SLOW DECLINE

The Social Organization of Mental Health Care

in a Prison-Hospital

by

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ABSTRACT

Within Canada’s federal correctional system, prison-hospitals provide both in-patient and ambulatory services to incarcerated male offenders. With at least 12% of incarcerated men being identified at intake as having a mental health disorder, the need for these services is significant (Sampson, Gascon, Glen, Louie & Rosenfeldt, 2007). While some description of the mental health services provided, internal operational reviews, and external health services accreditation surveys of these prison-hospitals are available, there has been very little attention paid to the challenge of trying to balance the dual correctional and mental health mandates of these facilities. Research in comparable facilities and services in the United States describe mental health care as a ‘non-system’ of care and state that mental health staff receive very little system-wide direction regarding the provision of services (Cruser & Diamond, 1996; Elliot, 1997).

This is a study that critically analyses how mental health care has become subordinated to correctional and security priorities in a Canadian prison-hospital. Five key elements identified in the policy implementation literature are used to explicate the everyday experiences of frontline staff as they work to provide mental health services in this correctional environment. The thesis argues that the mental health work of frontline prison staff is subverted by a lack of vision for mental health care within organizational policy structures, allowing the detailed correctional policy structures to become the dominant force in implementation and decision making.

Using the theory and method of institutional ethnography developed by sociologist Dorothy Smith, the analysis displays how the everyday activities of frontline staff are
systematically organized by routine organizational policy structures to advance the correctional mandate of the prison-hospital while mental health care has slowly declined. The study finds that mental health care is socially organized as a ‘zero-sum game’. As policy texts have concerted and coordinated the everyday activities of frontline staff in predictable ways, gains for the correctional and security priorities of the prison-hospital have meant significant and repeated losses for mental health care. However, there are ‘windows of opportunity’ for frontline staff to advance the mental health mandate of the prison-hospital if they work together.
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This thesis is dedicated to Dave Champagne
You have challenged me, inspired me, provoked me,
and taught me the power of writing a letter!
To do good to mankind is the chivalrous plan,
And is always as nobly requited;
Then battle for freedom wherever you can,
And, if not shot or hanged, you’ll get knighted.

- George Gordon, Lord Byron

from ‘When a Man Hath No Freedom to Fight for at Home’
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1.1 The problematic: Subordination of mental health care

My interest in conducting this study arose from my own experience working as an occupational therapist within the prison-hospitals of Canada’s federal correctional system. There is a prison-hospital in each of the five regions of the federal correctional system and the purpose of each is to provide in-patient and ambulatory mental health care to incarcerated male offenders within their respective regions (Commissioner’s Directive 850, 2002). While employed at the prison-hospital under study, I frequently observed and experienced the frustrations of being prevented from doing mental health work due to the emphasis on security and case management priorities. A key example of this was the frequent closure of the activity building, where many mental health and correctional program staff carry out individual and group interventions. While certain time-limited closures of the activity building were planned to off-set correctional overtime costs, most of the time decisions to remove the correctional officers and close the building happened on a day-to-day basis depending on the need for correctional officers in other security functions. It became common practice for the activity building to be closed more often than it was open.

Other examples of being prevented from doing mental health work included, therapeutic groups being terminated, vacated mental health positions being left unfilled, and requests for continuing professional education of mental health staff being turned.

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1 I was employed by the Correctional Service of Canada for 10 years, six of those years at the prison-hospital that is the focus of this study. My employment at this prison-hospital, and with the Correctional Service of Canada, ended just as data collection for this study began.
down. One day, a colleague remarked to me that, “it seems as though, somehow, at the regional and national levels we are being systematically destroyed.”

I found this statement intriguing and provocative. It caused me to wonder about the source of our frustrations as frontline mental health workers. I began to wonder about the reasons for decisions regarding operational adjustments, service priorities, and human resource management. I also began to wonder about the value placed on the work of mental health professionals and about the tensions created by the dual mandates of the psychiatric prison-hospital to provide both custody and care.

As I explored research paradigms for addressing these matters, I found the theory and method of institutional ethnography as developed by Dorothy Smith (1987, 1990a, 1990b, 2005, 2006) helped me to understand what I had seen and experienced as a systematically organized way of doing things. Smith describes the circumstances I had experienced as examples of social relations. What Smith calls the social relations of everyday life is peoples’ activities and the ongoing and purposeful arrangement and coordination of those activities. People participate in social relations, often unknowingly, as they act competently and knowledgably to arrange and coordinate their actions with professional standards or cultural expectations or organizational rules. Social relations of everyday life actually organize what goes on, including people’s own decisions and actions and how they are coordinated with outside events. The interplay of social relations constitutes social organization – things being put together systematically but more or less outside a person’s knowledge and for purposes that may not be their own.

Smith believes that texts are essential to this form of social organization as they function to make invisible connections between layers of activity at different localities.
Text has the power to coordinate and arrange things as various people handle and process the same text. They find their actions coordinated by the requirements of working with that text. Analyzing texts as part of social relations allows the discovery of how people are related to each other in pre-determined ways, even if they do not know each other and never meet. Institutional ethnography “begins with some issues, concerns, or problems that are real for people and that are situated in their relationships to an institutional order” (Smith, 2005, p.32). The concepts put forth by Smith enabled me to consider my experiences as predictable, coordinated events that were tied to the activities of others through routine organizational structures.

In institutional ethnography, the notion of ‘text’ refers to words, images or sounds set into a material form that can be read, seen, heard, etc. They are commonplace objects such as books, bus passes, student cards, the radio, e-mail messages, movies, and so on such that anyone else anywhere else can read, see, or hear the same words, images or sounds as any other person engaged with the same text (Smith, 2006). Within the current study, policy texts are understood to be a central part of the social organization of the prison-hospital. National, regional, and institutional policies are routine organizational structures that make invisible connections between various sites at differing levels of the correctional organization.

1.2 The current study

The current study examines the disjuncture between the experiences of frontline staff providing mental health care and the formal organizational structures as an important dimension of institutional power. It examines how the provision of mental
health care by frontline workers in a prison-hospital is shaped by organizing structures that exist at organizational, systemic and social levels and is informed by the problematic outlined above. Attempts are made to explicate how organizing structures came to shape the everyday practice of frontline workers in the prison-hospital in ways that appear to subordinate the mental health mandate of the prison-hospital.

An increasing body of mental health and criminal justice literature suggests that there is value inherent in the provision of mental health care within prison systems (Elliott, 1997; Green, Miranda, Daroowalla, & Siddique, 2005; McCoy, Roberts, Hanrahan, Clay, & Luchins, D., 2004; Reed & Lyne, 2000; Ruddell, 2006). This body of literature also shows that mental health care in prisons is characterized by ‘tensions’ between two different ideologies and types of practice. These are not the tensions of frustration or interpersonal difficulties that may arise between particular individuals in particular settings. Rather, these are socially organized tensions. The social relations that have developed within the prison-hospital being studied appear to have produced a gradual deterioration in mental health care through the implementation of organizational policies.

The approach taken to study this problem has been to use an extant policy implementation framework from the literature to describe the major elements influencing the policy implementation process. Then, from my standpoint of 10 years as an occupational therapist in Canada’s federal correctional system, I developed an institutional ethnography of frontline staff’s implementation of mental health policies in a prison-hospital. Institutional ethnography was developed as a feminist sociology (Smith, 1987; 1990a; 1990b; 2005; 2006) but has been applied more broadly to examine topics
including nursing work (Campbell, 2001; Gregor, 1994), child neglect (Swift, 1995), literacy (Darville, 1995), palliative care (Miller, 1997), and others. It is used here to analyze professional practice in a prison-hospital and captures a process of organizational change brought about through a series of critical events.

Qualitative data directly link the study to the Correctional Service of Canada’s policies as well as policy implementation theory that provides a framework for explicating the social organization of power and ruling relations of the prison-hospital. Peoples’ work is understood to be systematically arranged and coordinated by something not visible from within the everyday activities of the local setting. An individual’s story, such as my own, necessarily implies the presence and doings of others caught up in and participating in the relations that coordinate their doings. “Learning how peoples’ lives are organized outside of their own knowledge and control makes it possible to understand domination and subordination” (Campbell & Gregor, 2002, p.61).

This institutional ethnography explores with frontline staff their experience of providing mental health care in a prison-hospital and how this is connected with what is beyond their own experience. It goes beyond what is experienced at the prison-hospital to discover the social organization that governs the local setting. The analysis examines policy implementation literature as well as the actual practice of frontline mental health professionals in a prison-hospital. Actual practice was documented during an 11 month field study conducted from July 2006 through May 2007. During that period, I spent time at a prison-hospital where frontline staff consisted of registered nurses, registered psychiatric nurses, correctional officers, psychiatrists, psychologists, occupational therapists, social workers, behavioural science technologists, teachers, institutional parole
officers, correctional programs officers, recreation officers, chaplaincy, and native liaisons.

The empirical account developed through this methodology holds particular significance for policy implementation. It displays how texts, particularly policy documents, have the capacity to coordinate and control people’s actions – how power is generated by texts concerting and mobilizing people’s work. In particular, this account explicates how routine forms of policy in the Correctional Service of Canada have the capacity to control and mobilize the work of frontline staff in a way that produces a power for the correctional mandate of the prison-hospital, which subordinates the mental health mandate. It provides the frontline staff with a look at how their experience of what is happening with mental health care is hooked into the larger organizational fabric that is not directly observable from within their everyday work. Institutional ethnographies are also designed to enable people to relate the locus of their experience to where they may want to go. With the knowledge that this empirical account provides, frontline staff at the prison-hospital will be able to envision possibilities and identify opportunities for participating in the policy process and bring about positive change within their own work environment.

For the purpose of this study, the framework from Hambleton’s (1983) work on planning systems and policy implementation is used to organize the findings. He presents a five-part framework for analyzing implementation processes as a means for simplifying a very complex phenomenon. While this framework has not received much attention or prominence in the policy implementation arena, it has been considered generic enough to include most issues likely to be encountered in implementation (Pederson, Edwards,
Marshall, Allison & Kellner, 1988). The five key elements Hambleton puts forward as shaping policy implementation are: 1) the policy message, 2) the multiplicity of agents, 3) the multiplicity of perspectives and ideologies, 4) resources, and 5) the politics of planning.

While such frameworks are designed to describe and appreciate individual factors, it is crucial to understand the interaction of these elements in the process of implementation. Each of these key elements will be described in greater detail and used to organize and understand the social organization within the prison-hospital in Chapters 5 through 9.

1.3 Position of the Researcher

“Institutional ethnographers generally have critical or liberatory goals; they undertake research in order to reveal the ideological and social processes that produce experiences of subordination” (Devault & McCoy, 2006, p.19). I am no exception to this statement. I took on this research project in order to shed light on the subordination of mental health care as I had experienced it. My ontological (what is the nature of reality) and epistemological (how do we come to know the world) stance has necessarily influenced the values and assumptions that frame the way I view mental health and the provision of related services, as well as the way I view public safety and the exercise of supervision and control by correctional systems. This section offers an exploration of my personal experiences that have influenced the ontological and epistemological perspectives of this study as well as illuminating the advantages and disadvantages that these experiences have brought to the research process.
1.3.1 Personal Experience

I am trained as an occupational therapist. Occupational therapy is a health profession that centers on enabling people to do the tasks and activities they value despite any physical, mental/emotional, social or environmental barrier. Throughout my training I was actively focused on developing a career in forensic mental health and was hired by the Correctional Service of Canada upon graduation to provide services to incarcerated offenders with mental illnesses. I was invested in bringing the skills and perspectives of my profession to this unique environment.

I spent the first four years of my employment working in structured, well-defined programs with broad-based multi-disciplinary mental health teams. I learned much about the nature of my profession and it’s fit within a multi-disciplinary context. I also learned much about dynamic security\(^2\) and every employee’s role in ensuring the security of the facility as well as the safety of those who live and work therein. While aspects of security became integral to my everyday work activities, it was abundantly clear that the facility, and my role within it, was focused on mental health care. My perspective on the importance of providing mental health care to incarcerated offenders was greatly influenced by this experience.

After four years, I transferred to a prison-hospital in another region of the Correctional Service of Canada and I carried these early experiences with me into this next environment. The purpose of this facility and the individual programs within it, while operating under the same federal policy structure as the previous facility, were not well articulated. I did not have a clear work description and was left to carve my own role.

\(^2\) Dynamic security consists of meaningful interactions between offenders, employees and the public designed to optimize a safe environment (Commissioner’s Directive 560, 2006).
based on my own assessment of patient needs and personal preferences. Also, the lines between health care roles and security roles were more polarized. Correctional officers did not participate as active members of the multi-disciplinary teams and health care staff did not engage in, nor were they held accountable for, the same range of dynamic security activities.

Without a well-defined structure for mental health care in this facility, and as the balance between the dual mandates of care and control became increasingly skewed towards correctional control, I began to lose my already vague place within the organization. How could I provide health care without access to patients? How could I meet the requirements of my regulatory college without the resources required for providing quality care? How could I account for patients being released from prison without having received essential health care, thereby contributing to issues of public safety and criminal risk? What was I doing here if I wasn’t doing the job I was hired to do… the job I trained for?

1.3.2 Doing Research in My Own Workplace

The chances of ethnographic research being successful are increased in a setting that does not call direct attention to the activities of the investigator (Spradley, 1980). As a mental health professional employed at the prison-hospital until just prior to the start of data collection, I entered the setting easily, moved about freely to observe work activities, and recorded my observations. My presence around the institution was not unusual or unexpected therefore I was able to achieve a high degree of unobtrusiveness. With the knowledge I already had of the work processes and practices in the prison-hospital under
study, I set about studying how these practices are carried out, how they are discursively shaped, and how they organize, and are organized by, other settings.

There are a number of examples of institutional ethnographies being built upon the personal experiences of the investigators (deMontigny, 1995; Grahame, 1999; Griffith, 1984; Griffith & Smith, 2004; Ng, 1986; Parada, 2002; Rankin, 2001; 2003; Walker, 1990). I, too, was living the situation that I wanted to learn more about. It involved people I knew, worked with, and cared about. Just as the work I did to define the problematic helped to identify a place to begin my inquiry, it also helped to identify my own relationship to the inquiry. “This may seem… a peculiar idea about the conduct of scholarly research, but it is how institutional ethnographers think about their stance… In institutional ethnography, this moment of decision about the problematic is crucial to framing the interests represented in the research… It becomes the basis for how the research is conducted” (Campbell & Gregor, 2002, p.48). I committed to knowing about the subordination of mental health care on behalf of the colleagues with whom I had worked side-by-side for six years, taking the side of the frontline staff who had begun to question the world we had experienced.

These existing relationships were of benefit to me as a researcher in that I could be the proverbial ‘fly on the wall’ because no one considered it remarkable that I was there. I knew who to go to for different types of information – not just positions within the institution or organization, but the specific individuals who held those positions currently or in the past. Numerous informants provided unfettered access to info-net materials, internal reports and emails, as well as access to space and people for data

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3 The Correctional Service of Canada maintains an ‘info-net’ or internal network for employees, consisting of various informational and communication tools not available to the general public via the world wide web.
collection. As data collection progressed, it became increasingly clear that my established relationships with key informants significantly affected their openness during research. During the third month of data collection I remarked to a correctional officer about how accepting everyone was of my presence as a researcher and their openness in exhibiting typical work behaviours and sharing their experiences and opinions. She responded by saying, “That’s because it’s you, Crystal. Because of the work you’ve done here.” Even nine months after my formal employment with the organization had ended, while data collection was still ongoing, a senior manager invited me to participate in an employee event: “We still think of you as one of us.”

However, Spradley (1980), in his definitive work on participant observation, cautions that “the more you know about a situation as an ordinary participant, the more difficult it is to study it as an ethnographer” (p.61). Being effective as a qualitative researcher in a familiar setting requires the researcher to ask herself what there is about her identity or persona that might affect data collection (Glesne & Peshkin, 1992). Being an insider to the professional discourse of the prison-hospital made it necessary for me to consciously resist plugging in missing pieces from my own knowledge. I continuously asked myself the following questions: What have I overlooked because it is so second nature to me? What have I brought in, that others didn’t display or mention, because I had been there, saw that, did that? What have I filtered out because I know peoples’ personalities, because I’m used to placing more or less value on the knowledge and opinions of certain individuals?
1.4 Research question and definitions

The problematic, as described in section 1.1, directed my attention to matters of subordination and dominance, power and oppression, and the complexities of policy implementation. As I considered questions about the value placed on mental health care within the prison-hospital and tensions created by the dual mandates of care and custody, and as I explored the literature on these topics, I was able to frame the following research question: how is mental health care in a prison-hospital subordinated to correctional and security priorities through the implementation of policies? 

Within the mental health field, an ‘institution’ is commonly understood as the building(s) that house an established organization – a place of care for people who have mental illness. However, in institutional ethnography an institution is understood as a complex (a whole composed of interconnected or interwoven parts) embedded in the ruling relations that are organized around a distinctive function (Smith, 2005). In this study, the institution under study is the complex of mental health care and the buildings that provide a place of care for offenders with mental illness, the prison-hospital where data collection began, are referred to as a ‘facility’. The prison-hospital provides mental health services for ‘offenders with mental illness’, men with psychotic and/or mood disorders (as defined by the Diagnostic and Statistical Manual IV-Text Revision (American Psychiatric Association, 1994)) who have been convicted of a serious crime and are serving out their sentence of two years or more in Canada’s federal correctional system. The ‘correctional system’ or ‘corrections’ refers to the full range of organizational structures designed to ensure custody and supervision of criminal
offenders (including those with mental illness) (Corrections and Conditional Release Act, 1996).

In the provision of mental health services, the practices that coordinate individual service providers’ talking, writing, reading, watching, etc. are understood as ‘discourse’ and the individuals engaged in these coordinated practices are ‘agents’ (Smith, 2005). The term agent is used analogously with how the term ‘subject’ has come to be used in post-structuralist thinking (Campbell & Gregor, 2002) and is applied to the frontline staff and managers of the Correctional Service of Canada who informed this study. The discourse creates positions and performance opportunities for agents. ‘Agency’ occurs when individuals participate in the discourse and their participation reproduces it (Campbell & Gregor). Within the discourse there is a system or range of economic activity that includes the production, distribution and consumption of goods and services. In this study, ‘economy’ is comprised of the system or range of activities for producing, distributing and consuming mental health services within the correctional system (Hambleton, 1983). When distinct forms of coordinating agents’ activities emerge and are reproduced again and again, this is understood as ‘social organization’. Translocal forms of social organization mediated by texts of all kinds is conceptualized as ‘ruling relations’ (Campbell & Gregor). The ruling relations explicating in this study direct attention to the coordination of agents’ activities in the prison-hospital by connecting them to what other agents are doing in other locations throughout the correctional system.
1.5 Organization of the thesis

Chapter 2 provides an overview of background literature on mental illness and mental health services in prisons, policy implementation, and the construct of power. Chapter 3 describes the method and theory of institutional ethnography and its application to the current study. Chapter 4 presents the central thesis of the study and explicates a series of critical events that played a significant role in the decline of mental health care in the prison-hospital. Chapters 5 through 9 comprise the analysis of the study, with each chapter representing an element of the policy implementation process: the policy message, the multiplicity of agents, the multiplicity of perspectives and ideologies, resources, and the politics of planning. Each chapter begins with a review of literature specific to that element of policy implementation, tensions specific to that element are identified, the social connections of that element are traced, and ideologies of the element are displayed. Chapter 10 provides a final synthesis of the data, identifying organizational policy structures that shape mental health care in the prison-hospital. Chapter 11 discusses the findings of the study in relation to a series of significant mental health policy changes that are on the horizon throughout the Correctional Service of Canada and explores opportunities for frontline staff to bring about positive change in their own work environment through engagement in the policy process.
CHAPTER 2
LITERATURE REVIEW

2.1 Prevalence of Mental Illness in Prisons

There is international recognition that the number of people with mental illness entering the criminal justice system has been increasing, and that prevalence of mental disorders in prisons is higher than the general population (Diamond, Wang, Holzer, Thomas & Cruser, 2001; Elizabeth Fry Society of Mainland Nova Scotia, 2005; Sampson, Gascon, Glen, Louie & Rosenfeldt, 2007; World Health Organization, 2008). There have been several studies on the prevalence of mental illness in jail detainees (Guy, Platt, Zwerling & Bullock, 1985; Kal, 1977; Lamb & Grant, 1983; Monahan & McDonough, 1980; Petrich, 1976; Piotrowski, Lasacco & Guze, 1976; Snow & Briar, 1990; Swank & Winer, 1976; Teplin, 1990; Whitmer, 1980). In 1994, a Canadian study of people admitted to the Calgary Remand Centre (Arboleda-Florez) found that 56% of men and 49.5% of women were diagnosed with a mental disorder, with the substance-related disorders being most frequent (31.7% for men, 26.1% for women). However, differences between prisons and jails limit the degree to which these findings can predict the prevalence of mental illness in prisons (Diamond, et al., 2001).

