following)

A. Patient/prisoner appears to be responsible for his or her behavior at or near the time of the alleged misconduct. (Complete following section and forward to Hearings Officer.)

B. Patient/prisoner is not responsible for his or her behavior at or near the time of the alleged misconduct. (Forward this review to social worker. Do not complete the following section.)
Comments_____

_____

_____

_____

ONE OF THE FOLLOWING MUST BE CHECKED IF "A" ABOVE IS CHECKED:

Appropriate health care CANNOT be provided to this patient in punitive segregation.

Appropriate health care CAN be provided to this patient in punitive segregation. However, the following conditions must be met: (specify)

_____

_____

_____
Signature - Psychiatrist/Phy.

_____
Date

APPENDIX H

Security Classification Screen-Review Form

MICHIGAN DEPARTMENT OF CORRECTIONS
4835-3481
CSJ-481 10/88

SECURITY CLASSIFICATION SCREEN - REVIEW

Prisoner Name (last, first)	Prisoner Number	Date Entered on CMIS
Date	Institution	Screened By

CONFINEMENT LEVEL

EARLIEST RELEASE Date = month_____ year_____
Term = years _____ months_____

CONF. LEVEL

1. Any escape attempt or conspiracy to escape secure adult custody in last 5 years?
   ☐ no yes ☐ → V
2. Two such escape incidents or any involving hostages or violence in last 10 years?
   ☐ no yes ☐ →
3. Is prisoner within 6 years of ERD, or if not has served more than one-third ERD term?
   ☐ yes no ☐ → IV
4. Does prisoner have a record of predatory homosexual behavior in an institutional setting?
   ☐ no yes ☐ →
5. Is prisoner serving or pending service on escape sentence or had a non-CRP adult walkaway in last 5 years?
   ☐ no yes ☐ →
6. Are there 3 or more instances of escape/absconding/walkaway/AWOL in last 10 years?
   ☐ no yes ☐ →
7. Is prisoner within 3 yrs of ERD, or within 4, with 2 years served?
   ☐ yes no ☐ →
8. Is there a juvenile arrest record as well as a walkaway from juvenile or non-CRP adult facility in last 10 years?
   ☐ no yes ☐ → II
9. Is prisoner VH (or first year and potential VH assault risk), without a definite parole or discharge date within next year?
   ☐ no yes ☐ →
10. Is prisoner serving a life sentence?
    ☐ no yes ☐ →
11. Major pending felony charges?
    ☐ yes →
    ☐ no → I

CONFINEMENT LEVEL [1]

MANAGEMENT LEVEL

Management Score at last screening
Dated_____ was (A) [ ] Enter Points

SINCE THAT DATE

1. Number of acts resulting in separate major misconducts =____
2. Number of those which were non-bondable or resulted in felony conviction X2=____
3. Number of those involving serious injury X2=____
4. Has assault risk increased to V.H. =4=____
5. Classified one or more times to involuntary segregation =4=____
6. Found guilty of homicide, rioting, striking or inciting riot or strike =10=____

SUBTOTAL, Unfavorable Behavior (B)____

7. Number of six month periods completed without any major misconducts or invol. seg. or convictions
   Date of the periods:_____ X3=____
8. Number of six month periods completed with satisfactory work/school performance. Date of the periods:_____ X2=____
9. Reached age 26 since last screening =2=____
10. Completed G.E.D. or earned vocational certificate or college degree. =1=____

SUBTOTAL, Favorable Behavior (C)____

TOTAL CHANGES (Indicate plus or minus) (B-C=D) (D)____

NEW SCORE (A+D=E) (If minus enter zero) Range 0-35 (E)____

0-6 Level I; 7-10 Level II; 11-14 Level III; 15-22 Level IV; 23-35 Level V

NEW MANAGEMENT LEVEL [2]

TRUE SECURITY LEVEL

1. Cross out the lower of the two levels above
2. If you agree that the remaining box correctly identifies this prisoner's true security needs, enter that level again here: [3]
   (If not, enter here the level which does, and the reason for the difference) _____

Two Level Difference Requires C.O. Approval APPROVED BY _____ DATE _____

TRUE SECURITY LEVEL

ACTUAL PLACEMENT LEVEL

If there is a placement available at the prisoner's true security level enter that level here: [4]
(If not, enter level where prisoner will be placed and reason for the difference) _____

Two Level Difference Requires C.O. Approval APPROVED BY _____ DATE _____

ACTUAL PLACEMENT LEVEL

DISTRIBUTION: White - Record Office; Canary - Central Office; Pink - Counselor; Goldenrod - Prisoner

APPENDIX I

CCU Concurrent Review

HURON VALLEY COMPREHENSIVE CARE UNIT

CONCURRENT REVIEW

IDENTIFYING DATA:

NAME _____ ID NUMBER _____ D.O.B. _____ AGE _____ SEX _____

ADMISSION DATE _____ DISCHARGE DATE _____ LENGTH OF STAY _____

DISCHARGE INDICATORS

A patient is to be released through a clinically-approved discharge if one or more of the following criteria are met:

[1] Withdrawal of voluntary consent

[2] Pending planned parole, CRP transfer, or suggested maximum time

[3] Able to maintain an acceptable level of functioning with mental health services provided by OPMHT in general population

[4] Failure to comply with treatment recommendations of the Interdisciplinary Treatment Team

[ ] Requires placement in an acute psychiatric inpatient hospital setting due to change in condition

[6] Meets criteria for placement in P.E.

COMMENTS: _____

_____

_____

_____

HURON VALLEY COMPREHENSIVE CARE UNIT

CONCURRENT REVIEW

IDENTIFYING DATA:

NAME ______ ID NUMBER ______ D.O.B. ______ AGE ___ SEX ___

ADMISSION DATE ______ ANTICIPATED DISCHARGE DATE ______

CONTINUED STAY REVIEW

	30 DAYS	180 DAYS	365 DAYS
REVIEW DATE			
REVIEWER'S INITIALS			
APPROVE			
REFER			
SEVERITY OF ILLNESS [circle at least one]	1. Unable to maintain an acceptable level of functioning with mental health services provided by OPHMT in general population 2. Does not meet criteria for placement in P.E. 3. Need for continuous skilled observation, supervision, and control of behavior 4. Lack of improvement of admitting symptomatology 5. Continued destructive threats/behavior toward staff, others, and/or property	1. Unable to maintain an acceptable level of functioning with mental health services provided by OPMHT in general population 2. Does not meet criteria for placement in P.E. 3. Need for continuous skilled observation, supervision, and control of behavior 4. Lack of improvement or admitting symptomatology 5. Continued destructive threats/behavior toward staff, others and/or property	1. Unable to maintain an acceptable level of functioning with mental health services provided by OPMHT in general population 2. Does not meet criteria for placement in P.E. 3. Need for continuous skilled observation, supervision, and control of behavior 4. Lack of improvement of admitting symptomatology 5. Continued destructive threats/behavior toward staff, others, and/or property

COMMENTS ______

HURON VALLEY COMPREHENSIVE CARE UNIT

CONCURRENT REVIEW

IDENTIFYING DATA:

NAME_____ ID NUMBER_____D.O.B._____AGE_____SEX_____

ADMISSION DATE_____ ANTICIPATED DISCHARGE DATE_____

ADMISSION DIAGNOSIS [The condition chiefly responsible for admission of patient to the unit]

DSM-III-R CODE

_____ _____

_____ _____

ADMISSION REVIEW [Required at the time of admission]

REVIEW DATE_____ REVIEWER'S INITIALS_____

APPROVE: YES_____ NO_____ REFER: YES_____ NO_____

INDICATORS [Circle at least one]:

1] Has a serious chronic mental disorder

2] Requires services which are more comprehensive than those available in a general population setting, even with the support from the Outpatient Mental Health Team

3] Inappropriate for placement in a Protective Environment (P.E.)

4] Unable to make the transition from P.E. into general population within six months

5] Not acutely mentally ill requiring inpatient psychiatric hospitalization

6] Willing to participate in the services of Comprehensive Care Unit. Signed written, voluntary consent to treatment

APPENDIX J

Institutional Rules And Regulations

Please Post On All Bulletin Boards

Housing Unit

I. **RULES AND REGULATIONS**

The following areas are out of bounds:

1. Any corridor or wing other than the one on which you live.

2. Laundry, study recreation, and dining room except during scheduled hours.

3. No loitering om window ledges, unit doorways, corridors or officer's desk.

4. No prisoner is allowed to sit in the officer's chair or on officer's desk.

5. No prisoner is to enter another prisoner's room for any purpose unless accompanied by an employee. Employees are not allowed to permit a prisoner to enter another prisoner's room, except for maintenance reasons or to assist a prisoner in an emergency.

Please Post On All Bulletin Boards

Housing Unit

II. **DINING ROOM**

1. No one other than dietary staff is allowed behind the food counter.

2. Prisoners must enter the dining room through the door by the telephones and exit through the door by the dishwasher as a group.

3. Nothing will be taken from the kitchen except one piece of fresh fruit which must be eaten the same day. Snacks are allowed per detail.

4. Prisoners are not allowed to bring cups, containers or other items in the dining room.

5. Unit prisoners are not allowed in the dining room or to converse with those prisoners from other units who are entering, leaving or eating.