Studies conducted in the United States and United Kingdom have shown significantly higher prevalence rates of schizophrenia, bipolar disorder, and major depression in prisons than the general community population (Bean, Meirson & Pinta, 1988; California Department of Corrections, 1989; Neighbors, Williams, Gunnings, Lipscomb, Broman & Lepkowski, 1987; Powell, Holt & Fondacaro, 1997; Singleton, Meltzer & Gatward, 1998). In the United States, there is consensus that there are 2-6
times as many people with serious mental illness in jails and prisons than are in state mental hospitals (Fisher, Packer, Simon & Smith, 2000; Teplin, 1990; 1994; Torrey, 1995) and it is estimated that up to 35% of offenders require mental health services (Diamond, et al., 2001; James, Gregory, Jones & Rundell, 1980).

Canadian studies of the prevalence of mental health disorders found similar results. A 1991 study (Motiuk & Porporino) randomly sampled 2185 offenders from various prisons within the Correctional Service of Canada, including the organization’s five prison-hospitals, and found that approximately 20% of the general prison population had a major mental health disorder in their lifetime. A 1999 study of people admitted to one regional reception center of the Correctional Service of Canada (Brink, Doherty & Boer) found that almost one third of study participants had a current mental illness, with mood and anxiety disorders being most frequent, and 84% of participants had experienced a mental health disorder at some point in their life. In 2004, a study of intake assessments done at reception centers throughout the Correctional Service of Canada (Bouchard) found that only 3% of offenders were identified at intake as having a mental health disorder but that 14% had experienced recent psychological or psychiatric treatment prior to being incarcerated and that 21% of women and 14% of men had attempted suicide within the previous five years.

A recent review of the Correctional Service of Canada (Sampson, et al., 2007) reports that 12% of men were identified at intake as having a mental health disorder (an increase of 71% between 1997 and 2006) and 21% of women (an increase of 61% between 1997 and 2006). This review also noted that the actual number of offenders with
significant mental health concerns is likely underestimated due to inadequate screening and assessment upon admission.

2.2 Mental Health Services in Prisons

In 2007, Keith Coulter, then Commissioner of the Correctional Service of Canada, stated that “there is a direct link between how well we respond to the needs of offenders with mental disorders and keeping Canadian communities safe” (p.3).

In the United Kingdom, mental health care in prisons is based on the principle of equivalence. That is, mental health care provided within prisons should be equivalent to the mental health care offenders would receive if they were not in prison (Wilson, 2004). Clinical in-reach teams provide services to the general population in regular prisons, including segregation, as well as those offenders housed in prison health care wings. Offenders with serious mental illness are typically moved to a prison health care wing where they may wait for months before being transferred to a community hospital (Reed & Lyne, 2000). Staff within the British prison system have begun to question the appropriateness of these prison health care wings as ‘alternative places’ of care and the ‘timeliness’ of waiting for months for transfer to hospital (Wilson).

In the United States, mental health services vary from state to state. A survey of prison mental health services in the state of Georgia found that “mental health services constituted a ‘non-system’ of care” (Elliott, 1997, p.433). Clinical practices were left to the discretion of individual mental health staff with very little system-wide direction despite the prevalence of mental health problems among offenders throughout the system. Across the United States, common challenges in providing mental health care to incarcerated offenders, such as continuity of care following transfer within a prison or
release from prison, family involvement, and professional credentials among staff responsible for providing mental health services (Kerr, Roth, Courtless & Zenoff, 1987; Ogloff, J., 2002; Steadman, Barbera & Dennis, 1994), are gradually being addressed on an individualized basis. One example of this is the Harris County Jail in Texas, the third largest jail in the country. This correctional facility has a larger mental health program than any psychiatric hospital in the state and functions as an in-patient psychiatric unit (Cruser & Diamond, 1996). Services provided include medication maintenance, counseling and nursing services as well as follow-up care to offenders housed throughout the mega-jail. Life-skills training and group therapies address criminogenic with psychological factors, counseling is provided to inmates’ families, prevocational and work programs have been developed, and dual diagnosis substance abuse programs have been formed (Cruser & Diamond).

In Canada, the provision of health services, including mental health care services, for incarcerated offenders does not fall under the same authority as for the general population: “Incarcerated federal offenders are excluded from the Canada Health Act and their treatment is not covered by Health Canada or provincial/territorial health systems. Under the [Corrections and Conditional Release Act], the [Correctional Service of Canada] is responsible for the mental health of offenders, and must provide or obtain mental health care services in its penitentiaries and in the community for offenders under supervision” (Sampson, et al., 2007, p.54).

Providing assessment, primary and intermediate mental health care is an ongoing challenge for the Correctional Service of Canada. While there is a new computerized screening tool in development, there is no systematic effort to screen offenders for mental
disorders at admission or to follow up with in-depth mental health assessments, and mental health care is limited to crisis intervention and suicide prevention in most federal prisons. Primary and intermediate care is insufficient and many offenders with mental health concerns are moved into correctional segregation for protection due to their inability to cope with regular prison settings (Sampson, et al., 2007). Mental health services that are available in Canada’s federal prisons include ambulatory services, voluntary and involuntary in-patient care, and discharge planning.

Ambulatory nursing and psychiatric services are provided to all prisons. The primary activities of these services are a) mental health teaching to both offenders and the non-mental health care staff who work with them; b) monitoring the effectiveness of psychotropic medication to determine whether the offender also needs to be seen by a psychiatrist; c) making referrals to a psychiatrist when warranted; and d) mental health discharge planning for offenders who are getting ready to be released from prison (Folsom, 2007). If it is determined that an offender’s mental health has deteriorated to the degree that he requires hospitalization, each region of the Correctional Service of Canada has a prison-hospital that provides acute, sub-acute, chronic, and rehabilitative care. These facilities qualify as hospitals under the relevant provincial mental health legislation and are authorized to provide both voluntary and involuntary mental health services (Commissioner’s Directive 800, 2009; Commissioner’s Directive 803, 2002; Commissioner’s Directive 850, 2002). Offenders access these facilities very much like the general population would access a community hospital. Offenders live in a ‘home’ prison, referred to as their ‘parent institution’. If it is determined that an offender requires in-patient mental health care he is transferred to the prison-hospital in the region where
his parent institution is located. There, he engages in mental health services and, when he experiences a degree of recovery or requests to be discharged from hospital, he returns to reside once again at his parent institution. Essentially, he leaves ‘home’ to be hospitalized and returns ‘home’ once he is well enough to do so.

There are a number of offenders residing within the prison-hospitals when their correctional sentence dictates their release from prison. For such offenders there are discharge planning services. Mental health staff work with offenders being released from the prison-hospitals to develop a comprehensive, individualized plan to address transitional and longer-term discharge needs. On the day of release, staff accompany the offenders through their first day out of prison to ensure that appointments are kept, paperwork completed, and the offenders connect with essential services in the community (eg: housing, finances, health care, parole, police reporting, etc.) (Champagne & Felizardo, 2007). It is important to note that this service is not consistently available in prison-hospitals across the country.

Within this continuum of care, there are a variety of services available for offenders with mental disorders including chaplaincy and other faith-based programs (Isaac, 2007; Tervo, 2007), dialectical behaviour therapy and other psychological services (Webster, 2007), and employment programs (Bennett, 2007; Davidson & Wilson, 2007; Offord, 2007). A 2002 study (Grass) developed a descriptive profile of offenders with mental illness who had been released from one of Ontario’s federal prisons in 1999. It was found that most offenders identified as having a mental illness (88%) participated in nursing and psychiatric services during their incarceration while just 16% of offenders with mental illness participated in a wider range of mental health
services provided on an in-patient basis by social workers, occupational therapists, and behavioural science technologists.

A new comprehensive mental health strategy was launched in 2007 which is a wide-ranging, well-funded strategy to expand and improve intake screening and assessment, primary care, intermediate care, intensive care in the regional prison-hospitals, and transitional care for offenders returning to the community (Bouchard, 2007).

2.3 Policy Implementation Theory

The volume of publications on policy implementation has grown exponentially into the twenty-first century, particularly in literature outside the core fields of public administration and public policy, making it substantially larger and more multi-disciplinary, such that the boundaries of the study of implementation have become less clear (deLeon & deLeon, 2002; Saetren, 2005). Doctoral students pioneered the study of policy implementation, with well over 100 dissertations on the topic being completed prior to 1970. There was a predominant focus on the education policy sector with 65% of these dissertations emerging from graduate schools or departments of education in North America. Implementation scholars have also consistently paid attention to the policy issues of health, environmental, social and economic issues with health journals accounting for 15% and law journals accounting for 7% of all implementation articles (Hill & Hupe, 2002; Saetren). The trend at the turn of the 21st century is that the number of policy implementation studies focusing on health issues is beginning to rival, or even surpass, the number focused on education.
Following Pressman and Wildavsky’s (1973) seminal work on policy implementation in the American Economic Development Administration, implementation studies began to reveal that public programs were not achieving their intended objectives due to the manner in which they were being implemented (Derthick, 1972; Bardach, 1977; Howlett & Ramesh, 1995). The following key factors are understood to contribute to what was thought to be ‘implementation failure’: 1) lack of clear policy objectives; 2) multiplicity of actors and agencies with problems of communication and coordination; 3) differences in perspectives and priorities between actors and agencies affecting policy interpretation and motivation for implementation; and 4) limits of administrative control (Barrett, 2004; Dunsire, 1978; Gunn, 1978; Hanf & Scharpf, 1978; Hood, 1976; Pressman & Wildavsky, 1984; and Sabatier & Mazmanian, 1979).

This research has largely defined the field of policy implementation and comprises what is known as the first generation of implementation research. This generation of implementation studies generally consisted of case study analyses that brought forward the complexities of policy implementation (deLeon & deLeon, 2002). The result was a plethora of interesting ideographic case studies, each with its own individualistic lessons on implementation.

The second generation of policy implementation studies was more directed to uncovering a generic theory of implementation (deLeon & deLeon, 2002). Within this work, three distinct perspectives of implementation emerged: 1) the top-down perspective, 2) the bottom-up perspective, and 3) the policy-action continuum.

A series of institutional and commitment-oriented hypotheses assumed a ‘command and control’ orientation that came to be known as the top-down perspective
(Mazmanian & Sabatier, 1983; Nakamura & Smallwood, 1980; Berman, 1980). These researchers committed to finding the best way to move a policy proposal to its successful result. Policy was taken as given and explanations of policy success or policy failure were done by inquiry into what is wrong with the implementation process and with the organization responsible for implementation (Hambleton, 1983). In this perspective there is an implicit assumption that policy-makers control the organizational, political and technological processes affecting implementation (Elmore, 1978). This approach relies on two inter-related assumptions: 1) that policy-making and administration can be neatly separated, and 2) that there are clear and explicit policy goals, for which progress is comparatively simple to measure (Hambleton, 1983). Hambleton asserts that these two assumptions conceal much of the considerable complexity that actually exists between policy and implementation.

At the same time, another group within the second generation was putting forward a bottom-up perspective of policy implementation. Scholars proposed that implementation occurred only when those primarily affected were actively involved in the planning and realization of programs (Hjern, 1982; Hjern & Hull, 1982; Lipsky, 1971; 1980; Weatherly & Lipsky, 1977). These researchers argued that those individuals “were better able to capture the full range of implementation’s intricacies” (deLeon & deLeon, 2002, 470). This approach starts with the individuals who have direct contact with the public and are required to make decisions about people’s lives every day and graduates into a more formalized policy structure: “The lowest levels of the policy chain are regarded as the makers of policy and the higher level of decision-making is seen as circumscribing, albeit in important ways, the lower level policymaking context”
(Weatherley & Lipsky, 1977, p.173). This approach takes what is done as central and attempts to understand how and why groups and individuals act the way they do (Hambleton, 1983).

Also in the second generation of implementation studies, the work of Barrett and Fudge (1981) contributed to the conceptualization of implementation as a policy-action continuum. This is an interactive framework consisting of an ongoing negotiative process between those seeking to put policy into effect and those responsible for enacting it. It is the convergence of both top-down and bottom-up perspectives into the interactive continuum, reflecting them as an integrated process rather than mutually exclusive approaches, that has been incorporated into a number of frameworks for understanding the implementation process (Goggin, Bowman, Lester & O’Toole, 1990; Hambleton, 1983; Matland, 1995; O’Toole, 1986; Sabatier, 1988; Wittrock & DeLeon, 1986).

The third generation of implementation research is considered more scientific – proposing a number of hypotheses to be tested. Goggin, et al. (1990) sought to explain “why behavior varies across time, across policies, and across units of government and predicting the type of implementation behavior that is likely to occur in the future” (p. 171). Attempts to capture the full range of activities in defining policy implementation have resulted in definitions that are murky, complex and cumbersome (deLeon & deLeon, 2002; Mazmanian & Sabatier, 1983; Bardach, 1977; 1980). Other definitions of policy implementation work to simplify the underlying concepts. Schneider and Ingram (1993) focus on affecting changes in behaviour patterns, while Ferman (1990) expresses the connection between policy expectations and perceived results. O’Toole (2000), who is widely considered an authority in the field of implementation, defines policy
implementation as that which “develops between the establishment of an apparent intention on the part of government to do something, or to stop doing something, and the ultimate impact in the world of action” (p.266).

At the same time, other policy scholars began to express doubts about the possibility of neatly segmenting the policy process into discrete, sequential stages (Jenkins-Smith & Sabatier, 1993; John, 1998; Nakamura, 1987; Sabatier, 1988, 1999). It was thought that discrete stages oversimplified and misrepresented a complex and recursive policy process. Scholars proposed contingency theories suggesting that different conditions may require different implementation strategies (Matland, 1995; Ingram, 1990; Scheberle, 1997). As Matland and others suggest “there is no single best implementation strategy, that the appropriate strategy is very much contextual in terms of what are the contingencies surrounding the policy issues and how they can best be addressed in terms of implementation” (deLeon & deLeon, 2002, p.471).

The challenge of developing a theoretical framework for understanding and studying policy implementation that is all-encompassing and reflective of the complexity of the policy process remains. The field of policy implementation has not yet reached conceptual clarity. As stated by Schofield (2004): “None of the models have dealt with the messiness, ambiguity and complexity of implementation” (p. 286).

2.4 Policy implementation in prison-hospitals

Lin’s (2000) award winning study of the everyday world of programs in five prisons in the United States provides valuable insights and evidence of the complexity of implementing mandated programs within the prison environment. The prisons she studied
are not prison-hospitals or therapeutic communities, yet they provide crucial information about policy implementation experiences surrounding the provision of correctional or rehabilitative programs. Lin posits that correct or incorrect policy implementation can be differentiated by examining policy activities rather than policy outcomes. She states that “implementation with respect to rehabilitation fails… because programs do not satisfy the institutional needs of staff and prisoners, and/or violate institutional values” (p.60-61).

Attempts at improving policy implementation would need to first address organizational factors affecting the social relations within an institution.

A very limited amount of literature is available on policy implementation within prison-hospitals. Explorations of social policy, organizational culture, and service planning for mental health care in prisons provide evidence that the mental health and correctional systems often interact in ways that create obstacles to providing care and promote unhealthy organizational environments. Correctional and mental health staff often blame each other for problems related to offenders with mental illness and these problems arise in part from interactions between the correctional and mental health systems (Steadman, McCarty & Morrissey, 1989; Freeman & Roesch, 1989).

Tensions between correctional and mental health systems have arisen because these two social policy structures are derived from incompatible value structures such as ‘sickness-badness’, ‘therapy-custody’, and ‘treatment-punishment’ dichotomies (Cruser & Diamond, 1996). Frontline prison-hospital staff have a tendency to operate from one value system or the other rather than considering a permutation of possibilities and making decisions based on a continuous range of options. When staff mutually disregard or misunderstand each other’s values, inter-system conflicts occur making it difficult for
mental health staff to provide care to offenders with mental illness in the correctional
environment (Cruser & Diamond).

Examination of an organization’s closely held values from which their policies
arise can lead to enhanced models of collaborative programming and improved use of
resources in both systems (Cruser & Diamond, 1996). Having different views does not
preclude agreement, and may even enhance problem solving and lead to synergistic
solutions when shared and shaped into common goals (Diamond, et al., 1999). Successful
implementation of public policy changes hinges on opening channels of communication
between leaders and followers, and between correctional and mental health staff, and on
clarifying roles and relationships (Cruser & Diamond).

2.5 Constructing Power

Foucault (1976) theorized that power only exists in action and is intrinsic to all
social relations.

“Power must be analysed as something which circulates, or rather as something
which only functions in the form of a chain. It is never localized here or there,
ever in anybody’s hands, never appropriated as a commodity or piece of wealth.
Power is employed and exercised through a net-like organization. And not only
do individuals circulate between its threads; they are always in the position of
simultaneously undergoing and exercising power. People are not only its inert or
consenting target; they are always the elements of articulation. In other words,
individuals are the vehicles of power, not its point of application”

(Foucault, 1976, p.234).

In institutional ethnography, power is understood to be generated by institutions through
the coordinating functions of language and texts (Smith, 2005). Power is organized and
produced through textually sanctioned agency and manifested in people’s work activities.
People who feel a need for power, that is “a desire to control others, to influence their
behaviour, or to be responsible for others” (Braveman, 2006, p.156), prefer to take charge of work tasks and influence others, as well as seek attention and recognition for playing a central role in decision-making and activities.

Power and oppression are interactive, making an understanding of oppression essential to any analysis of power and mental health. Oppression can be defined as “a state of asymmetric power relations characterized by domination, subordination, and resistance, where the dominating persons or group exercise their power by restricting access to material resources and by implanting in the subordinating of persons or group fear or self-depracating views about themselves” (Prilleltensky & Golnick, 1996, p.129).

Power imbalances are inextricably linked to one’s position within an organization as well as institutional expectations (Mason & Boutilier, 1996). Braveman (2006) distinguishes power, also called personal power, from formal authority, or legitimate power. He understands personal power as “the ability to force compliance to one’s wishes through coercion despite resistance” (p.144), while formal authority is considered to be “the right to issue orders or direct action by virtue of one’s formal position” (p.144). Within health care settings, supervisors and managers rely on formal authority to get their staff to act in a particular way or to achieve a particular goal (Braveman). However, since power is not an attribute or resource, its fluidity confounds the implementation of policies and guidelines (Mason & Boutilier). Foucault’s point that “it is the nature of power to remain unstated and hidden with in professional organizations and social relations” (in Mason & Boutilier, 1996, p.148; Lemert & Gillan, 1982) challenges scholars to illuminate practices that oppress.
2.6 Summary

The background literature reviewed provides an understanding of mental health needs and services within correctional environments, approaches to policy implementation, challenges in implementing policies with prison-hospital environments, and the construction of power imbalances within social relations. The current study is concerned with how mental health care in a prison-hospital becomes socially organized through the implementation of two competing policy structures. The objective is to trace the social relations of everyday work in a prison-hospital and explicate how they are systematically coordinated and organized by organizational rules. In particular, this study focuses on the influence of ideology and policy structures on the social organization of mental health care in a prison-hospital.
CHAPTER 3
METHODOLOGY

3.1 Introduction

The current study used the theory and method of institutional ethnography to examine how mental health services are subordinated to correctional and security priorities within a prison-hospital. It uses this knowledge to further explicate how policy implementation in Canada’s federal correctional system is approached and experienced with a view to identifying opportunities for frontline staff to engage in the policy process in ways that will improve their own work situation. Institutional ethnography, first proposed by Canadian sociologist Dorothy Smith (1987; 1990a; 1990b; 1998; 2005; 2006), is a method of inquiry that makes visible the relations that connect one local site to others. It is a materialist theory and method, which analyses the ways that organizational processes produce a generalized way of living in the everyday world regardless of individual and circumstantial differences (Townsend, 1998). The everyday world is often experienced as disorganized and events may seem disconnected, incoherent, or not making sense. Institutional ethnography aims to make visible how everyday work in an institution is connected into the extended social relations of administration and governance, their intersection, and point toward next steps to change the social relations that subordinate mental health care (Grahame, 1998; Smith, 2005; 2006). “Like the map of the underground mall, with its arrow pointing to a particular spot accompanied by the words YOU ARE HERE! Institutional ethnographies are designed to enable people to relate the locus of their experience to where they may want to go” (Smith, 2005, p.51).
3.2 Institutional Ethnography

Institutional ethnography explores the social relations organizing institutions from the perspective of the people who participate in them. It draws on peoples’ experiences to make clear how everyday activities are organized and how they are coordinated and concerted purposefully in ways they cannot see (Campbell & Gregor, 2002; Smith, 2005; Wright, 2003). It opens up that level of organization otherwise assigned to ‘the system’ and is “a method of inquiry into the social that proposes to enlarge the scope of what becomes visible from that site, mapping the relations that connect one local site to others. Like a map, it aims to be indexical to the local sites of the people’s experience, making visible how we are connected into the extended social relations of ruling and economy and their intersections” (Smith, 2005, p.29).

Institutional ethnography is firmly situated within a critical research paradigm where issues of power and justice, and other social institutions, interact to construct a social system. Critical theory is concerned with the social construction of experience and understands social theory to be a map that helps us devise questions and strategies for exploring our world. Competing power interests within a particular society or social arrangement are analyzed (critical enlightenment), exposing forces that prevent people from shaping decisions that affect their lives and locating opportunities for these people to gain the power to control their own lives (critical emancipation) (Kincheloe & McLaren, 2003).

The researcher’s purpose in institutional ethnography is to find and describe social processes that have generalizing effects that may produce similarities of experience or may organize various settings to sustain broader inequalities (Devault, 1999; Devault
& McCoy, 2006). Institutional ethnography begins with the standpoint of those typically excluded from institutional discourses and restores the presence of active subjects who are knowers of their everyday worlds. “What has been excluded from much of standard sociology, according to Smith, is not just certain topics or phenomena, but the standpoint of subjects who know and experience their worlds, and who might begin to ask questions about these worlds” (Grahame, 1998, p.356). It begins in the actualities of the lives of those involved in the institutional process and focuses on how those actualities are embedded in the social relations of ruling and economy. It begins with issues, concerns, or problems that are real for people and that are situated in their relationships to an institutional order. A standpoint in that institutional order is located and provides the guiding perspective from which the institutional order will be explored (Smith, 2005). The perspective and experiences of those involved in institutional processes begin to define and organize the direction of the researcher and specifies the ‘problematic’ under study. According to Smith, each step of the inquiry learns more from those involved of how their everyday work brings into being the institutional processes that are the focus of investigation: “Each next step builds from what has been discovered and invades more extended dimensions of the institutional regime. The mapping of social relations expands from and includes the original site so that the larger organization that enters into and shapes it becomes visible” (Smith, 2005, p. 35). An awareness is produced that enables us to find our bearings, making it possible to begin to consolidate a knowledge outside the institutional discourse (Grahame, 1998).

Social organization is the interplay of peoples’ ordinary activities being concerted and coordinated purposefully, by something beyond their own motivations and intentions.
These translocal social relations pass through local settings and shape them according to a continuous transformation that begins and gathers speed somewhere else. Linkages between everyday life, organizations, and the translocal processes of administration and governance constitute a complex field of coordination and control that Smith (1999) identifies as ‘the ruling relations’ (Devault & McCoy, 2006).

Any number of institutional complexes are at play in the relations of ruling. Recognizing that the institutional complex under study is mental health care in the prison-hospital setting, the term ‘institutional discourse’ refers to the translocal processes coordinating the practices of individuals’ talking, writing, reading, watching, etc. as they provide mental health care in the prison-hospital. This type of institutional discourse is key to the coordinating of the work that people do everyday in bringing into being the institutional complexes embedded in the ruling relations of the correctional organization.

Institutional ethnography’s focus on texts comes from the recognition that technologies of social control are increasingly and pervasively textual and discursive (Smith, 1999). Smith (2005) argues that, “Texts that constitute and regulate establish agency, that is, textually specified capacities to control and mobilize the work of others. Textually sanctioned agency produces a power that is generated by the concerting and mobilization of peoples’ work” (p.183). A text has the power to hold people to acting in particular ways although people may not recognize how their actions are being shaped by texts when they meet face-to-face and relate to each other as individuals (Campbell & Gregor, 2002).

Texts are documents such as medical charts, strategic plans, e-mails, laws, policies, and so on that are mechanisms for coordinating activity across many different
sites. It is the relatively fixed and replicable character of texts – “that they can be stored, transferred, copied, produced in bulk, and distributed widely, allowing them to be activated by users at different times and in different places” (Smith, 2006, p.34) – that allows them to organize and dictate social and cultural space for particular individuals and groups (Grahame & Grahame, 2000; Wright, 2003). Institutional ethnography is designed to reveal the organizing power of texts, making visible how activities in local settings are coordinated and managed extra-locally. “Institutional ethnography aims to provide, for any of us, a way of… discovering how our activities – wherever we are at work, and often without our conscious awareness – are brought under the jurisdiction of the ruling texts of institutional life” (Devault, 2006, 297).

Texts have an author that can be ‘met’ and learned about from the text. The reader of a text ‘activates’ it, inserting the text’s message into the local setting and the sequence of action into which it is read (Smith, 2005). “Smith’s notion of activation is similar to the notion of articulation mentioned by Foucault... Activation posits that the human factor is the enabler of a text’s ability to coordinate action and get things done in specific ways… The [text] is powerful only when [individuals] know how to use it and [others] know how to respond” (Wright, 2003, 245). Institutional ethnography brings into view how individuals’ histories organize their own reading practices and what they come to know, believe, reject, and so on. Whatever response individuals have to a text, it is their response, which marks where they are now and where they have been in their experiences. Divergent responses from different individuals reflect the social location of each.
Institutional ethnography has the capacity to demonstrate the inner relations driving the processes of change, the nature and direction of change that we experience, and the shifting bases of power (Smith, 1987). It is not the aim of institutional ethnography to study and map out an institution in its totality, rather the aim is to explicate pieces of actual work practices within a specific institution in ways that reveal points of disjuncture with governing processes and practices (Campbell & Gregor, 2002). Devault & McCoy (2006) state that “the aim of institutional ethnography is to explore particular corners or strands within a specific institutional complex, in ways that make visible their points of connection with other sites and courses of action” (p.17).

The disjuncture, that moment of disquiet between the actuality of a person’s experience and the actionable institutional realities, is imposed by the regulatory frames, such as law, policy, and other regulatory corpora, that govern the structure or organization of textual devices – the forms, charts, and computerized fields used by frontline workers. “The work of fitting the actualities of people’s lives to the institutional categories that make them actionable is done at the front line. The categories, questions, or other specified particulars are governed by and responsive to frames established at a more general level” (Smith, 2005, p.199). In the current study, the disjuncture between the mental health policies of the Correctional Service of Canada and the experience of frontline staff in providing mental health care was fundamental in identifying the problematic of how mental health care is subordinated to correctional and security priorities.
3.3 Using Institutional Ethnography to Explore Policy Implementation

The role of individuals in activating texts is also recognized by the literature on policy implementation: “The political processes by which policy is mediated, negotiated, and modified during its formulation and legitimation do not stop when initial policy decisions have been made, but continue to influence policy through the behaviour of those responsible for its implementation and those affected by policy acting to protect or enhance their own interests” (Barrett & Hill, 1984, p.220). This view of implementation places greater emphasis on the multiplicity of agents involved and the variety of linkages between them, the perceptions and ideologies, relative autonomies and power bases of these agents, and the interactions taking place between them – particularly negotiation and bargaining behaviours (Barrett & Hill).

Smith uses the concept of ‘ruling’ to name the socially organized exercise of power that shapes peoples’ actions and their lives. More than the imposition of rules, ruling relations rely on “people knowing how to take them up and act in the appropriate manner” (Campbell & Gregor, 2002, p.33). When concerned with issues of power and justice and the ways that social institutions and cultural dynamics construct a social system, the investigator seeks to make clear the forces that prevent individuals and groups from shaping the decisions that crucially affect their lives (Kincheloe & McLaren, 2003). The goal is to identify who gains and who loses in specific social arrangements and the processes by which such power plays operate.

Institutional ethnography will explicate oppressions as happening in the routine exercise of power. Rather than just oppression and domination as products of morally reprehensible people acting badly, institutional ethnography provides a method for
understanding how social relations influence the delivery of the prison-hospital’s dual mandates of custody and care. With the expressed concerns of a corrections-dominated agenda, a disproportionate influence of security issues, and the strong view that health, and those who work in the health field, are not valued, and are therefore disadvantaged, at the prison-hospital (Orr, 2002; CCHSA, 2004), it is assumed that competing power interests lie at the core of the social construct from which these concerns have arisen.

I attempt to create a deeper, richer understanding of policy implementation, one which is based on broader definitions than those currently used by correctional organizations and which is more reflective of the experiences of frontline workers. Institutional ethnography is used to explicate, in a more subjective and intimate manner, how mental health care is subordinated to correctional and security priorities as it is experienced and lived out by the frontline workers in a prison-hospital. I make clear the processes by which decisions are currently being negotiated and how individuals both reproduce relations of oppression and counter or resist those relations. I am primarily interested in the processes by which mental health care decisions by frontline workers are constituted. The everyday lived experience of frontline workers implementing policies is explicated and these experiences are situated within the working processes and organization of a prison-hospital within the Correctional Service of Canada. I explore the actual social relations of implementing mental health and correctional policies as they arise in the prison-hospital and seek to uncover what organizes and maintains the problematic experience of policy implementation.
3.4 Point of Entry

The point of entry in institutional ethnography is taken from the experiences of “specific individuals whose everyday activities are in some way hooked into, shaped by, and constituent of the institutional relations under exploration” (Devault & McCoy, 2006, p.18). The problematic organizes the direction of the research providing a focus for data collection and analysis. Therefore, the research question, selection of participants, data collected and the analysis of the data all arise from the problematic (Campbell & Gregor, 2002). The research question for the current study is: how is mental health care in a prison-hospital subordinated to correctional and security priorities through the implementation of policies?

3.4.1 Selection of Study Informants

In institutional ethnography, the people inhabiting the setting(s) being studied are the source of much important information. Individuals who participate in an institutional ethnography are not viewed as ‘subjects’ but as informants to the study. Informants are selected to learn about ‘how things work’ in the local setting and to build an understanding of how activities are coordinated across multiple sites.

In the current study, the local setting under investigation is one of five prison-hospitals in Canada’s federal correctional service that are mandated to provide mental health care. All five of these settings are governed by the same federal correctional legislation while incorporating the health care legislation specific to the province where they are located. However, as noted by my own experiences as an employee at two of
these prison-hospitals\textsuperscript{4}, the everyday work processes and practices of frontline staff within these prison-hospitals vary significantly. The prison-hospital under study was chosen based on my knowledge of the facility as well as the expressed concerns about the state of mental health care in this facility from numerous sources both internal and external to the organization.

3.4.2 Entering the Field

“It is far easier to gain access to study the residents of a remote Alaskan community than to study the lives of prison inmates and/or those persons whose task it is to keep them within the prison walls.” (Pantenaude, 2004, p.69S). Pantenaude, a correctional officer turned researcher, discusses the challenge of access for conducting qualitative research in correctional environments as a test of the researcher’s credibility and personal integrity prior to, as well as upon entering the field (2000; 2001; 2004). Gaining the trust of offenders, frontline staff and managers can be accomplished by providing evidence that the researcher is aware of the relevant issues affecting the potential participants and being transparent about the purpose of the study, funding sources, methods of information gathering, and assurances of confidentiality (Patenaude, 2004).

In the current study, the researcher drew upon her own position as an employee of the prison-hospital to gain access to the research site. Detailed discussions about the study and its purpose, as well as data collection strategies were held with institutional managers to ensure respect for all staff and the security of the facility. A detailed overview of the study was sent by email to all employees of the prison-psychiatric

\textsuperscript{4} The personal experiences of the researcher are discussed in the introductory chapter.
hospital and care was taken to discuss the purpose of the study and emerging insights with a wide range of participants in order to maintain the trust of key informants.

3.5 Data Collection

Institutional ethnography designs data collection as a step in the analytic process. Having located the problematic, data collection begins from the standpoint within everyday practice by recording the actual work processes and the actual material conditions (time, space, funding, etc.) in which these processes occur.

This study is based on field study conducted over 11 months in a prison-hospital within Canada’s federal correctional system. The institutional complex of mental health care was well represented in the prison-hospital under study as a regional provider of both in-patient and ambulatory mental health services for incarcerated offenders. The facility, employing over 150 clinical, correctional and administrative professionals, produced a significant amount of data addressing the research question. As institutional ethnography follows the natural shape of everyday practices, the number of data sources (informants, documents) was not part of an a priori design but emerged out of the research process. Townsend (1996; 1998) recommends regarding the data collection process as a funnel where data collection begins broadly in describing the everyday world of frontline staff making decisions about mental health care then gradually narrowing until no new variations or contradictions emerge in everyday practice. There is no absolute point at which data collection has been completed. In an institutional ethnography, data collection continues until sufficient data have been collected to record how everyday practice actually works within an institutional framework (Townsend,
Data on the institutional organization of practice were collected as questions arose on site but also throughout the analysis and writing of the thesis.

I used multiple methods of data collection common to any type of ethnography that helped me to find and interpret points of disjuncture or disconnection between objectified knowledge used to coordinate and control mental health services and the subjective experience of the frontline workers. The three primary methods of data collection common to ethnography (participant observation, interview, document review) are interconnected in that data collected from one source will inform the data that can or should be collected from another (Townsend, 1996).

To record the full scope of practice, data were collected full-time for two weeks during month 1 in the nursing/security stations of the prison-hospital’s living units (see Figure 1). During the three weeks before data gathering in the second month, initial analytical ideas were developed through informal story-telling with response from a policy expert who is familiar with the correctional system. After data were collected at the same locations within the institution, again full-time for one week, during the second month, these initial analytical ideas were further developed and presented for response from frontline staff who work on those units. After three more weeks of reflection on the comments of frontline staff, data gathering during month three was extended to include other areas of the institution such as the security control office, activity and program areas, and operational meetings. Additionally, analytic ideas were reviewed with institutional managers. Data gathering in the fifth, ninth, and eleventh months was extended to include regional and national managers to attend to variations associated with
different levels of managerial authority. Data collection was extended across the three levels of the organization until no new variations and contradictions were documented.

Data collection was analytic in that it incorporated participant observation, interview, and document review consistent with institutional ethnography’s theoretical approach. The data recorded included the staff’s actual actions and talk as well as the people involved, means of communication employed, locations, timeframes, and use of available equipment and technologies, which create the material conditions of everyday practice. Policies and procedures, legislation, mission and value statements, budgets, and other organizational data were collected to show the practical processes and practices used to govern mental health care in the prison-hospital.

For example, a summary of one informal decision-making discussion regarding the transfer of patients between units within the prison-hospital shows the types of data collected from a standpoint of everyday practice. One day, I observed two nurses, two correctional officers, and a psychiatrist negotiating a number of requests to transfer patients between units. As a team, they considered the presence of incompatible security risks, mental status, bed availability, availability of staff to coordinate each transfer, and the timing of each move. I recorded each person’s actions and talk in that discussion and through other parts of the day. Notes included reference to the number of people listening to the discussion and the interaction of these people with the nurses, psychiatrist, and correctional officers. I noted the location, day of the week, and time of day. I also noted the texts they referred to for information (e.g.: clinical chart, case management reports, preventative security file) and for direction (e.g.: policies on inmate movement, placement of offenders, privilege level system).
Data collection continues into the second analytical process of making connections between actual work activities and the social organization of that work. Interviews with the nurse and correctional officer were used to ask about the connections between decision-making discussions such as the one described above and the institutional processes and practices, which organize that work. Also, I collected the policies and procedures, work descriptions, and other documentation related to this and other informal decision-making discussions between various staff. As questions, analytic ideas and other thoughts came to mind, they were recorded as reflections in observation or interview notes.

In total, the data collected in this study include:

1. 30 days of participant observation data of frontline mental health staff recording:
   a. a variety of individual and team work activities
   b. 10 clinical and operational team meetings
   c. record keeping (health and case management records as well as operational and observation reports for specific events/incidents)
   d. miscellaneous (staff supervision, planning with other correctional institutions, interacting with community representatives, and other activities)
2. 17 interviews with 15 institutional staff
3. 8 interviews with 6 regional managers
4. 4 interviews with 4 national managers
5. A broad range of documents including: forms for health and case management records, institutional standing order policies and procedures, regional instruction
policies, national commissioner’s directive policies, national correctional legislation, provincial health/mental health legislation, staff surveys, accreditation survey reports, prison-hospital reviews, work descriptions

3.5.1 Field observations

Data collection began with field observations of frontline staff working in the living units, or ‘ranges’, of the prison-hospital. As suggested by Campbell and Gregor (2002) and Devault and McCoy (2006), the perspective and experiences of individuals applying policies to everyday situations, garnered from these initial observational findings, organized the direction of the research. Decisions to spend time observing specific individuals or groups in order to focus on specific types of activities and processes emerged as a result of the initial observational findings.

The goal of field observations was to observe the activities, people, and environmental aspects of providing mental health care. Observations included nursing and correctional shift work in the offender/patient ranges, weekly multi-disciplinary treatment team meetings, morning operational planning meetings, mental and physical health care for individual offenders/patients, security control to and within the facility, and ambulatory care services in other prisons. These observations served as a vehicle for seeing how policies and protocols are implemented when negotiating mental health care decisions. All observations were recorded in a notebook.
3.5.2 Formal Interviews

Formal interviews were arranged with several key informants including mental health professionals, correctional professionals, and managers. Due to the federal nature of the government organization of which the prison-hospital is a part, it was recognized that not all decisions regarding provision of service were made by individuals located in that setting. In order to glean insight into the governing structure of the prison-hospital individuals involved in regional and national level decision-making processes were also interviewed. Informants were selected based on their level of experience and knowledge of the setting.

The formal interviews were semi-structured in nature using a number of open-ended questions prepared in advance to guide the interview process. Often questions were prepared based on earlier observations and/or interviews (formal or informal). Interview topics varied across informants in order to uncover organizing structures affecting various aspects of mental health care. Interview topics included the history of the prison-hospital, resource allocation, working relations, legislative and policy structures, overarching ideologies, and priorities of the prison-hospital. Formal interviews were tape recorded with permission of the interviewees and transcribed for analysis.

3.5.3 Informal Interviews

Institutional ethnographers listen for the sort of ‘talk’ that contains and expresses informants’ expertise in living their own lives (Campbell & Gregor, 2002). From the start of data collection through field observations, informants spontaneously engaged me in
**Figure 1: The Funnel Process of Data Collection**

<table>
<thead>
<tr>
<th>Month</th>
<th>Institution</th>
<th>Duration</th>
<th>Observation Days</th>
<th>Interviews</th>
<th>Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1</td>
<td>institution</td>
<td>2 weeks</td>
<td>10 OBS*</td>
<td>2 INT</td>
<td>extensive DOC</td>
</tr>
<tr>
<td>Month 2</td>
<td>institution</td>
<td>1 week</td>
<td>5 OBS</td>
<td>3 INT</td>
<td>extensive DOC</td>
</tr>
<tr>
<td></td>
<td>regional management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 3</td>
<td>institution regional management</td>
<td>1 week</td>
<td>5 OBS</td>
<td>7 INT</td>
<td>extensive DOC</td>
</tr>
<tr>
<td></td>
<td>national management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 5</td>
<td>institution regional management</td>
<td>1 week</td>
<td>5 OBS</td>
<td>7 INT</td>
<td>few DOC</td>
</tr>
<tr>
<td></td>
<td>national management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 9</td>
<td>institution regional management</td>
<td>1 week</td>
<td>5 OBS</td>
<td>7 INT</td>
<td>few DOc</td>
</tr>
<tr>
<td></td>
<td>national management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Month 11</td>
<td>national management</td>
<td>1 day</td>
<td></td>
<td>3 INT</td>
<td></td>
</tr>
</tbody>
</table>

*OBS = observation days; INT = interviews; DOC = documents*
informal interviews when I was in their local setting. Their way of talking included both expressions of their expertise in how to be a competent participant in the prison-hospital setting and common-sense theorizing, their views and opinions, about why people do things a certain way (Campbell & Gregor, 2002). This type of informal interview was common during initial field observations until informants felt that their thoughts and experiences had been heard. Other informal interviews took place during field observations when the investigator asked those she was observing to explain what they were doing, why they were doing what they just did, what they need to think about to do the work, etc.