Please Post On All Bulletin Boards

Housing Unit

6. Prisoners are to report to all meals in appropriate attire - sleeve-less tops, lounge ware, curlers or slippers are not allowed at any time.

7. Prisoners are not permitted to use the kitchen facilities for personal food preparation.

8. Prisoners are to return to rooms if count is on when finished eating. No stopping for ice or hot water.

9. Prisoners on special diets details must eat at specified time in designated dining room.

10. No snacks will be given out unless ordered by the clinic.

11. Kitchen is open during meals only. 5 minutes after the first call for meals is given, the doors are locked. 20 minutes are allotted for meal.

Please Post On All Bulletin Boards

Housing Unit

12. Prisoners are to recieve only their alloted portion of food on tray, and must recieve all food the first time through the line. No cutting in the line. Prisoners electing not to eat will be locked in their rooms except in U-2. Prisoners in Units 1,3, and 8 are locked down 10 minutes before noon and dinner meal.

13. No smoking in dining room.

III. **RECREATION ROOM AND STUDY ROOM**

1. No screaming, dancing, horseplay, etc., allowed.

2. No eating of food allowed, drinks are permitted.

3. Radios and tapeplayers with earplugs only in recreation room.

4. Furniture must be arranged so that prisoners are in full view of the officers. No sitting in window ledges and no feet on radiators.

Please Post On All Bulletin Boards

Housing Unit

5. No lying down on the couch. No body contact. No lying or sitting down on the floor or on tables.

6. Prisoners must be properly dressed - robes, loungeware and pajamas are not allowed. Slippers not allowed.

7. The study room is for these designated activities with the following limitations. Ironing; 2 prisoners, Grooming; 4 prisoners, Study: 3 prisoners.

8. Lights must remain on until 2220 hours in the recreation and study room.

IV. TELEPHONES

1. Telephone hours:

Mon - Fri.	1530 p.m. - 2100 p.m.
Sat. & Sun.	0800 a.m. - 2100 p.m.
Holidays	0800 a.m. - 2100 p.m.

2. Only use the telephone on your wing.

Please Post On All Bulletin Boards

Housing Unit

3. No calls are to placed when the count is on. All calls in process are to end when count comes on.

4. Only one person to a phone call, no sharing conversations.

5. There is a ten minute limit on calls when others are waiting to use the phone. When no one is waiting to use the phone, conversation may be extended to not more than fifteen (15) minutes.

V. LAUNDRY

1. Washers and dryers are to be used by classified laundry workers only. Personal hand wash be done when laundry is completed.

2. Limit is one in laundry room. No loitering. No personal laundry will be done while classified laundry worker is on duty.

3. There is to be no food, drink or sound equipment in laundry room.

4. The laundry rooms are to be left clean after use including the dryer lint trap and drain.

5. Prisoners must use their own wing for laundry purposes. Personal clothing is not to be hung for drying in the laundry room.

VI. **RESIDENTS ROOMS**

1. All prisoners must be up at 0630 hours Monday through Saturday. Beds are to be made by 0700 hours, and rooms straightened before leaving for school or work assignments by 0730 hours (except lay-ins). Prisoners, are except medical lay-ins, should be dressed by 0730 hours. On Sunday and holidays, 0900 hours, wake up, 0930 hours - beds made, 1000 hours - prisoners should be dressed. Lock up time is 2300 hours, lights out at 2400 hours midnight. Prisoners who do not have Saturday and Sunday day off days will have their second off day treated as Sunday for wake up purposes.

2. All clothing, shoes and personal items, etc., are to be neatly stored in locker and desk. Only a Radio, Television and Lamp are to kept on desk tops.

3. Pictures etc. must be hung on bulletin boards or inside lockers only.

4. Furniture must be arranged according to regulation floor plan.

5. Door windows are not to be covered except for dressing, undressing or using the toilet. They must not be covered at count time. Window coverings may not be affixed to the door.

6. No items should hang from curtains, lights or ceiling.

7. Mirrors should not be removed from the wall.

8. Stuffed items and stuffed quilts of any sort are not permitted.

9. All completed hobbycraft items are contraband in the unit.

10. Prisoners in Units 2 & 3 are given a room key and locker key. Prisoners in Unit 1 & 8 only receive a locker key. Prisoners are responsible for these keys.

    *Issuance of keys on the CCU will be done according to the treatment plan.

11. Rooms are to be maintained in a clean and orderly fashion at all times. Unit cleaning supplies will be on Saturday for individual room cleaning. Buffers are not to be used in individual rooms.

12. Rooms vents are not to be plugged at any time. Prisoners are to clean room vents weekly.

13. Curtains must permit light to enter room and only one set may be hanging. Non-Commissary curtains must be labeled flame retardant.