Informal interviews occurred spontaneously and opportunistically. They were recorded as completely as possible in the investigator’s field notes as soon after the event as possible. A detailed outline of the conversation was recorded including verbatim excerpts, descriptions of the general mood of the interview and context surrounding the interview.

3.5.4 Document review

Institutional ethnography is designed to reveal the organizing power of texts, making visible how activities in local settings are coordinated and managed extra-locally. Campbell & Gregor (2002) emphasize that, “understanding the textual architecture of routine organizational action is crucial to institutional ethnography” (p.24). Document review shows how texts build organizational versions of what people say, do or know for organizational action as well as how people at different sites are tied together to act in concert with one another (Campbell & Gregor).
The documents reviewed for the current study included policy and procedure documents, legislation, mission and vision statements of the organization and institution, governmental review reports, and planning documents. Documents were made available to the investigator by key informants at institutional, regional and national levels, as well as through a formal access to information request. The purpose of gathering these particular documents was to provide the investigator with foundational knowledge of work processes as they relate to the provision of mental health care. The investigator also focused on collecting documents that inform mental health practice including standards of practice, operational requirements and adjustments, health service accreditation documents, and job descriptions.

3.6 Data Analysis

Data analysis is done using iteration, an interpretive/interactive field-based approach, that is consistent with the analytic processes for institutional ethnography described by Campbell and Gregor (2002) and Townsend (1998). This approach to data analysis involves reflecting on the information that has been gathered in the field to determine ‘what is going on’ assuming that a specific social organization coordinates what was seen and heard by the researcher. It avoids the dangers of ‘cutting up’ the data (as with computer assisted data management strategies) and categorizing data in a way that is artificial or that obscures the social relations at the crux of the study (Campbell & Gregor, 2002; Smith, 2006). Grbich (1999) describes iteration “at its simplest level… involv[ing] going out into the field, collecting information by observing or interviewing, transcribing this information, reflecting upon it and subjecting it to an initial analysis to
determine ‘what is going on’, then using the information gained to guide the next venture into the field” (p.231). This iterative method is supported as an ideal mode of analytical procedure in qualitative research (Coffey & Atkinson, 1996; Grbich, 1999; Miles & Huberman, 1994).

The analysis moves from the particular to a general analysis by way of tracing the social relations, or connections between work processes, that people are drawn into through their work (Devault, 2006). What informants know and what they are observed doing is used to identify, trace and describe the social relations that extend beyond the informants’ experiences and explicate how the local setting is brought into being (Campbell & Gregor, 2002). The idea is to shift from a focus on the provision of mental health services to a kind of investigation that could be useful in efforts to change the social relations that subordinate the institutional complex of mental health care.

The analytic process began with the collection of data to find and interpret points of disjuncture, or disconnection, between objectified knowledge used to coordinate and control mental health services and the subjective experience of the frontline workers. Informal story-telling with a policy expert as data came in helped to critique the information using various concepts and frames to see if they shed light on the initial issues being identified. In storytelling, that moment of ‘disjuncture’ or ‘disquiet’ motivating my initial interest remained analytically important. I went back to the problematic and it’s conceptual frame to recall what I did and did not understand previously. The policy specialist asked questions that challenged my insight and focused me back to the driving issues of policy implementation and sound methodology as well as directing me back to the data for examples and evidence.
The second analytic process in institutional ethnography involves tracing how the work being studied is connected with other types of work in the same institution to display how actual experience is embedded in the particular historical relations that determine that experience (Townsend, 1994; Smith, 1987). It uncovers how actual work is embedded in institutional social processes that coordinate and control various types of practices within a particular institution. With each new chunk of data, tentative themes evident from the preliminary analysis were examined for patterns of language and behaviour, and propositions were generated relating to particular themes (taking the whole down to its parts). These propositions were viewed across all of the other themes looking for more complex aspects and associations (‘mapping’ the parts back into a whole). The connections that are made are not theoretical. Interpretation of the data “relies on, explores, and explicates linkages that are lived, brought into existence in time and space by actual people doing actual things” (Campbell & Gregor, 2002, p.98).

The third analytic process extends the analysis to display how ideological processes and practices coordinate and control the interconnected work processes to accomplish specific functions of an institution and is primarily focused on the ‘textual’ practices of an institution. Here, ideology is not considered a theoretical framework, but rather as actual processes and practices that are observable in everyday situations that invisibly coordinate and control people’s experiences in the everyday world (Smith, 1987; 1990a; 1990b). These processes and practices, used to manage institutional complexes such as mental health care, are ideological in that they categorize and incorporate the ideas, values, and beliefs of a ruling apparatus that governs institutional functioning (Townsend, 1994; Smith, 1987). “To analyze ideology, then, is to analyze
how generalizing processes and practices coordinate and control interconnected practices in which different workers act on the same person or object in the same or different locations and time. The analysis of generalizing processes and practices reveals the broad social relations of an institution” (Townsend, 1994, p.35).

The policy implementation framework (Hambleton, 1983) was utilized as a tool for organizing and presenting the analysis of everyday work activity rather than as an analytic tool. Data collection was complete and analysis was well underway when the framework was applied as a means of communicating the findings. To complete the analytic process I repeatedly read and reflected on the observation, interview, and documentary data on the frontline staff’s mental health work and its connections with other correctional work processes. Reading and reflection also included an ongoing review of the policy implementation literature from which I knew to be particularly attentive to the processes and practices used to influence, affect, constrain, shape, guide or limit policy actions and the relationships between participating actors and agencies.

3.7 Rigor

Rigor in institutional ethnography lies primarily in its method and theory. There is an inherent truth in ethnography as it is based on an empirical account of actual activities of people in real practice situations (Spradley, 1980). Multiple strategies of data collection, such as participant observation, interview, and document review, provide a method for triangulation of the emerging analysis by ‘filling in’ the researchers knowledge and ‘checking’ the account of social organization that is being built. “Truth is sustained in the ethnographic account by presenting evidence which can be traced to the
actual people [and] method of data collection” (Townsend, 1994, p.41). Initial impressions and identification of tensions arose from data collected through observation of frontline staff. Individuals were approached for interviews based on their involvement in actions and activities related to tensions being observed and this new data was used to strengthen the initial impressions and formulate arguments about the social organization of mental health care. Through both observation and interviews, documents identified by frontline staff as being relevant to their everyday activities, including policy documents, were identified for review and used to solidify my understanding of tensions in practice and fully develop the arguments of how extended social relations produce a generalized way of working within the prison-hospital.

As a student researcher, supervision also played a key role in ensuring rigor. Including my supervisor in the data analysis process, by talking through everyday events during data collection as well as both of us simultaneously reflecting on specific sections of data to identify and interpret points of tension, provided a means of ‘checking’ and ‘cross-checking’ my own interpretations.

The problematic of the current study was grounded in an everyday life experience that provided a guideline for the systematic approach to data collection and analysis. Mental health care varies significantly in the different living units and program areas of the prison-hospital under study so that I needed to observe practice until no new general features were identified. I collected multiple overlapping data for ‘triangulating’ or ‘cross-checking’ the analysis through observations, interviews and documentation. I was careful to construct an account of social organization that is faithful to the standpoint of the frontline staff providing mental health care in the prison-hospital. The design
included informal summary sessions with frontline staff from each living unit and activity area of the prison-hospital. The emerging analysis was presented and feedback from the informants verified the account from their perspective and provided direction for further analysis.

My position as researcher, including the values and assumptions that influenced the perspectives of the study, revealed areas where I needed to be rigorous. I kept detailed notes on the formation of the research question, access to the field, the data collection and analysis process, including questions posed by the policy specialist as well as questions I used to challenge myself, and final interpretations.

3.7.1 Ethics

In negotiating access to the organization, the kind of data that institutional ethnographies typically seek can make the process challenging (Campbell & Gregor, 2002). Ethical approval from the Tri-Council Research Ethics Board (Appendix D) satisfied the organization’s questions about the scientific merit of the project, however further negotiations were required to gain permission from the prison-hospital management. The issues that the prison-hospital had about opening their operations to the investigator’s, and thus to the public’s, scrutiny challenged the investigator to present the benefits of the project for the organization as well as organizing her approach to key informants in a way that would not create new or contribute to existing concerns within their workplace. The highly political environment of this government agency also required additional attention to matters of confidentiality for key informants. Approval from the organization (sought through the Regional Research Committee and granted by
the Director General - Research) (Appendix E) was contingent upon both the permission of prison-hospital management and the approval of the Tri-Council Ethics Board.

Once all formal approvals were in place, all frontline staff, middle and senior managers, and labour union representatives expressed interest and support for the project. All potential informants approached for field observations as well as formal and informal interviews agreed to participate. At times, individuals clarified the confidentiality of what was being shared and the investigator took time and effort to verify that confidentiality in order to establish and maintain the trust of all key informants.

Spradley (1980) cautions that the more you know about a situation, the more difficult it is to study it as an ethnographer because, as an insider, it is more difficult to see the tacit cultural rules of a situation at work. I was careful not to take too much for granted because the culture at the prison-hospital is a part of my own knowledge. I was careful not to overlook language differences – terms unique to the setting – with which I was already familiar. Also, it seemed to some informants that I was asking oversimplified questions, questions that I should already know the answers to because of my background in the organization, or that I was testing them in some way. I incorporated into each interview, formal and informal, explanations of what the project was about, reasons for recording or documenting the interview, and reasons for asking certain types of questions.

3.7.2 Generalizability

With just five dual prison-hospitals in Canada’s federal correctional service, this one facility represents one fifth of the potential sites for exploration. All five of these
settings are governed by the same federal correctional legislation while incorporating the health care legislation specific to the province where they are located. They also share a similar mandate to provide in-patient mental health care to incarcerated offenders. Therefore, these five settings, while not exactly the same in their operation, should be somewhat similar to the institution under study in their organizational structure.

However, each of these prison-hospitals has a very different history and environmental context. The prison-hospital being studied occupies buildings that are almost 200 years old, while another prison-hospital occupies a new facility that is less than 10 years old. Two prison-hospitals exist within their own fence or wall, while the other three are within the secure perimeter of a larger, regular population prison. The range of mental health staff making up the multi-disciplinary mental health teams also varies. While two prison-hospitals have a full range of staff including psychiatry, nursing, occupational therapy, social work, psychology, art therapy, and horticulture therapy, other prison-hospitals are limited to psychiatry, nursing, psychology, and social work.

While the differences between these five settings are significant enough to preclude absolute generalizability of the research findings, the similarities in policy content and structure as well as environmental culture of a correctional setting, are significant enough for each of the five settings to identify with the findings and policy implications of this study to some degree. The research method provides enough description to enable application of analytic generalizations across other sites that also operate under dual correctional and mental health mandates.
3.8 Organizing the Analysis

Chapters 4 through 9 present the findings of this study. Chapter 4 presents the chain of critical events organized around and through the policy documents that coordinate the frontline staff’s activities across time and place within the institutional relations of mental health care. Chapters 5 through 9 have been organized according to Hambleton’s (1983) policy implementation framework. This framework provides a structure for tracing the tensions that arise through five key elements of policy implementation: policy message (chapter 5), multiplicity of agents (chapter 6), multiplicity of perspectives and ideologies (chapter 7), resources (chapter 8), and politics of planning (chapter 9). The ultimate intention is to map how the work processes and practices of frontline workers in the prison-hospital are aligned with relevances produced elsewhere, illuminating the powerful organizing forces that shape the policy implementation experience, typically through texts. Data within the thesis are presented in the form of quotes, and italicized. Data sources are identified in superscript at the end of each quote using alpha-numeric codes as listed in Appendix F.
CHAPTER 4
SLOW DECLINE

4.1 Introduction

This chapter introduces the central thesis and describes a series of critical events that provide context for the analysis of policy implementation elements in Chapters 5 through 9. Section 4.2 presents the central thesis that a lack of organizational vision about the role or intent of the prison-hospital brought about a process of organizational change that moved the correctional mandate forward while, essentially, leaving mental health care behind to slowly decline. There is some memory of an organization with better balance between the mental health and correctional mandates (section 4.3). However, over several years mental health care has slowly declined through a dynamic series of events that are plotted out in this chapter. These critical events were identified as significant in instigating and perpetuating the decline of mental health care. They are described as historic relations that, while appearing to benefit mental health care, also brought about some sort of loss, and determined the current experience in providing mental health care in the prison-hospital (section 4.4). The chapter ends with an introduction to the policy implementation framework (Hambleton, 1983) used to organize and present the interconnections and ideologies at work in the ruling relations of the institution (section 4.5).
4.2 Slow Decline (deconstructing mental health care through ‘lack of vision’)

The first evidence of a ‘vision’ for mental health care came in a 1991 review of mental health services within the Correctional Service of Canada where a national strategic framework was proposed. The framework was designed to address the organizational objective for development and implementation of policies and programs that address the specific mental health needs of offenders.

“Mental health care contributes to the Mission and Strategic Objectives of the Correctional Service of Canada – to reduce recidivism, assist the offender to become law-abiding, and facilitate reintegration into the community – by developing, implementing and evaluating an integrated continuum of mental health promotion, assessments, treatment, and relapse-prevention services from reception to sentence expiry, aimed at reducing the incidence and impact of psychological dysfunction, through social and cognitive skills development and the promotion of healthy, positive interactions between the offender, the Service and the community.”

Thirteen years later, in 2004, an unpublished internal review of the organization’s five prison-hospitals identified a lack of clarity in the roles and responsibilities for providing mental health care across the organization. A new organizational model for the prison-hospitals, along with change management strategies for implementation, was sought. It was expressed that, “there is a need to formally recognize [prison-hospitals] as unique and distinct, and to establish appropriate standards and resourcing levels based on their specific requirements.” During the time period between the two reviews, mental health care was described as essentially a ‘non-system’ of care with a few ambiguous policies directing mental health programs and services buried in a sea of highly prescriptive security and case management policies. The 2004 health services accreditation report recognized that, “usually there is only a quick response to a crisis situation and then only after some form of ‘damage’ has been done. This seems to apply
A vision for mental health care, and the role of the prison-hospitals in providing that care, had not been integrated with the organizational structure.

The Correctional Service of Canada follows a hierarchical organizational structure. Figure 2 shows the hierarchical location of various staff within the prison-hospital, as well as at regional and national levels, at the time the study was conducted. It is important to note that this is not an official organizational chart and does not specify all employee positions, nor does it use official job titles or classifications. Instead, it provides a basic understanding of the hierarchical location of different groups of staff within the organization.

Through the 1990s and early 2000s, the lack of vision about the role or intent of the prison-hospitals in providing mental health care left the organization uncertain as to how to proceed with organizational change that included mental health care. It wasn’t known what to do with the unique features of the prison-hospitals, compared to other prisons, so essentially nothing was done. “I think its probably an issue of will in the Service, that there are many other priorities... a lack of feeling like they needed to focus their attention on this particular area.” The status quo was held for mental health care while moving forward with proactive organizational change across the rest of the correctional system (including the security and case management features of the prison-hospitals). Without organizational direction for the development of mental health care, the prison-hospital under study found its own path of organizational change that incorporated national and regional policy initiatives for security, case management, and resource management as well as a number of locally-driven initiatives that responded to
Figure 2: Organizational Structure

Commissioner of Correctional Service Canada

National Managers for Health Care, Programs, Finance, Operations

Mental Health Care          Security

Regional Deputy Commissioner

Regional Managers for Health Care, Programs, Finance, Operations

Mental Health Care          Institutional Heads (Including Executive Director of the Prison-Hospital)

Executive Director of the Prison-Hospital

Managers for Psychology & Rehabilitation, Psychiatry, Programs, Nursing

Managers for Operations, Security, Case Management

Frontline Nurses, Social Workers, Occupational Therapists, Chaplain

Frontline Correctional Officers, Parole Officers

Behavioural Science Technologists, Program Officers, Psychologists, Psychiatrists
its own unique needs and features as a mental health facility.

Through the preliminary analysis, it became clear that subordination of mental health care was not a ‘situation’ or ‘status’. Numerous informants stated that “it didn’t used to be like this”, leading to an understanding of the current experience of frontline staff as being determined by the historical context of organizational change. When asked when and how it changed, everyone, without exception went to the same point in time. They were able to “actually pin-point it back to probably the early, or the mid 1990s.”

The implementation of new and revised policies that emphasized development of the correctional mandate of the prison-hospital brought about this slow decline, which gradually caused mental health care to become subject to, and secondary to, the correctional and security priorities. “That whole ’95–’96, that’s when the whole slant went away from a clinical focus to a case management/parole office kind of focus.”

4.3 Before the Decline

“I’ll just give you a little history first.”

The building that housed the prison-hospital was first constructed in 1835 as part of Canada’s first federal prison. It was designated a prison-hospital in the 1970’s following a recommendation that prison-hospitals be established in each of the five regions of the Correctional Service of Canada for the purpose of providing psychiatric care to incarcerated offenders. As described in section 2.1.2, offenders leave their parent institution to receive in-patient mental health services within the prison-hospital. In doing so, they leave behind their ‘home’ environment, the peers with whom they have relationships, support staff with whom they are familiar, and they suspend participation in
programs and services that will lower their risk of re-offending, essentially halting their progress towards achieving day parole or full parole. While there are a wide range of programs and services that benefit offenders with mental disorders, these programs are not recognized within the official structure for achieving such forms of release from prison.

All informants described the period before the decline as a positive time and the prison-hospital as a relatively healthy work place: “We were bustling, we had a lot of work, we were building... we were all excited, things were happening. We were all jumping in there, very busy.” IM3 The frontline staff who had been at the prison-hospital since the 1980s described the period of time before the decline as one of action, improvement, and hope. The relations of ruling, now so extensively organized, were only then appearing.

In the early 1990s, a new organizational mission statement was developed and the federal Corrections and Conditional Release Act (1996) came into effect. These two documents brought a greater degree of organization and accountability to the correctional mandate of Canada’s federal prison system. The cohesion of these policy structures was recognized in 1995 by the first health services accreditation survey team: “There is strong evidence of the focus on security and protection of society, staff and the physical environment. Policies and procedures surrounding these needs are sophisticated and well exercised.” D1 While the mental health mandate of the prison-hospital was stated in the facility’s vision and mission statements, an operational review of the prison-hospital found that “there appear[ed] to be no clearly formulated plan to deliver psychiatric services in the region. The services developed appear to have been reflex responses to
crises without benefit of the development of plans”. Within the prison-hospital, the nursing staff had a policy and procedure committee that governed nursing standards of practice. The quality and content of these nursing policies and procedures was praised by health services accreditation surveyors for “ensur[ing] quality of service and maintain[ing] a professionalism that enhances the overall therapeutic milieu of the [prison-hospital]”. Balancing the mental health mandate of the facility with the correctional mandate of the broader organization presented a formidable challenge that was recognized in the Correctional Service of Canada’s mission statement: “The two elements [care and control] are inseparable, although achieving the right balance between them is often difficult”.  

Frontline staff spoke of inter-professional work activities and role blurring as evidence of balance between the two mandates. There was a dynamic interaction between disciplines in team meetings and in active support of each other’s clinical work. Responsibility for planning and delivery of mental health care was shared by all frontline staff and it was recognized that inclusion of correctional officers in the teams resulted in greater continuity of care. As one nurse described, “There was no ‘it’s a guard’s job, or it’s a nurses job’… a guard could be busy with a nurse doing groups and I would be going through a guy’s effects, doing a frisk with another [guard]”.  

Relations between frontline staff were significantly shaped by the physical structure and use of space in the facility. The facility had an open-concept layout with a central nursing station that facilitated interaction between staff working on different units. “In the old building... the whole middle of the building was open... If I was out on the landing outside the third floor, I could talk to you on the first floor through the grate...
People socialized a lot more because we all had one central congregating area.” IMI

Interactions between frontline staff and patients were also significantly shaped by the physical structure and use of space. With the nursing office for each unit located in the first cell of each living unit, nursing staff were always on the unit interacting face-to-face with patients.

The overall leadership and experience of managers and supervisors was considered a stabilizing factor at the prison-hospital. Through the 1980’s there had been consistent leadership from one Associate Warden\(^5\) for a period of 10 years. Much of the clinical focus of those years was attributed to this person’s leadership style. However, the ineffectiveness of the prison-hospital’s management team in dealing with dysfunctional situations and/or personality clashes among staff prompted frontline staff to begin challenging the way managers addressed concerns among the staff: “I used to give a little analogy, it’s like cancer. Why would you metastasize by splitting... they were going to split these 5 negative people among the units. Well that would just make every unit miserable. Why don’t you (a) deal with these people or (b) keep them together so they just wear on each other. So they don’t wear on the good staff.” IMI

Having a full complement of health care and program staff allowed frontline staff to participate more fully in the context of care and to have influence within the multi-disciplinary context. “Nursing staff started getting assigned to go back there with them to groups... with the occupational therapist... to art class... to music... and gym, we went down and played volleyball with our [recreation] officers... we’d get assigned to do that.” IMI With program and health care staff having the primary role of direct interaction

\(^5\) The Associate Warden was the senior manager of the prison-hospital and reported to the Warden of the maximum-security prison on the same compound.
with patients, and the dual training of support workers in both health care and security work activities, there were few correctional officers. The correctional officers’ role was ‘complementary’ to that of the program and health care staff, controlling movement into and out of the living units and activity building as well as providing visual surveillance throughout the building. Because the prison-hospital was, at that time, under the authority of the maximum-security prison within the same compound, many of the reporting structures between the two facilities were intertwined. Although correctional officers were working posts in the prison-hospital, they were supervised by managers located at the maximum-security prison. Since they were not designated specifically to the prison-hospital, correctional officers could be pulled from the prison-hospital for operational requirements in the maximum-security prison. Alternately, posts at the prison-hospital could be filled by correctional officers who typically worked at the maximum-security prison.

Despite some of the inconsistencies with correctional officers, there was a rich contingent of nursing staff and managers in the prison-hospital. The structure included a Director of Nursing, Nursing Supervisors, Head Nurses, and frontline nurses. Each eight-hour shift would have three nurses and a nursing supervisor working each unit. In the late 1980s there were a number of nurses about to leave through attrition and there was active resource planning to avoid gaps in the staffing complement. “They would always have foresight, they kind of knew... they would hire a bunch of nurses, like 4 or 5 at a time... they’d be there 2 years before the attrition, it’s like you’re down 5 nurses but they never lost a beat because they already had 2 years of experience and this always kept the complement of nursing staff. It never dropped low.” IM1 However, there was concern that
approximately half of the resources of the prison-hospital were devoted to ‘non-psychiatric’ patients, meaning patients in need of physical health care.

The frontline staff, including nurses, social workers, psychologists, programs officers and correctional officers, spoke positively about having enough resources for consistent access to the activity building, where many individual and group programs and services were based, during regular working hours: “At one time we had a full complement of staff, we had representation at all of the multi-disciplinary meetings... We were more vocal in... basically any function because we had the staff to put in different spots and carry out the concerns of the program area”. However, among managers there was a concern about a lack of resources for program staff (social development and recreation officers) to facilitate evening and week-end activities for patients. The resulting impact on program delivery was characterized by regional managers as “seriously restricted”.

The lack of clarity in the role and responsibilities for merging the mental health and correctional mandates was already apparent in numerous ways. Despite the existing staffing complement, the number of health professionals and correctional officers required to meet ‘operational requirements’ was not clearly identified; federal legislation on sharing correctional case management documents varied from provincial legislation on distribution of health care information; and national training standards were in place for maintaining qualifications in security activities but none existed for maintaining currency in mental health standards of care. Yet, the mental health mandate was the primary focus of everyday work practices at the prison-hospital. Multi-disciplinary teams
were moving the institution forward with their dedication and professional work. “We had all our stressors but it felt good because we were still active.”

However, as a series of policy decisions and organizational changes, or critical events, took place, implementation of the mental health mandate slowly declined. These critical events were designed to move the correctional mandate forward, however, without a clear vision for the provision of mental health care within the correctional context, a gradual process of subordination of the mental health mandate emerged.

4.4 Describing Critical Events as Historical Relations

There were a number of critical events that took place between 1990 and 2005 that appear to have had a significant and lasting impact on the provision of mental health care in this particular prison-hospital. These critical events included: a) a major retrofit of the main building; b) introduction of a unit management model; c) acquisition of a second building; d) frequent turn-over of institutional management; e) participation in health services accreditation surveys; f) administrative separation from the maximum-security prison; and g) a shift of the budget allocation system into an envelope or silo system along with the creation of resource indicators for all aspects of the organization except mental health care (see Figure 3). Individually, each of these events benefited an immediate need of the prison-hospital or the broader organization. However, each event also brought a significant setback to the ongoing provision of mental health care. This was spoken about by mental health staff as a process of taking one step forward and two steps back: “That, to me, was a major dip… then there was another huge setback,
another major dip... and then I see a major dip, a big fall... and then there would be a quieting and then there would be a major dip again. “IM3

The series of critical events that were catalysts for the slow decline of mental health care have shaped the current experience of frontline staff. Everyday work processes and practices for the frontline staff were significantly altered: who they saw on a day-to-day basis, how they communicated with other frontline staff and managers, as well as the quantity and quality of direct interactions with patients. The critical events are described in the sections that follow.

**Figure 3: Timeline of critical events**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;1990</td>
<td>Before the decline</td>
</tr>
<tr>
<td>1990</td>
<td>Facility emptied for retrofit</td>
</tr>
<tr>
<td>1992</td>
<td>Facility re-filled after retrofit</td>
</tr>
<tr>
<td></td>
<td>Unit management model implemented</td>
</tr>
<tr>
<td>1995</td>
<td>Acquisition of second building</td>
</tr>
<tr>
<td></td>
<td>1(^{st}) health services accreditation</td>
</tr>
<tr>
<td>1998</td>
<td>Designated a stand-alone facility</td>
</tr>
<tr>
<td></td>
<td>2(^{nd}) health services accreditation</td>
</tr>
<tr>
<td>2001</td>
<td>3(^{rd}) health services accreditation</td>
</tr>
<tr>
<td>2002</td>
<td>Envelope system implemented</td>
</tr>
<tr>
<td>2004</td>
<td>4(^{th}) health services accreditation</td>
</tr>
<tr>
<td>2006&lt;</td>
<td>New governance models</td>
</tr>
<tr>
<td></td>
<td>Correctional officer deployment</td>
</tr>
<tr>
<td></td>
<td>Comprehensive mental health strategy</td>
</tr>
</tbody>
</table>
4.4.1 Retrofit of the original building

The activity building had been renovated in the 1980’s to provide some of the required program and recreational space, however a significant number of deficiencies in the main building prompted a major retrofit of the physical structure in the early 1990’s. These deficiencies included insufficient and inadequate space for administrative offices, absence of assessment and treatment space on each living unit, using existing patient cells and support spaces for administrative functions, and poor movement between buildings and between related functions (getting from one space to another for related work activities). These deficiencies, coupled with the anticipated increase in the number of offenders requiring mental health care, and in those needing high intensity sex offender treatment, presented a significant concern for operational requirements. The facility was “inadequate to reasonably handle the existing numbers of offenders who should be receiving... care”.

The retrofit was also identified as a solution to the lack of resources, specifically the insufficient number of correctional officers to support off-range recreational activities during evenings and weekends. This lack of ‘off-hours’ human resources exacerbated the need for on-range dayrooms where activities could take place during evening and weekend hours under the supervision of existing nursing and correctional officer resources.

The proposed changes to the prison-hospital facility included providing direct access to the activity building from each of the living units, constructing offender dayrooms on each living unit, installing a controlled-access elevator for accessibility, and relocating administrative functions that were occupying patient cell space. There were
also a number of repairs proposed for improving the condition of the existing structures. Significantly, the structural changes proposed by the regional planning team were designed to “recognize the required separation between staff and [offender] specific areas.” This separation was not consistent with the unit management model that was being implemented across the country (described in section 4.4.2), nor was it supported by frontline nursing staff who valued having such close quarters with the patients. It was at this time that frontline staff began to feel that their input was not valued and that consultations with frontline staff were more ‘procedural’ than meaningful.

The practical implications of doing the retrofit had a profoundly negative effect on communication amongst frontline staff. In 1989, the staff and patients of the prison-hospital were divided into three groups: staff and patients for the sex offender treatment program were temporarily relocated into a older, smaller building within the compound; the remainder of the staff and mental health patients were divided into two groups and temporarily relocated to the two maximum security prisons in the region. The frontline staff developed strong and well-coordinated working relationships within these groups but there was no interaction between groups for a period of two years while the retrofit was being done.

Upon completion of the retrofit, all of the patients and staff moved back in on one day: October 8, 1992. Upon returning, each of the groups expressed that they worked well together and were able to continue working together on their respective units. The strong working relationships between nursing and correctional officers on each unit enabled new staff to integrate into the routines of the prison-hospital. For the most part,
the coordination of work activities that resulted from these strong relationships continued the way it was prior to, and throughout, the retrofit.

However, the groups of staff on different units continued to be separated from each other as they had been while relocated to different institutions during the retrofit: “So we go into the new [prison-hospital] and its first, second and third floor all with doors locked off where it’s a self-contained unit. There’s no central meeting area. “

Figure 4 presents the layout of the first floor living unit following the retrofit. It is important to note that this is a rough diagram drawn from sketches in observational fieldnotes.

**Figure 4: Layout of Living Unit in Main Building**
The earlier sense of ‘team’ and ‘teamwork’ in carrying out everyday work activities was seriously compromised. “Unless you actually physically went to another unit, you’d never see another nurse... other than the nurses you were working with that day... you could go weeks without seeing another nurse that you used to see all the time.” The isolation from a broader range of colleagues took its toll on the groups working each unit: “Every unit had its own little idiosyncracies and personalities which they never had in the past because we all saw each other all the time.” This first critical event instigated the decline through establishing barriers that compromised communication and healthy working relationships between groups of frontline staff.

4.4.2 Unit management

While other prisons around the country implemented the new unit management model in July 1990, unit management came into effect in the prison-hospital in October 1992 when staff and patients returned following the retrofit. The unit management model was designed as the organizational standard for all facilities of the Correctional Service of Canada. It was a decentralized approach to offender management to ensure that lines of authority were well defined, that decision-making was delegated to the unit level under the individual unit managers, and that there was extensive staff and offender interaction. It was anticipated that this model would ensure the integration of the key elements of case management, correctional programs, and security functions. Correctional officers were designated to the prison-hospital and the reporting structure shifted to the correctional supervisors at the prison-hospital. However, the flexibility to move
Correctional officers between posts in the prison-hospital and the maximum-security prison remained.

The model was designed to ensure that a team of security and case management staff worked consistently with the same group of offenders. It was intended to promote “positive staff/inmate association through mutual, open communications; staff teamwork; the delegation of decision-making authority to the lowest level possible; accountability on the part of both staff and inmates, and consistency of operations for all institutions.”

The model did not address the in-patient service structure of the prison-hospitals or the additional consideration of provincial health care legislation that was an inherent part of the prison-hospital. Units were to be semi-autonomous and self-sufficient in the areas of case management and security, while health care was considered a separate service shared by all units within an institution and, therefore, not subsumed within the unit management model. Prison-hospital managers were required to implement this correctional model with no clear direction as to how to incorporate mental health care within this new model of service.

In an effort to acknowledge and address the unique needs of the prison-hospital, unit managers for the psychiatric units were re-named ‘patient care managers’. The delegation of the decision-making to the lowest possible level gave the patient care managers authority over decisions regarding the mental health care functions of the unit as well as case management and security functions. Unofficially, patient care managers were expected to have some type of clinical background however, formal job descriptions did not require these managers to have health care training or experience. Without this requirement written into formal job descriptions, clinical patient care managers were
gradually replaced with unit managers who had no clinical or health care experience:

“Here’s where we made our mistake, we allowed a unit manager to take over the psychiatric floor. And he was a great guy, he was the kind of guy that said ‘I know nothing about nursing, I know you’re good nurses, just do what you do and I’ll take care of the [correctional officers] and case workers’... But we had opened the door to that.”

The introduction of unit managers produced a visible shift in power for clinical decision-making: “[The unit manager] got into a conflict with the nursing staff and it was sort of dictatorial... authoritarian... it was bad. She was removed from the position.” This conflict was followed by a series of unit managers with backgrounds as case management officers and correctional officers who had little understanding of mental health issues or the roles and responsibilities of mental health professionals. “He once told me that parole officers’ jobs are more legally complex than a nurse’s job. I said ‘well, how do you figure that?’ and he said ‘well, they have to do reports’... Writing it on the nursing chart didn’t [matter], but if his parole officers did good [correctional] reports then it [mattered].”

4.4.3 Acquisition of a second building

In the early 1990s the organization’s Director General of Health Services challenged each of the regions to expand their in-patient mental health services. Building a new prison-hospital was not a consideration at that time since the existing facility had just undergone a significant retrofit. With the prison-hospital located within the maximum-security prison, both geographically and administratively, the only viable
option was requesting that the maximum-security prison reallocate a second building for use by the prison-hospital. The identified building had served a number of purposes over the years – office space, offender accommodation, program delivery, a school, and had been the ‘insane ward’ in the late nineteenth and early twentieth centuries.

**Figure 5: Location of Prison-Hospital within the Maximum Security Compound**
At this particular time, the maximum-security prison was using it as a kind of positive reinforcement for its general offender population. It was located directly across the correctional compound from the main building of the prison-hospital (see Figure 5).

The prison-hospital acquired the building in February 1995. The top two floors were to be used for patient accommodation where “rooms on each floor were twice as large as the cells in the main block... each [offender] with a key to [his] room. All inmates had free access to the spacious hallway, laundry/showers, and common kitchenette.” The main floor was renovated for office and program space. Figure 6 presents the layout of the third floor living unit of the acquired building.

Figure 6: Layout of Living Unit in the Acquired Building

From a leadership perspective, this was “one of the really good examples where it just shows you how the voice of mental health began to become a little bit stronger.” because it was a decision made in the best interest of the organization as a whole. The
regional needs for increased capacity of in-patient mental health beds came before the interests of a single institution. However, consultations with frontline staff for acquisition strategies and renovation plans for office and program space reinforced the perception that the input of frontline staff was not valued. The acquisition was characterized by many frontline staff as a “take-over” of the building and is consistently described as a defining moment at the start of the decline of mental health care: “So that was sort of the start of a change, in terms of a big change… of the decline.”

The correctional officers who had worked in that building as part of the maximum-security prison were given the option of staying in the building and now working as part of the prison-hospital. They remained together in the newly acquired building and now had to work side-by-side with the prison-hospital’s nursing staff. The nursing staff approached the new unit the same way they did the other units of the prison-hospital – with the understanding that they would work as a team and that there would be some blurring of roles as they worked together. However, the correctional officers approached the new unit as they did when they were part of the maximum-security prison, where there were no nurses on the units and the correctional officers held authority for unit routines. Because these correctional officers were not integrated with correctional officers who had experience working in the prison-hospital, they did not have help in adjusting to the prison-hospital’s work practices, a strategy that had previously worked so well for integrating new staff on other units. “Some of them didn’t want anything to do with the [prison-hospital] or nursing… whereas, before, when they came into the [prison-hospital] they were integrated with the other [correctional officers] who would say ‘this is Rome, and when in Rome this is what you do’.”
The earlier precedent of having a unit manager without clinical or health care experience overseeing a psychiatric unit was carried into this new setting: “Again, a unit manager who knew nothing about psychiatry. Correctional background; previously a correctional supervisor and correctional officer. He took over and that’s when everything became very slanted towards [correctional officers] and parole.” This was the only manager actually located in the new building. His presence was designed to ensure the hands-on approach of the unit management model with decision-making authority at the lowest possible level. However, this staffing decision, supporting the views/experiences of the new correctional officers and disregarding the concerns and experiences of the nursing/clinical staff, perpetuated this event as a turning point in the decline of mental health care. The staff in this new building found themselves separated again from the staff and activities of main building. Senior managers, who typically dropped into other units to talk with frontline staff and address issues arising, very seldom crossed the compound to talk with frontline staff in the second building.

The staffing complement of the prison-hospital started to noticeably change as human resources were allocated to provide custody and care of the additional patients in this second building. Frontline staff understood that, “the resources [were] supposed to come through a year ahead of the initiative... it was always one of the benefits of getting additional accommodation or additional bed space or programs.” New resources had been earmarked for the additional units but only a portion arrived at the same time that the units opened. The stabilizing resources didn’t come through until two years later. Base funding for the increased complement of beds was not received until the 1997-1998 fiscal year. For two years the budget allocation process continued to credit the prison-
hospital with resources for only the 96 beds in the original building, though it was now operating a total of 143 beds.

Initial nursing staff for the new building came from the psychosocial rehabilitation unit in the main building of the prison-hospital, setting a precedent for resource distribution that frontline staff routinely refer to as “stealing from Peter to pay Paul”. Under the pressures of operating a larger facility without all of the promised human resources, requests were made for frontline staff to ‘make do’: “Can you carry the load for a while? Just until we get going? Could you be a team player? Well, of course, you want to be a team player when you think you’re growing and you’re thinking ‘I’ll do my part to show them’. And you know that’s your devil’s decision.” This was the first visible evidence of mental health staff being spread thin, as if they weren’t actually needed where they were. It was experienced as a devaluation of mental health care, being reduced to basic services and falling behind community standards for evidence-based best practice. This event stands out, in the experiences of frontline staff, as a turning point that changed the hope and expectation of the facility being or becoming a clinical ideal to a situation of conflict and tension in day-to-day relations.

4.4.4 Frequent turn-over of prison-hospital management

It appears, in the years following the retrofit, that there were conflicting views on the value of consistent leadership at the prison-hospital that contributed to an operational change in the assignment of management positions. The consistency of senior management at the prison-hospital before the decline disappeared in exchange for the frequent turn-over of Associate Wardens (later called Executive Directors) and Deputy
Wardens. With these frequent changes in management, the leadership of the prison-hospital began to separate from the concerns of the frontline staff. A new Associate Warden came on board after the retrofit and he was “a bureaucrat... he had a very abrasive personality. He wasn’t a real people person... He had an antagonistic relationship with the nurses and the nursing union. He had an antagonistic relationship with the [correctional officers]. He was just antagonistic everywhere.” The trust and respect that had enabled frontline staff to operationalize the mental health mandate became tenuous.

Many difficulties experienced by frontline staff as they went about their everyday work accumulated over time as certain issues weren’t dealt with due to the frequent turnover of the management team. “It’s not that other managers didn’t address things necessarily, it was more like you weren’t there long enough to deal with long standing issues. A lot of stuff that I dealt with was ancient history, it had been bubbling for years.” A number of former Associate Wardens/Executive Directors agreed that an effective manager needed to spend time there to get to know the place and the issues: “People weren’t going to run to your door the first day you’re there and tell you about all the things that need to be dealt with.” Without consistent management to provide leadership, support, and guidance frontline staff found their own way to deal with various situations as they arose.