14. Ear plugs must be used with T.V.s, radios and tape players. Sound equipment, T.V.s and lights must be turned off when leaving rooms.

Please Post On All Bulletin Boards

Housing Unit

15. There are to be no flammable coverings on prisoner's toilets, desks, footlockers, or any flat surfaces in prisoner's rooms. Crocheted or knitted afgans should not be on top of the beds.

VII. GENERAL REGULATIONS AND INFORMATION

1. Residents are to use only the front door of the wing where they live.

2. Saturday is general cleaning day for housing units and everyone who is not on work assignment on Saturday is to help clean the unit.

3. Prisoners may not leave the unit without an I.D., plus a pass from staff or detail.

4. Prisoners on medical lay-in will be required to remain in their or rooms, except for meals and bathroom privileges.

Please Post On All Bulletin Boards

Housing Unit

5. All prisoners classified as unemployable are confined to their area or rooms except for meals and bathroom privileges from 0830 to 1545 hours. Prisoners who are unassigned due to irresponsible behavior, poor perfomance or disciplinary reasons will be confined to their rooms as unemployable.

6. Smoking is allowed in rooms and designated areas only.

7. CCU prisoners will not be allowed to have personal sewing supplies. They will be allowed to check out sewing supplies through housing staff.

8. Prisoners on the CCU will not be allowed to keep medication of any type (including over the counter medications) in their rooms. All medications will be issued by the nurse.

G. Williams, Deputy Warden (Date)

Resident Unit Manager (Date)

APPENDIX K

Consent For Treatment With Psychotropic Medication

MICHIGAN DEPARTMENT OF CORRECTIONS - Bureau of Health Care

4835-7157 10/89
CHJ-157

I, _____, am a patient of Dr. _____.

My physician has informed me that he/she recommends that I receive the medication

_____ which is an _____.
(Generic or trade name of medication) (specify antipsychotic, antimanic, antidepressant)

He/she has informed me of the nature of the treatment and has explained to me the risks of possible side effects including dry mouth, excessive thirst, blurry vision, constipation, tremor, muscle spasms and restlessness.

If an antipsychotic medication has been recommended, he/she has specifically discussed with me the risk of tardive dyskinesia, which may cause involuntary tic-like movements in the face, tongue, neck, arms and/or legs, and which may persist even after treatment when the medication has been stopped.

I understand that although my doctor has explained to me the most common side effects of this treatment, there may be other side effects, and that I should promptly inform him/her or another member of the staff if there are any unexpected changes in my condition.

I understand that I may discontinue this medication if I choose, but that I should inform my doctor before doing so. I also understand that although my doctor believes that this medication will help me, there is no guarantee as to the results that may be expected. I have been informed of the risks of refusing the recommended treatment. I have been informed that refusing medication does not prevent me from receiving other types of treatment offered here.

On this basis, I authorize my doctor or anyone authorized by him/her to administer the above-named medication at such intervals as he/she deems advisable.

DATED: _____ SIGNED: _____
(PATIENT)

DATED: _____ SIGNED: _____
(WITNESS)

CONSENT FOR TREATMENT WITH PSYCHOTROPIC MEDICATION

PATIENT IDENTIFICATION

Full Name:

Number:

D.O.B.

DISTRIBUTION: White - Health Record; Canary - Patient

APPENDIX L

Michigan State University Committee On Research Involving Human Subjects Letter

MICHIGAN STATE UNIVERSITY

UNIVERSITY COMMITTEE ON RESEARCH INVOLVING
HUMAN SUBJECTS (UCRIHS)
206 BERKEY HALL
(517) 353-9738

EAST LANSING • MICHIGAN • 48824-1111

August 10, 1989

IRB# 89-318

Nobuhle Chonco
915 B Cherry Lane
East Lansing, MI 48823

Dear Ms. Chonco:

Re: "THE MENTALLY ILL FEMALE INMATES: DO LABELS MATTER BEHIND BARS **IRB# 89-318**"

The above project is exempt from full UCRIHS review. I have reviewed the proposed research protocol and find that the rights and welfare of human subjects appear to be protected. You have approval to conduct the research.

You are reminded that UCRIHS approval is valid for one calendar year. If you plan to continue this project beyond one year, please make provisions for obtaining appropriate UCRIHS approval one month prior to August 10, 1990.

Any changes in procedures involving human subjects must be reviewed by the UCRIHS prior to initiation of the change. UCRIHS must also be notified promptly of any problems (unexpected side effects, complaints, etc.) involving human subjects during the course of the work.

Thank you for bringing this project to our attention. If we can be of any future help, please do not hesitate to let us know.

Sincerely,

John K. Hudzik, Ph.D.
Chair, UCRIHS

JKH/sar

cc: M. Morash