In contrast, a belief was also expressed that consistent leadership is a small piece of the broader management perspective, and that a manager’s capacity to influence major structural changes is minimal in relation to the impact of the broader organization: “Some will argue the need for consistency, some will argue the need for having some
stabilization. My own intuitive experience is that it's a small piece relative to... how you just pick up the files where they are and give them the consideration that they need.”’\textsuperscript{IN3}

4.4.4 Health services accreditation

Pursuit of health services accreditation was one of the primary initiatives at the prison-hospital following the retrofit. When it was first proposed in the mid 1980’s, there was some resistance born out of workload concerns and the newness of this territory but a 1989 operational review called for a reconsideration of that decision. The new Associate Warden, when the prison-hospital re-opened in 1992, saw accreditation as a positive step for the prison-hospital and put effort into reuniting the management and frontline staff behind this initiative. “Accreditation was exciting a bit at that point because we thought it was going to be a nice thing to advocate for improvements.”’\textsuperscript{IM3}

The prison-hospital was granted it’s first accreditation certificate by the Canadian Council on Health Services Accreditation in 1995, at about the same time that the decline was beginning to be felt by prison-hospital staff. The frontline staff viewed the accreditation process with cautious hope: “The introduction of accreditation, even achieving the accreditation, during an environment where the correctional focus was stronger than the treatment focus, in some ways was really something.”’\textsuperscript{IM1}

Subsequent accreditation surveys took place in 1998, 2001, and 2004 and provide a clear depiction of the decline of mental health care at the prison-hospital. The first three accreditation surveys (1995, 1998, 2001) recognized the quality of mental health care provided in the face of significant limitations and commended the staff and leadership of the prison-hospital on the progress made towards previous survey recommendations.
However, the 1998 surveyors found that health care objectives were often significantly affected by correctional objectives and recognized that “the balance between ensuring that the security needs of society are being maintained and that the therapeutic needs of clients are being effectively addressed is an ongoing challenge”. The 2001 survey report characterized the previous 5 years (1996-2001) as chaotic, evidenced by significant changes in management, making it hard for staff to adjust to new leadership styles and leaving the institution without a sense of direction. “Staff feel that they do not have a vision and there is concern about staff morale.” The 2004 surveyors reported that a perceived lack of senior leadership had developed which had allowed clinical functions to deteriorate. Many of the recommendations from the previous survey did not appear to be addressed and the surveyors questioned the prison-hospital’s commitment to providing quality mental health care:

“What is critically... important is the fact that three of the four quality dimensions contain at least one repeat high urgency recommendation. This indicates that little or no attention has been given to addressing previously identified recommendations. This seriously puts in question the [prison-hospital’s] commitment to making the delivery of quality services a priority throughout the organization.”

Increasingly, frontline staff became frustrated and disillusioned with the accreditation process. The staff found justification for their frustrations when the issues of concern and recommendations for improvement in the 2004 survey report were a virtual repeat of the concerns and recommendations expressed in the original 1995 survey. In particular, the need for a quality improvement plan/process that includes indicators of performance was emphasized in the recommendations for all areas of the organization: “There is risk associated with the organization not complying to its own policies.”
4.4.5 Stand-alone facility

The drive to become a stand-alone facility began in the early 1990’s when everyone returned after the retrofit and a new associate warden came on board. “There was wide spread consensus of the need to make the mental health frame a bit stronger, a little bit more understood and a little bit more focused. And it could be best served by having the facility as a stand-alone”. IN3

Although Associate Wardens/Executive Directors at the prison-hospital began to turn over more frequently following the retrofit through the 1990’s and early 2000’s, they presented a consistently strong perspective about the indirect and limited representation mental health care had at regional levels. The concerns of the prison-hospital were being represented at the regional management table by the Warden of the maximum-security prison. With the number of complex issues faced by this larger institution, it was felt that the voice of the mental health facility “wasn’t as focused or as strong as it could have been, should have been, needed to be.” IN3 As a result, senior managers felt that the concerns and priorities of the prison-hospital were not being adequately addressed. “One of the difficult things I found… was when you were part of a larger complex, and being a smaller institution... you weren’t as big on the agenda as the broader level institution.” IR2 The prison-hospital management team wanted the institution to have its own voice at the regional management table.

An Associate Warden in the mid-1990’s, in speaking individually with the regional deputy commissioner and the regional management committee, found support for a regional role of the prison-hospital: “At that time, a warden could do what he wanted to with the resources... and the warden at [the maximum security prison] isn’t
going to give that up too quickly. But with the [acquisition of the second building] and with the change in the way that they viewed the [prison-hospital], this became an opportunity. This opportunity became the driving force for an administrative separation of the two facilities that would provide the prison-hospital with that mental health voice within the regional management structure.

In contrast, frontline staff identified this pursuit to become a stand-alone facility as a critical event that contributed to the deterioration of mental health services. It directly pulled the priorities of the prison-hospital from mental health care to prison management:

“The [prison-hospital] would be autonomous as its own institution with its own policies, which was fine and dandy because that’s what we kind of always wanted. We didn’t want this landlord-tenant sort of relationship. But again, from a nursing standpoint, from a health care standpoint, be careful what you wish for… with that comes the Deputy Wardens, the [Institutional Preventative Security Officer’s], the Chief of Correctional Operations, the Chief of Case Management, the chief of this, the chief of that – to the detriment of no Director of Nursing, no Chief of Ambulatory Services, and for a while there was no Chief of Psychiatric Services.”

The prison-hospital was designated a separate, stand-alone, institution in May 1998. The two facilities were then considered a ‘clustered site’ for regional planning strategies and resource allocation. The operation of ‘clustered sites’, where some services and resources are shared, was common practice within this region of the Correctional Service of Canada, however, two years after the prison-hospital had been administratively separated from the maximum-security prison, significant work was still being done with regional and national management to establish an appropriate funding base for the prison-hospital. The finances between the two institutions had not yet been deciphered and, as a result, the facility was plagued with difficulties in its everyday
operations. For example: “The [maximum-security prison] provided food services to both institutions, however when they split the resource indicators and gave [the maximum-security prison] food services money for the inmates at [the maximum-security prison] but they forgot to add in the inmates at [the prison-hospital]. So we were short several hundred thousand dollars to feed the inmates.”

4.4.6 Resource indicators and the envelope system

Budget allocation previously operated using a main-estimate process. Roughly, this consisted of local sites submitting statements of what resources they would need for the coming year. These would go to the respective Regional Headquarters where the local site statements would get ‘rolled up’ to reflect regional needs and priorities. The regional statements were sent to National Headquarters where the statements from each region would get ‘rolled up’ to reflect the organization’s needs and priorities and decisions would be made on distribution of the base budget for the coming year. Within this process, the annual budget for the prison-hospital was distributed through the maximum-security prison within which the prison-hospital then operated. There was a great amount of flexibility for wardens to manage their budgets. “Some of the wardens would take money from one area to fund another... Years gone by, for instance, the construction money was taken to pay for correctional officer overtime when many of our facilities were – what they are calling ‘rusting out’.”

Through the late 1990s and early 2000s, the Correctional Service of Canada engaged in a large-scale workload measurement process to develop resource indicators for most areas of the correctional system. The resource indicators provided a system
internal to the Correctional Service of Canada for allocating funds down through the organization. The indicators for the entire correctional service, except for mental health care, were instituted in 2002 followed by the new envelope system in 2003. The indicators for correctional management resources were required to be implemented in all penitentiaries, including the prison-hospitals. This included standards for funding correctional officers, correctional managers, and numerous operational activities based on the number of offenders housed by the facility, size of the physical plant, and other cost measures. However, without resource indicators for the mental health aspects of a prison-hospital, such as nursing, occupational therapy, social work, health records, and other health care management roles, there were no standards for funding such services.

The envelope, or silo, system was for protecting funds and ensuring that they go to their intended purpose. Without resource indicators for mental health services, there was no way for national and regional managers to determine the appropriate resources for the mental health envelope. However, the envelope system did bring a greater transparency to the management of funds at all levels of the organization:

“I like the envelope system because it keeps everybody honest... this is the money for health care and you can’t take the health care money to pay for tables and chairs. It has allowed us to be able to determine what our true pressures are, because before we had the envelope system... sometimes because of financial pressure during the year, you move the money around so much that at the end of the year you couldn’t remember where the money began... was your pressure really health care, or was it that you really had no money to buy tables and chairs, all the tables and chairs were breaking, but you were borrowing the money out of health care to pay for the tables and chairs, and all of a sudden at the end of the year, health care had a pressure.”

Without resource indicators, the budget for the prison-hospital was allocated based on an expenditure snapshot from the month of July two years prior. For example, what was being spent during July 2004 was the budget allocated for mental health
services at the prison-hospital for the 2006-2007 fiscal year. At the time of data collection, four years after the original implementation of resource indicators, indicators for mental health care had yet to be developed.

Overall, the development and implementation of resource indicators and budgetary envelopes is poorly understood by frontline staff. This gap in knowledge has left room for misunderstandings and tensions to develop between frontline staff and managers at all levels of the organization, as well as between different professional groups within the frontline staff.

4.5 Summary

Each critical event described above was intended for a positive purpose – improved and expanded physical space, a management structure designed for improved communication between staff and offenders, external reviews acknowledging strengths in mental health care and providing recommendations for positive change, and protection of funds designated to mental health care through a new financial allotment system. However, with a lack of vision about the role or intent of the prison-hospital in providing mental health care, there was uncertainty in how to proceed with these events in a manner that would ensure positive organizational change that included mental health care. Instead, these events followed a process of change that promoted the correctional mandate of the prison-hospital while the mental health mandate slowly declined. The following chapters present an analysis of this slow decline according to five key elements of policy implementation beginning with the content and communication of the policy message.
CHAPTER 5
POLICY MESSAGE

5.1 Introduction

Chapter 5 is the first of five chapters analyzing policy implementation. Section 5.2 begins the analysis by using policy literature to describe the first key element that shapes the policy implementation process: the policy message, which is understood as both the substance, or content, of the policy and the manner in which it is communicated. The literature is analyzed to display how the clarity or ambiguity of the policy message can support or subvert implementation behaviour. Points of tension identified in the experiences of frontline staff arise from the dichotomy of ambiguous mental health policies juxtaposed with very clear correctional policies (section 5.3). Connections between the work of frontline staff and work done in other areas of the institution are traced (section 5.4) and the ideological processes and practices used to manage mental health care are displayed (section 5.5). The chapter ends with a summary of tensions surrounding the implementation of the policy message in mental health practice (section 5.6). Analysis of this element shows how clarity and ambiguity used by an institution to provide direction to frontline staff advances or undermines the objectives of that institution.
5.2 Literature

There are varying opinions among policy implementation scholars about the degree of clarity or ambiguity in messages from the top of an organization recommended for effective implementation of organizational objectives. Supporters of top-down approaches to implementation view ambiguity as leading to misunderstanding and uncertainty and suggest that effective implementation requires ‘unambiguous policy directives’ from central government and that ‘perfect’ implementation requires complete understanding of, and agreement upon, the objectives to be achieved (Gunn, 1978; Hambleton, 1983; Matland, 1995; Sabatier & Marzmanian, 1979). When a policy mandate is clear from the outset, the direction provided for implementers is more valuable (Diamond, et al., 1999; Goggin, et al. 1990). In their exploration of policy changes in a mental health program within an American mega-jail, Cruser and Diamond (1996) found that “policy clarifications gave the staff a feeling of stability and consistency. Knowing what was expected of themselves and of the inmates enabled them to be proactive, flexible and rational in their response…” (p.136). For this level of clarity to occur, those affected by the policy change must have adequate information about the change issue and nature of the areas targeted for change.

Alternately, it has been argued that there are sound reasons for ambiguity in policy. Legislative decision-makers are often reluctant to provide detailed outlines of their expectation of policy results (Ingram, 1990; Matland, 1995). Ambiguity may be fostered deliberately by policy-makers to conceal conflicts of objectives between the different actors involved – to leave room to maneuver, negotiate and renegotiate. A vague and general policy message leaves enormous scope for local interpretation as well as

However, rather than using ambiguity with purposeful intent, policies from the top are often ambiguous due to imperfect understanding of the topic, difficulty identifying indicators, or having little control over implementers. Central government has great difficulty in expressing a clear message that can be understood even by those disposed to receiving it (Hambleton, 1983). In some policy areas it is extremely difficult to identify clear performance indicators. When understanding of the policy area is imperfect or when policy-makers have little control over the implementers, the temptation is always present to leave policy as vague as possible. This is particularly true when policy is broad or complex or far-reaching in its goals. At times, vague policy intentions have been combined with detailed guidelines on service standards and these, because they have tended to harden into firm targets, have often created further confusion (Hambleton, 1983).

The power of a policy lies within peoples’ knowing how to use it and others knowing how to respond (Campbell & Gregor, 2002). Tensions arise in the way that clarity or ambiguity in an institution’s policy message coordinates and motivates the everyday activities of those individuals tasked with enacting those policies. Unless a policy is very narrow and prescriptive, local interpretation and implementation will inevitably develop and evolve the policy message, as well as carry out the policy
(Hambleton, 1983). The interpretation at local sites has the capacity to ‘re-create’ the policy message, which may support or subvert the institution’s objectives.

5.3 Identifying Points of Tension in the Policy Message

The degree of clarity or ambiguity in the prison-hospital’s policy message is markedly different across two distinct policy areas. The breadth and complexity of mental health care combined with the organization’s limited familiarity with mental health care makes it extremely difficult to identify clear performance indicators as part of a national policy. This complexity was recognized by the report on mental health, mental illness, and addiction by the Standing Senate Committee on Social Affairs, Science and Technology (Kirby & Keon, 2006):

“The committee does not believe it wise to attempt to dictate a uniform model that could be implemented somehow across the country. It is not even possible (or desirable) to do this on a province-wide basis because the effectiveness and efficiency with which services are delivered depend critically on a number of local particularities, including the history of local institutions and the number and characteristics of the people who live in each community.” (p.105).

The vagueness of the organization’s national mental health policy (Commissioner’s Directive 850, 1995) leaves room for the authority of the provincial health and regulated health professions legislation under which each of the five prison-hospitals operate. It also requires the prison-hospital, as a local site, to determine its own understanding of the policy and develop its own protocols and practices for enacting that understanding. Alternately, correctional and security processes and practices are directed by a single piece of federal legislation (Corrections and Conditional Release Act, 1996), allowing the organization to formulate highly specific policies that can be applied consistently in prisons across the country.
The following example illustrates how daily activities of frontline staff in one of the living units of the prison-hospital become coordinated by policy messages that hold frontline staff to act in ways beyond their own motivations and intentions. The potential conflict between the vagueness of mental health policy to ‘ensure appropriate access’ to services and the specificity of security policy to ‘control inmate movement’ also unfolds:

“One day, I was observing work activities on one of the living units of the prison-hospital. Three nurses were in the nursing station of a patient living unit with two correctional officers nearby in the open vestibule between the nursing station and the patients’ cell range. A patient locked in his cell hollered a request to go to the activity area five minutes after other patients from the unit had been released from lock-up and escorted to that part of the institution. A correctional officer expressed the view that granting the request would constitute ‘special treatment’ for that patient and believed that the patient had ulterior motives for wanting to go. A nurse countered that the staff are responsible for enabling patients to access activities if they are willing and able to go. The correctional officer argued, “We don’t have to let him go. We can decide he’s not in any shape to go”. The discussion quickly escalated into a verbal argument with raised voices that could be heard throughout the living unit and ended abruptly with the correctional officer’s refusal to release the patient from the unit and the nurse turning away with obvious signs of restrained frustration.”

The source of tension is directly related to the staff’s knowledge of what was expected of them as providers of both mental health care and institutional security. Personal frustration arises from security protocols constraining the ability to carry out primary activities associated with the provision of mental health care due to the balancing of what appears to be inconsistencies in the policy message. Specific expectations regarding inmate movement arising from national policies and individual security post procedures are juxtaposed to vague policies about “ensuring appropriate access to essential and non-essential mental health services” (D1). Both the nurse and the correctional officer, in the above example, display their intent to carry out their jobs as
outlined in relevant policy documents. However, conflicting expectations create a power struggle to see who will gain and who will lose in this particular social arrangement.

This struggle for power does not appear to reflect difficult people acting badly, but rather a dichotomy of rules and regulations that compel people to act in an oppositional manner to carry out their jobs. The histories of the nurse and correctional officer have organized the way they read and respond to policies and their divergent responses reflect the location of each within the social relations of the institution. Mental health professionals, such as nurses and psychiatrists, determine ‘appropriate access’ to services according to a health care perspective. Such an interpretation has been built into the prison-hospital’s ‘level system’. This system consists of a range of privileges for movement within the living unit and throughout the facility based on patients’ mental status as assessed by the multi-disciplinary team. This is a qualifying decision, through which patients qualify for access to various parts of the institution and, therefore, to various programs and services as their mental status improves.

Correctional officers, on the other hand, determine ‘appropriate access’ from a security perspective. Actual access to programs and services throughout the institution is determined by specific correctional policies regarding patient/offender movement. How and when patients will be allowed off the living unit is based on the timing of correctional officer ‘walks’ down the cell range at specified intervals, the name of the offender being placed on a ‘pick-up list’ the previous day, and the availability of correctional officers to ‘open’ various program spaces and ‘escort’ patients to these areas. The precision in this policy message deprives both the correctional officer and the nurse from negotiating and exercising flexibility in determining ‘appropriate access’. The level
of specificity in security policies precludes misunderstanding, not only of the objectives of the policy, but of the actions to be carried out to meet those objectives. The correctional policy structure, where policy-makers have tried to provide direction for every possible situation, removes autonomous action as an option for correctional staff.

The specificity in correctional policies regarding correctional and security processes and practices ensures that the prison-hospital meets ‘operational requirements’. However, the vagueness of mental health policies does not establish comparable standards of ‘operational requirements’ for mental health care and “ultimately, it allows us to justify almost anything that gets done”. Ambiguity in the mental health policy structure to determine what is or is not ‘appropriate access’ in a given circumstance or at a particular point in time, was often used to meet institutional needs or organizational pressures. Several examples of this were observed: gradual reduction of minimal nursing staff per living unit based on budget pressures; determining frequency of direct nursing contact with offenders/patients based on correctional ‘walk’ schedules; decreased psychology and rehabilitation services, as well as correctional programs, due to activity area closures implemented to balance correctional overtime costs.

The degree of ambiguity in mental health policies does leave room for mental health professionals to change and grow with developments within their professions and within the mental health field. The nurse involved in the above example commented: “We have far more autonomy here at [the prison-hospital] than at other places. There’s a responsibility attached to that… but in the decision making process there is far more autonomy for nursing here.” However, this autonomy and flexibility also works to conceal conflicts between correctional objectives and mental health objectives. The high
degree of clarity in correctional policies has resulted from the organization’s familiarity with the correctional role of the prison-hospital. The correctional mandate of the prison-hospital has been clear from the outset and correctional staff know what is expected of them. “I think there’s a difference when you have correctional officers being affected because they’re not really being affected at the core of their work... for most of them, ‘if I’m put at a post, it’s my post and I’ll take care of it’. I’m still getting my job done.”

The mental health mandate of the prison-hospital has not been so clear. Professional standards that leave room for mental health care to shift and change with a growing evidence base and the organization’s lack of familiarity with the mental health role of the prison-hospital have resulted in a vague and general mental health mandate, precluding the need for congruency in the details between the two policy areas, but also preventing frontline staff from knowing what the organization expects in the provision of mental health care. Does the organization expect the nurse and correctional officer in the example above to ensure that the patient gets off the unit to access mental health services, or is the expectation that they will concede to the correctional processes for inmate movement?

5.4 Tracing Social Connections of the Policy Message

The lack of clarity in what is expected in the provision of mental health care was also evident at the managerial level of the prison-hospital. In the mid-1990’s, the mental health needs of offenders were gaining greater recognition and recommendations were made that focused on infrastructure and administrative authority. In-patient mental health beds in the prison-hospital were increased through the acquisition of a second building
from the maximum-security prison and a stronger mental health voice at the regional management table was pursued through efforts to administratively separate the prison-hospital from the maximum-security prison. Decision makers knew, from existing policies on the administrative structure of federal prisons, the correctional requirements to achieve that administrative separation. However, without an organizational vision for mental health care and the role of the prison-hospital in providing that care, there were no policy structures outlining requirements for meeting the mental health mandate of the prison-hospital.

The pursuit to become a ‘stand-alone facility’ to provide a stronger mental health voice at the regional management table in order to better serve the mental health needs of offenders in the region, quickly developed into an effort to become a ‘stand-alone prison’ that meets the same ‘operational requirements’ as other prisons in the region. Managers who were instrumental in achieving stand-alone status spoke of their intentions to strengthen the voice of mental health care in the region: “Everything that I wanted to have or focus on at that particular point in time was that the voice for the [prison-hospital] would sit at the regional management committee table”. However, the actual actions taken to achieve this status appear to have been coordinated and controlled by forces beyond their own motivations and intentions.

Recognition as a ‘stand-alone facility’ comes from within the correctional organization, therefore managers at the prison-hospital garnered its understanding of what was expected of it as a prison from the clarity of policies on correctional institutions. “Hence the correctionalization, I guess, of the unit and the expansion of the number of [correctional officers] and the introduction of unit managers who are really
Managers at the prison-hospital understood that they would have to demonstrate the institution’s ability to function as an independent correctional facility but without a clear framework for the mental health mandate, there was no extra-local source from which to garner a clear understanding of what was expected of it as a hospital. “I think that [managers] who went there had to manage the place creatively because the policy framework didn’t match. There wasn’t a national policy framework for [prison-hospitals]. You kind of limped along in terms of getting creative funding and creating policies on your own because there wasn’t anything. I mean you basically made it up as you went along.”

While the expressed intention was to strengthen the voice of mental health care through administrative separation from the maximum-security prison, frontline staff experienced a deterioration in mental health care through the separation process. Resources from departing health care staff, including the Director of Nursing and Chief of Ambulatory Services, were diverted to support the addition of correctional managers.

“It was all planned towards being a regular stand-alone institution. You know, wardens, deputy wardens, institutional preventative security officer, correctional supervisors, and less and less nursing... when he set us up as a stand-alone institution it was all that slant.”

With the deterioration of mental health leadership, the policy message heard by frontline staff was that mental health care isn’t a priority; that the priority was correctional ‘operational requirements’. Without nursing managers to advocate for professional standards, this message was compounded by the destruction of nursing policies and procedures that had been developed and maintained by frontline staff.
correctional unit managers were able to alter or eliminate policy content without going through the committee of frontline nursing staff: “We had a unit manager come in and he arbitrarily crossed out what the minimum staffing would be on this unit. And I said to another team leader, how can that be so? It’s got to go through the committee. That’s why we have a policy and procedure. And it was like, no… he can arbitrarily do that now.” IM1 The committee eventually resigned in frustration. One former committee member reflected, “that’s when you realize, as a nurse, you’ve lost a lot of clout” IM1.

Many mental health staff have developed an overwhelming sense of apathy about providing mental health care. The battle for power has so often resulted in mental health care losing, that many mental health staff appear to have ‘given up’: “I can certainly validate why anyone would feel apathy after this many years of seeing us on this very, very slow decline with really no reason to hope for anything better.” IM3 These losses have been experienced through decreased direct contact with patients, diminished resources, and compromised professional values and ethics. As a result, mental health staff have begun to question their purpose and professional identity within the prison-hospital.

Through the experiences of frontline staff the policy message has been ‘re-created’. Despite a stated organizational priority for mental health care and the facility’s vision statement for ‘mental health excellence’, the everyday activities of frontline staff, as controlled and coordinated by forces outside their conscious awareness, have established a generalized way of doing things that permits the dominance of correctional policy intentions.
5.5 Displaying Ideologies in the Policy Message

The value placed on the policy message for mental health care at the national level is evident through the lack of clarity in the policy review/revision process: “It used to be that they had a lot of staff in policy and so somebody was directed to work specifically with the health care [policies], so we would work in conjunction with that person to get a [policy] significantly revised... Now it's clear that we're really in charge of doing it ourselves.”

A number of years ago, as part of cost saving measures, health services at the national level was given responsibility for overseeing their own policy structure but most, if not all, are health professionals – nurses, psychologists, physicians – and are not trained or experienced in policy development or evaluation. They also don’t have the time or resources to commit to evaluation and revision of existing policies and because there is a learning curve to the process for them, it would take markedly more time to conduct such an evaluation/revision exercise than it would an experienced policy person. “If you're proactive and you go, ‘god, here is an out of date policy that I should do something about’, seven years later it might see the light of day... ten years ago I did a revision of [the national policy] on psychological services and that [policy] has never been probated, it hasn’t even been looked at.”

Much of the apathy among mental health staff appears to arise from a lack of organizational support to engage in work activities specific to their professional identity and training. Providing mental health care that meets professional standards, in accordance with evidence-based best practices and governed by regulatory colleges, is a continual battle for the mental health professionals. Imperfect understanding of this policy area means that correctional managers often do not have a full appreciation of the
weight that provincial regulatory bodies carry for mental health professionals. One nurse reported repeatedly explaining his relationship with his regulatory college to correctional managers: “I have a license to be accountable for. If I screw up I’m not accountable to you. I’m not even accountable to the warden. I’m not accountable to the commissioner. I’m accountable to the College of Nurses. Who, if they take my license, forget about me working in the Correctional Service of Canada, I can’t work period.” This nurse, and other mental health staff within the prison-hospital, expressed ongoing concerns that senior managers have an imperfect understanding of provincial mental health and regulatory legislation. These concerns were justified by the following quote from a senior manager within the prison-hospital:

“In general there is no conflict at all between those two, for me, in terms of what is required. Because all of the registered health care professions are required to meet the policies and standards of the Government of Canada, their employer, by their own licensing body. And all of us are required by virtue of the values and ethics of the public service to do no harm. So there isn’t an inherent conflict at the legislative or policy level at all for me.”

Yet, many times it was stated that the federal Corrections and Conditional Release Act (CCRA) supersedes any provincial legislation, on the presumption that the CCRA conflicts with provincial health law. While the CCRA provides for mental health care to be provided according to provincial health legislation, the concepts and values that are promoted through these texts conflict significantly. This is evident through the original example of ‘appropriate access’ provided in section 5.3. The nurse argued for the principle of ‘enabling access’ while the correctional officer argued for the principle of ‘controlling access’. The nurse pursued ‘flexibility’ in decision-making, while the correctional officer held to ‘prescription’ of action. These oppositional values compelled the staff to battle for power in determining ‘appropriate access’. The specificity of
correctional policies, juxtaposed to the vagueness of mental health policies, provide a degree of consistency and justification in decision-making that supports the clear correctional mandate while subverting the ambiguous mental health mandate.

5.6 Summary

Policy makers have little control over institutional heads and their discretion to manage their institution the way they see fit. Control from the national level seems to be exerted more through exclusion and/or afterthought of mental health care in national policy initiatives affecting every other area of correctional supervision, such as the Unit Management Model or the development of resource indicators. The lack of vision for mental health care, resulting from an imperfect understanding of the topic and its place within the correctional context and evident in its separation from major policy initiatives, has exerted a form of textually sanctioned agency producing a power in the prison-hospital that was generated by the concerting and mobilization of people’s work. It is this concept of agency, the tensions inherent in its formation and execution, and the concerting of power by a multiplicity of agents, that is examined in Chapter 6.
CHAPTER 6
MULTIPLICITY OF AGENTS

6.1 Introduction

Section 6.2 uses policy literature to describe the second key element that shapes the policy implementation process: the multiplicity of agents, which encompasses the difficulties that exist in achieving coordination between all of the agents involved in the implementation process. The literature is analyzed to display how the role of individual agents and the exercise of leadership can support or subvert implementation behaviour. Tensions identified in opportunities for agents to participate in the discourse of the prison-hospital arise from an ongoing battle among a multiplicity of agents to determine a correct reading and accurate execution of the mental health mandate (section 6.3). Connections between expressions of agency by individuals at various levels of the organization are traced (section 6.4) and the ideological perspectives, priorities and concerns of a multiplicity of agents to satisfy the needs of the prison-hospital environment are displayed (section 6.5). The chapter ends with a summary of tensions surrounding the roles of a multiplicity of agents in the implementation of mental health care (section 6.6). Analysis of this element shows how varying perspectives, priorities and concerns create a power imbalance for determining ‘the right thing to do’ when interpreting and executing the objectives of an institution.
6.2 Literature

A critical assumption in implementation is that policy makers can be of one mind in operationalizing a policy. However, various implementation models do not address the role of implementation agents, motivation of bureaucrats, unequal power distribution, or potential conflicts. It is important to understand that seemingly simple sequences of events depend upon extremely complex chains of reciprocal interaction. “The implementation process involves not merely activating pre-existing links between decision points but actually creating them: the basic assumption is that the process under study is one of creating and establishing links between separate bodies – making a chain, not just using one” (Hambleton, 1983, p. 408-409). Agents participate in the discourse (the practices that coordinate the activities and actions of individual agents), which constrains what they can say or write, and what agents say or write reproduces and modifies the discourse (Smith, 2005).

Barrett and Fudge (1981) asserted that policies do not implement themselves, yet a real gap remains in assuming that agents know what to do in order to operationalize policies (Schofield, 2004). Only when individuals know how to use a policy and others know how to respond, is the policy text powerful. It is the human factor that enables a text to coordinate action and get things done in specific ways (Wright, 2003).

When multiple agents are involved, “implementation becomes a battle to determine a correct reading of the mandate and its accurate execution” (deLeon & deLeon, 2002, 475). Tensions in implementation arise when at least two different agents act “in opposition to one another, not so much because one was correct but because both
thought they were doing the right thing” (deLeon & deLeon, 2002, 469). This multiplicity of agents includes those in positions of formal authority.

The leadership of managers and supervisors is a critical component of implementation. Often in discussions of leadership, it is the nature of leaders that is addressed rather than the nature of leadership. However, it is important to recognize that leadership is “a process of creating structural change wherein the values, vision, and ethics of individuals are integrated into the culture of a community as a means of achieving sustainable change.” (Braveman, 2006, p. 84). It is a continuous social process of adaptation and evolution that is significantly shaped by the perspectives, priorities and concerns of individual agents in positions of formal authority (Barker, 2001). Within this context, those responsible for implementing policy and those affected by policy act to protect or enhance their own interests.

It is important to recognize that an analysis of a series of discreet events is not equivalent to an analysis of continuous leadership (Barker, 2001). Therefore, it is not the decisions and actions of individual managers during critical events at the prison-hospital that is addressed in this aspect of policy implementation. Rather, it is the continuous social process of change, understood to be ‘leadership’, throughout the period of decline that is examined.

There is a premise that policy makers have goals and are interested in finding ways of implementing them, but also that implementers balance their own policy goals against others’, which may involve resisting compliance with particular policy intentions (Barrett & Hill, 1984). “Policy-makers will make decisions which will attempt to limit the power of other actors; actors will make decisions which will evade the power of
decision makers” (Younis, 1990, p. 12). Agents, including those in positions of formal authority, have the ability to shape policy and their work environment through subverting, neglecting, or abandoning the intentions of policy-makers (Carroll & Siegel, 1999; Lin, 2000). It is not that agents do not understand their work, nor are they shirking their responsibilities. Rather they try to make sense of their work as a series of related tasks all bent to a particular purpose while satisfying the needs of their organizational environment (Lin).

Lin (2000) posits two perspectives on this problem. One perspective is that of incompatible preferences whereby policy-makers impose their preferences by limiting the discretion of staff and regulating staff responses. The second perspective is that of differences in location, understanding that “policy-makers have better information about desirable ends, but staff… have better information about the best means to the end” (p. 163). In this perspective, policy-makers expand the skills and increase the discretion of agents to enable them to make their own decisions about how to best meet the policy goals. Both of these perspectives can be justified by either the need for accountability and uniformity or the efficiency and enhanced responsibility that comes with ownership of a solution.

6.3 Identifying Tensions in the Multiplicity of Agents

Battles between multiple agents to determine the correct interpretation of policies and apply them to mental health care within the prison-hospital are evident in seemingly simple sequences of events. In each situation or circumstance there are opportunities for
exercising agency – for numerous individuals to participate in and recreate the discourse of the prison-hospital.

A guiding principle of the organization is that “teamwork is essential to fulfilling our mandate”. When many agents work together to interpret policy and determine the most appropriate means of enacting that interpretation toward a particular purpose, this can be understood as ‘collective agency’. Such collective interpretation of policy and decisions for action in the prison-hospital are more likely to happen at team and committee meetings:

“The opportunities for healing are opportunities for teamwork and there still is a fabulous team. You go to a meeting or meet with staff on the unit to say ‘okay, what is the issue with the patient, is it medical, is it psychiatric, is it behavioural’? The multi-disciplinary team has to make that determination because they’re the ones who are working with the patient. I think that’s a really important process. I think that team process is what informs and manages the enterprise and directs the treatment. To me that process is more valid, and is recognized as more valid, than it ever has been.”

However, because each agent approaches the situation from her/his own perspective, bringing her/his own priorities and concerns into the event, there is opportunity for each agent to act independent of the collective, to exercise ‘self-agency’. Rather than reproducing the discourse or being coordinated by its constraints, these individuals break out of these constraints to act in a way that modifies the discourse.

The following example illustrates how the seemingly simple actions of a single individual participating in the discourse of the prison-hospital recreates and modifies the discourse. The potential conflict between expanding the discretion of agents and enabling ‘decision-making at the lowest level possible’ and attempts to ‘limit the power of individual agents’ through limited discretion and regulation of staff responses also unfolds:
“In the evening I was down there all the time talking to lock-ups... it made for a quiet night. We gave meds and then would go find them snacks. So, it took 15-20 minutes. One of the [correctional officers] wants to bring them out on evenings and give them a smoke break. Great! He’s getting a lot of flack for that. How dare you do that? Well, the last time they had a smoke break – they’re locked up 24 hours a day – last time they had a smoke break was 7 o’clock in the morning. That’s hardly fair. So he says ‘I’m going out anyways to have a smoke, what if I bring the lock-ups out with me? That’s my choice. Well, then the rest of us will have to do it. Now you’re creating a problem. He’s actually getting counseled by the deputy warden and the correctional supervisor about how he’s setting a precedent by doing this. He’s saying ‘so, what’s the problem? That other people now have to do it?’ Yes. I say, well good for you. Good for getting these guys out. They’re telling him not to do it because if the other guards don’t do it then all the patients are up yelling and screaming all night long. He said, ‘what were they doing before I got here? They were yelling and screaming all night long. That’s hardly an excuse. If I want to take them out for 20-30 minutes and lock them in the yard and I’m out there anyways, why do you have a problem with this?’ These guys need to get out more, they need to interact with each other more and with other staff. I thought, here’s a correctional officer taking initiative and he’s actually getting flack for it, he’s actually getting counseled. I said, good for you, good for doing that.”

The source of tension is directly related to the staff’s knowledge of how to use relevant policies and the other staff’s knowledge of how to respond to this usage.

Personal frustration arises when an individual agent’s interpretation of a policy and decision of what to do to execute that policy is thwarted or criticized by others who have a different idea of what is ‘the right thing to do’. This frustration was exacerbated when agents in positions of formal authority exercised the power of their position to promote or enhance their own interests: “We didn’t have total control of the services so that’s where the big frustration comes from.” The seemingly simple event recounted above is revealed to be a complex chain of reciprocal interaction between different agents acting in opposition to one another as they battle to determine a correct interpretation and accurate execution of policy. Both the correctional officer and the institutional managers demonstrate their intent to carry out their jobs as outlined in relevant policy documents.
for the prison-hospital’s level system, controlling inmate movement, institutional supervision, and institutional management, while satisfying the needs of the prison-hospital environment. However, conflicting interpretations of what is ‘the right thing to do’ creates a power struggle where frontline staff engage in ‘decision making at the lowest level possible’ and institutional managers in positions of formal authority attempt to ‘limit the power’ of these staff. The outcome of this struggle determines what will be done to operationalize these policies – how the discourse, the practices that coordinate activities and actions of individual agents, will be reproduced.

This struggle for power does not appear to arise from people who do not understand their work, but from each person believing they are doing the right thing to achieve the purpose of mental health care while satisfying the needs of the prison-hospital environment. The perspectives, priorities and concerns of the correctional officer and institutional managers, as well as those of the nurse relating the event, have organized the way each of them understand and respond to the policies and their divergent responses reflect the location of each within the social relations of the institution. Many correctional officers maintain the perspective that they play an integral role in the provision of mental health care. One correctional officer commented that, “it’s important to have consistency of staff that understand mental illness... [Managers] would like to see all the [correctional officers] doing the same things. I don’t think that’s the way to go. We should have [correctional officers] involved with inmates on the range along with the [nurses]”. At the same time, correctional officers spoke of the “disempowerment or devaluing of the frontline staff as capable professionals who know their job and are able to make decisions about care and security within the policy
structures that exist and can demonstrate it through the existing accountability structures such as paperwork and reporting processesFN. The ambiguity of policy in defining the scope of mental health care, along with the fundamentals of unit management policy that delegate decision making to the lowest level possible, left room for the correctional officer in the example above to interpret policies regarding the prison-hospital’s ‘level system’ and ‘inmate movement’ and enact that interpretation in good faith. However, if correctional officers interpret existing policies in a way that enables them to do something new, not only does the management structure criticize them for it, so do many of their co-workers, for setting a precedent that no one else is prepared to live with: “He shouldn’t have done that. It’s not good for the rest of us, because he did something on his own that now we’ll all have to do.”IC2

Institutional managers, however, determine the ‘right thing to do’ from a formal authority perspective. Their interpretation of ‘decision making at the lowest level possible’ is tempered by the responsibilities of institutional managers to provide ‘appropriate support and supervision’ for the intervention and operational functions of the prison-hospital. Decisions regarding the discretion of staff are determined by national policies for “ensuring the appropriate integration of activities”D10 and “establish[ing] internal decision review processes”D10, organizational priorities and pressures, as well as the perspectives and concerns of the individual agents in those positions of formal authority. In the example above, the institutional managers reveal their priority for ‘accountability’ among frontline staff and their management role in ‘ensuring effective decisions’ by ‘limiting the power’ of the correctional officer: “They don’t feel accountable for the environment in their workplace... they don’t feel accountable for the
delivery of that service today to that client. So, for me, some of it is about the clear recognition of client service.” The discourse is subsequently reproduced to support the priorities and concerns of agents in positions of formal authority as they direct frontline staff to participate in particular activities and actions.

The practice of ‘leadership’, the social process of creating sustainable change, is called into question when the response of agents in positions of formal authority is incongruent with the values and concerns of frontline staff. The perspective of frontline staff regarding ‘decision making at the lowest possible level’ is revealed by the nurse recounting the event in the example above: “The manager can only do so many things, can have his hand in so many things that are going on... so staff have to make a lot of decisions on their own on the unit by default.” Much of this perspective is grounded in the frequent turnover and limited presence of institutional managers at the prison-hospital. As a result, the priorities and concerns of many frontline staff have altered to protect their own interests: “With every new manager that would come in there would be policy changes, different perspectives, different focuses, and so what that did for me, in my position... you rely on ‘this is my job description, this is what I do’, but as far as going beyond that, you don’t want to take any risks. So you’re not going to give as much as you would if you were confident in who your manager is, if you felt supported.”

Asymmetric power relations within the battle to determine a correct reading of policy and its execution in the provision of mental health care allow the perspectives, priorities and concerns of agents in positions of formal authority to dominate the discourse as it is reproduced and modified. This promotes accountability in decision-making processes,
but limits the power of individual agents to make decisions at lower levels and creates a lack of confidence in formal authorities and the decisions they make.

6.4 Tracing Social Connections of the Multiplicity of Agents

The battle to determine the correct reading and accurate execution of policy in the provision of mental health care is also seen at the managerial level of the prison-hospital. In the early and mid-1990s, frontline staff were working well together and were uniting behind processes and events that would promote and develop the mental health mandate of the prison-hospital. There was a renewed sense of purpose among frontline staff upon returning to the prison-hospital following the retro-fit and a quality improvement process was begun through participation in the prison-hospital’s first health services accreditation survey to ensure that the provision of mental health care was consistent with professional standards. However, without an organizational vision for mental health care or clear policy requirements for the provision of mental health services, there was little support from regional and national managers to follow through on the survey recommendations. Institutional managers and frontline staff became increasingly disenchanted with the accreditation process and frustrated by the lack of organizational commitment to the quality of mental health services provided by the prison-hospital.

Accreditation is a voluntary undertaking for any health service or organization, as is following through on the recommendations that result from this process. When it was first proposed in the late 1980’s, there was hesitancy among managers and staff at the prison-hospital to engage in a health services accreditation process. After the retro-fit, new senior managers at the prison-hospital recognized the value of engaging in such a
process and made a strong effort to get staff invested: “I said, I think we are going to continue to proceed and we’ll look at alleviating some of the angst that you have here and move on. In the long run this will serve us very well. And once we achieved that, everyone was happy.” Accreditation provided an opportunity for frontline staff to work together, to engage in ‘collective agency’ for the particular purpose of ensuring that mental health services were consistent with professional standards as well as more clearly defining the mental health mandate of the prison-hospital. This ‘collective agency’ was recognized by the first accreditation survey in 1995: “As a result of accreditation preparation, [the team has] become more focused on the programming of the unit and improving team functioning. Communication between the professionals is open and is enhanced by regular team meetings. There is evidence of team work between professions and across function.” Collective agency was also evident among the management team: “The results-oriented management team... shows evidence of working together... developing a mission statement and values.” However, as mental health care declined over time, subsequent accreditation surveys recognized that the frequent turn over of institutional management had a detrimental effect on teamwork and ‘collective agency’. The 2004 survey stated quite bluntly that, “management are often unavailable, not visible, and are not regarded as being supportive of their staff”.

The frequent turn over of managers, and the related deterioration of teamwork at both institutional and regional/national levels, was indicative of the limited concern for the prison-hospital at regional and national levels:

“The accreditation process and pressure provided a wonderful opportunity for attempting to move forward on a bunch of initiatives. A lot of very good work had been initiated and was in danger of floundering, I think. Because there had been a change in leadership but more importantly that the organizational focus is not
usually on the longer term, it’s on the crisis of the moment. So, in fact, we define accreditation as the crisis of the moment.”

When the Correctional Service of Canada made participation in health services accreditation a policy requirement for all of the organization’s health services in the early 2000’s, a great amount of emphasis was placed on having accreditation but there were no requirements for individual health services or prison-hospitals to comply with recommendations of the survey team, nor were any resources set aside for improvement of mental health care based on these recommendations. As institutional managers felt pressured to abide by national directives for accreditation, yet powerless to promote or bring about change relative to the mental health mandate, this sense of powerlessness was passed along to the frontline staff. “I think [accreditation] has had a profoundly negative impact on the institution. It has the impact of false promises and asking all the people to dress up and play a part for a short period of time while we have these teams in to take a look at what we’re doing. That doesn’t build organizational capacity or strength, it doesn’t build longer term commitment.”

Senior institutional managers took steps to protect their own interests, and the needs of the prison-hospital environment, when policy requirements did not provide for the cost of implementing accreditation:

“We’ve taken a very strong stand. We will not be hosting the next focused visit because we have no control or authority over the issues... I briefed the regional administrator of health care, [the Executive Director] briefed and wrote the Regional Deputy Commissioner and there has been no response. There was a phone call saying ‘well, you’re going to be the only ones that aren’t doing it’. And I said that, ‘maybe we’re the only ones that are really desperate and don’t have any resources to put to it’. Now, [the Canadian Council on Health Services Accreditation] phoned us to try and schedule a focused visit and [the Executive Director] said ‘well, we’re not doing it’.”

In making this decision to subvert the national policy to participate in health services accreditation, institutional managers were protecting the interests of the prison-
hospital: “I don’t want to have to spend money that I don’t have for anybody to come back here... By me taking a stance that we’re not having them here, that’s going to ruffle feathers all the way up the line. But why the hell would you when you’re doomed to failure?” The anticipated response from national management never came, largely because of the lack of organizational commitment to the process: “We know about it but what can we do about it? We have no budget for that kind of thing and we have no authority over the regions.” In fact, there is a general belief that, instead of using national policies for mental health services accreditation as a form of leverage to gain support and resources for positive change, the best means of promoting or enhancing the interests of mental health care is to subvert, neglect or abandon the intentions of policy makers. “I have suggested to the region repeatedly – let this happen. Let it get so bad that you lose accreditation because it’s only when it’s a crisis that it’s going to get anyone’s attention. That’s just the reality.”

6.5 Displaying Ideologies of the Multiplicity of Agents

There is a strong and consistent perspective expressed at all levels of the organization that frontline staff look to managers to provide leadership: “I think staff expect a level of supervision and whether they’d say it or not, they want it. They need somebody that they can go to when they can’t solve the situation themselves.” There is an understanding that being in a position of formal authority affords power to that individual for determining how policy will be interpreted and carried out. It is how different managers wield that power to delegate ‘decision making at the lowest level
possible’ or to ‘limit the power of others’ that establishes confidence and builds links in the chains of complex reciprocal interaction.

The frequent turn over of managers at the prison-hospital, and their inability to deal with long-standing issues in the short time they were there, has produced a perception among frontline staff that they are lacking the kind of leadership skills necessary to achieve sustainable change. “You certainly lose faith in your management... with the changes particularly to middle and upper managers, or even the fact that people are put into positions that they are not prepared to handle... Don’t put somebody up [in a position of formal authority] if they don’t have an idea of what they’re doing.” IM4 This perspective is consistent among staff at all levels of the organization.

“It’s typically been perceived as a warden situation, and usually warden’s who are about to retire are put there, they are given that as a freebee, if I can say that. There was no recognition that it needs special skills to manage that, I think that’s been a very weak point.” IN2

Many current and previous senior managers at the prison-hospital felt the pressure of stepping into such a unique dual-mandate environment: “I had never worked in a [prison-hospital] ... so here was my first real operational experience in that context. So I had a huge learning curve on the hospital side.” IR2 With each subsequent manager, frontline staff developed a sense of apathy towards taking any kind of initiative or providing professional leadership among colleagues. “I used to have more autonomy and felt I could make some decisions. I would send proposals for new ideas to the executive director. But not anymore... I think most of us have just given up.” FN As this apathy has
grown, the frontline staff of the prison-hospital have become an untapped resource in the provision of mental health care.

Without an explicit vision for the role of the prison-hospital, managers unfamiliar with mental health care relied on the frontline staff as they adjusted to the prison-hospital environment: “I found the staff to be excellent... in assisting me to gain that knowledge. And while I was gaining it they would make sure, if I stepped over in being a little bit too correctional, they would try to pull me back.” However, the perspectives and priorities of managers are largely shaped by the textually sanctioned agency built into the existing policy structures. The language and content of correctional policies regulate staff responses and limit the discretion of staff in determining a correct reading and accurate enactment of correctional policies to ensure ‘uniformity’ and ‘accountability’. In contrast, the language and content of organizational mental health policies, as well as professional standards and practice guidelines, increase ‘discretionary decision making’ that enhances the responsibilities of frontline staff and provides them with a sense of ‘ownership’ of the actions and activities that comprise the institutional discourse. However, the interpretation and enactment of these policies are heavily influenced by the perspectives, priorities and concerns of the agents in positions of formal authority: “I think a lot of it is driven by the issues but a lot of it is driven by the personal approach. A lot of it is driven by style... A lot of it is driven by the other players that play here.” The varying perspectives on how policies should be interpreted and carried out (centralized authority vs. discretionary decision making, personal power vs. formal authority) have created a power imbalance within the multiplicity of agents at the prison-hospital, damaging the practice of ‘collective agency’ in carrying out the mental health mandate. As
opportunities for individual agents to protect or enhance their own interests by subverting, neglecting or abandoning the intentions of policy makers have opened up, the practice of ‘self-agency’ has not only grown, but has become a celebrated means of satisfying the needs of the prison-hospital environment.

6.6 Summary

The connections between a multiplicity of agents create complex chains of reciprocal interaction in the battle to determine a correct reading and accurate execution of the mental health mandate of the prison-hospital. With the frequent turn-over of institutional managers and subsequent lack of confidence in the process of leadership at all levels of the organization, those connections become fragile or severed, which impedes individual agents’ abilities to coordinate action and meet the needs of the prison-hospital environment.

If we understand that implementation involves making a chain of reciprocal interaction by establishing links between decision points, we can also understand that this process includes ‘selection’ of links that will support their priorities and concerns as well as ‘breaking’ links that do not serve their particular purpose. Without a vision for mental health care, the discourse of the prison-hospital is modified to suit the perspectives, priorities and concerns of the individual agents actively making (remaking) the chain to protect or enhance their own interests. It is the conflicting perspectives and ideologies held by various agents, or groups of agents, that are examined in Chapter 7.
CHAPTER 7

MULTIPLICITY OF PERSPECTIVES AND IDEOLOGIES

7.1 Introduction

Section 7.2 begins this piece of the analysis by using policy literature to describe the third key element that shapes the policy implementation process: the multiplicity of ideologies and perspectives, which encompasses the different understandings, expectations and anxieties that different agents at different levels of the organization bring into the implementation process. The literature is analyzed to display how conflicting ideas and values among agents, and groups of agents, can direct and strengthen implementation behaviour. Points of tension are identified where agents, or groups of agents, have incongruous views regarding the goals of a policy or the activities planned to carry out a policy (section 7.3). Connections between the ideas and values evident in decision making processes at various levels of the organization are traced (section 7.4) and the ideological processes and practices that coordinate decision making for providing ‘care’ and ‘custody’ are displayed (section 7.5). The chapter ends with a summary of tensions surrounding the influence of incongruent ideas and values in decision making processes in the implementation of mental health care (section 7.6). Analysis of this element shows how incongruent ideas and values toward an institution’s ideological framework create conflicts in determining appropriate actions for implementing related policies.
7.2 Literature

Public policy can be understood as a “broad framework of ideas and values within which decisions are taken and action, or inaction, is pursued by governments in relation to some issue or problem” (O’Neill & Pederson, 1992, p. s26). Examining the overarching ideas and values that underlie decision-making “ensures that we do not overlook the more subtle manifestations of policy, such as the capacity of certain values to become dominant and frame the decision-making process” (O’Neill & Pederson, 1992, p.s26). Success or failure of implementation can depend on a policy’s compatibility with existing perspectives and tendencies (Ryan, 1995). Differences in intra-organizational values and interests have been identified as a key factor in implementation failure (Barrett, 2004).

A number of subjective factors affect different agents’ appreciation for the ideas and values embedded in the policy message, including their cognition of the policy, the direction of their response to it, and the intensity of that response (Hambleton, 1983). Policy conflict can exist when different agents, or groups of agents, have incongruous views regarding the goals of a policy or the activities planned to carry out a policy, particularly when the subject matter of interest “produces deeply ingrained attitudes and values toward the policy” (Thain, 1987, p.70). The intensity of an agent’s response to a policy will increase in relation to the number of incongruent ideas and values as well as what they believe is at stake (Matland, 1995). Implementers may misunderstand, fail to carry out, or even openly strive to sabotage a policy because they reject its goals, it challenges their set of core beliefs, or it is outside of the cognitive framework they use to cope with day-to-day events (Hambleton, 1983; Thrasher, 1983).
There is a social phenomenon in criminal justice treatment settings referred to as a therapy-custody or treatment-punishment dichotomy, which defines two ideological end-points that co-exist in prison-hospitals (Steadman, et al., 1989). This dichotomy can exist across systems as well as within and between individual agents who carry out both care and custody responsibilities (Cruser & Diamond, 2000). Professional training provides a strong set of perspectives and tendencies for accepted work activities and effective problem-solving actions. Agents view their interests in relation to profession-specific policy definitions within which they are likely to ground decisions (Matland, 1995). Frontline staff become intensely involved in conflicts of ideology and each agent’s influence is tied to the strength of the group of which she/he is a part. Cruser and Diamond (2000) highlight this frontline tension between mental health and correctional staff: “Staff bring varying opinions of what prison should be, and can heavily influence the management of inmates with mental illnesses… Unless security and treatment personnel achieve a mutual understanding and support each other in making security and treatment decisions, the integrity of the prison mission… may be jeopardized” (p.128).

7.3 Identifying Tensions Among the Multiplicity of Perspectives and Ideologies

The prison-hospital carries responsibility for both providing mental health care and ensuring correctional custody for offenders with mental illness. While these two elements are inseparable in the prison-hospital environment, balancing the mandates for both care and control remains an ongoing challenge: “You’re forever balancing the penitentiary versus the hospital. And you really need to know when one supersedes the other and where you need to put the emphasis.”
The Correctional Service of Canada’s formal mission statement clearly expresses the basic and enduring ideals that give direction for agents carrying out work activities at all levels of the organization: “The Mission document is the framework within which our policies and plans are developed and our decisions made. Where situations arise that are not covered by a specific rule or procedure, the principles in the Mission will help guide the action we take.” D7 This framework expects that “special attention is given to addressing mental disorders” D7 as well as that “the risk presented by the offender is taken into account when making decisions.” D7.

Use of the emergency response team for administering medication to a patient who has been deemed incapable by the health review board is described as the ultimate example of “either the two coming together or the ultimate of demonstrating how the two were at odds.” IR2. The potential conflict between ‘giving special attention to addressing mental disorders’ and ‘ensuring that risk is taken into account’ arises from the incongruent values and perspectives of agents with different types of professional training: “A mental health professional would come in there and say ‘oh my god, what are you doing’ and from a correctional perspective I could say ‘look, I’ve got the authority to do it, and I need to make sure that everyone stays safe... so I’m going to deploy my team.’” IR2

The reasons for using this degree of force for providing a mental health service are not well understood:

“I don’t know. I’ve asked myself that question so many times. You really want to protect staff. When I look at some of the really crazed, out of control guys in other [prison-hospitals] and basically non-IERT (institutional emergency response team) uniformed guys go in and hold him down, while the nurse comes in and provides the injection. I don’t know if I’d want to be the first one to try that with some of the guys in [this prison-hospital].” IN1
Decisions regarding use of force are often dependent on the values and perspectives of the agents in positions of formal authority: “Nobody uses it in quite the same way as [this prison-hospital] does.” In another prison-hospital within the Correctional Service of Canada the use of force is “resorted to very quickly” and yet in another prison-hospital “they will do whatever they have to do to not use force.” In the prison-hospital under study, it appears that there are concerted efforts to balance the incongruent values on using force in the provision of mental health care: “Although it may look awful on tape, the reality is there seems to be a negotiation before hand in terms of trying to attempt to gain compliance without using the team. There is a well laid out plan, you know, it’s quite thoughtful and people are involved and everybody knows their roles, and nothing ever goes wrong... it’s hard to be critical.”

The example above illustrates how disparate views on the goals of a policy and the activities for carrying it out are balanced to coordinate a collective work activity. The following example illustrates how conflict can arise when professional training forms incompatible ideas on acceptable work practices and activities for transferring patients between units within the prison-hospital.

A correctional supervisor viewed the policies and practices for transferring patients between units through the policy definitions provided by his correctional training and experience working in a regular prison:

“My role at [the regular prison] was security and responding to incidents on the units, providing support to the correctional officers, and responding to needs on the units. Especially if I was the only supervisor on shift available for these kinds of responses, I would literally just sit and answer the phone and respond on an ongoing basis for the entire shift. If there were decisions to be made, I was the supervisor so I made them and I made sure they happened.”
Taking this practice of hierarchical decision making into the prison-hospital, he found it to be incompatible with the views and practices of decision making among the mental health staff:

“Here at the [prison-hospital], you walk in and start making decisions. You’re moving offenders from range to range based on the information you’ve got. You’re doing it in good faith, but that’s not the way it works here. Even if the decision you make as a correctional supervisor is consistent with what the team would have decided. So you go and you talk to the nurses later and you talk to the psychiatrist. They don’t necessarily disagree with the decision that was made but there’s a different process to be followed here. This is a multi-disciplinary place.”

Such a misunderstanding of the institutional discourse, based on policy definitions that are outside the cognitive framework of the correctional supervisor, prompts immediate concerns among frontline staff. “Yesterday we came on after days off and see a note that a patient is being moved over to the other building but we don’t know why. Turns out he complained about things over here so the [correctional supervisor] took it upon himself to show the patient the third floor over there and ask if he would rather live there. But we still don’t know why.”

With the power imbalance created by the specificity in correctional policies juxtaposed to the ambiguity of mental health policies, mental health staff feel they have limited influence in formal actions for defining decision making processes. Their professional training leads mental health staff, and correctional staff with strong histories in providing mental health care at the prison-hospital, to respond to such conflicts, instead, using a consultative team approach: “A couple of really good staff members sat down with me, a couple really good nurses and couple really good correctional officers, and said, you know, ‘try this’ or ‘this is why people aren’t happy’.”
Once misunderstandings are clarified, the potential remains for conflicts to emerge when policy definitions and practices challenge an agent’s set of core beliefs. With the introduction of the ‘non-smoking unit’, where patients were not permitted to have tobacco products in their possession, mental health staff found that transfer decisions within the prison-hospital were being made based, to some extent, on non-clinical considerations. “It was hard enough sometimes finding potential candidates for [the unit] based on their behaviour, medication compliance, suicidality, that stuff. Now we have the additional criteria that if they’re a smoker they can’t go to the second floor. Or if they’re a non-smoker they can’t go to the third floor. So all of a sudden, we have another artificial bottleneck. In my view, it was a mistake.”

Concurrently, correctional staff demonstrate gaps in appreciation for transfer decisions made based on mental health concerns: “I’ve encountered a couple situations where the psychiatrist determined that the person must move to another floor because the stress of trying to quit smoking was exacerbating his mental illness and his psychotic symptoms were increasing as a result of trying to quit smoking. And so for patient mental health, the psychiatrist was willing to choose compromising physical health. I didn’t necessary agree with that.”

Frustrations arising from these types of conflicts have developed a sense of “helplessness/hopelessness” among mental health staff. The ongoing state of conflict, and accumulation of concerns based on incongruent values, intensifies this response: “Someone moves up from floor one to floor two and there’s a big hassle and it goes to [the operations meeting] and the warden gets involved. There are emails and phone calls and someone says ‘I’m not doing that anymore’. People don’t want to get involved in
those things because what they find when they do, they get burned somehow and they say, ‘Shit, I’m not doing that again’. While some staff respond by ‘giving up’, others respond by ‘assuming responsibility’: “I guess I could have said ‘I don’t want to do this’ but that just would have made my life miserable because people would have showed up on [the unit] from various other decision points such as security, nursing, etc. and there wouldn’t have been a wholistic, multi-disciplinary decision making process take place.”

7.4 Tracing Social Connections Between the Multiplicity of Perspectives and Ideologies

The incompatibility of ideas and values for the mental health mandate of the prison-hospital is clearly evident across all levels of the organization. Despite the efforts of frontline staff working to provide mental health care within the custodial environment and the efforts of managers in positions of formal authority to strengthen the voice of mental health care within the correctional system structures, without an organizational vision for mental health care ideological conflicts have arisen from incongruent perspectives on the priority of the mental health and correctional mandates.

Frontline staff appear unified in their commitment to the mental health mandate of the prison-hospital. Mental health staff, with the ideas and values ingrained by their professional training, do not hesitate to place the mental health mandate as the top priority: “Is this a jail or a hospital? It’s a forensic hospital. The word forensic implying it’s locked secure, but it’s still a hospital... It’s a hospital first and a jail second.” Correctional officers identify more readily with the correctional mandate but recognize
that a different approach is needed when working with offenders who have mental
illness: “At [the prison-hospital], because of the make-up of offenders here, you need to
learn how to deal with people, to be less confrontational.” This perspective appears to
be supported by the ideals within the organization’s mission statement that assigns equal
importance to “aiming to assist to the extent possible and to control to the extent
necessary... but mentions assistance first... Control is not of lesser importance for being
mentioned second. However, the degree and nature of the control exercised should work
in support of reintegration efforts, not against them.” However, the settings in which
health professionals work are often more influential in decision making than their training
(Milio, 1986).

Ongoing negotiations for the future of the prison-hospital have underscored the
incongruent ideas and values toward ‘care’ and ‘custody’ among multiple agents in
positions of formal authority. “Her perspective was that we were a hospital first and we
serviced federal inmates. And I said we are a federal penitentiary first but, under the
[Corrections and Conditional Release Act], providing a service to mentally ill federal
offenders. And that was the fundamental difference.” These differences in ideology
generated conflicts in determining lines of formal authority within the unit management
model and in managing human and fiscal resources in the changing budget allocation
system. Frontline staff have responded to these conflicts with feelings of loss and
concerns about professional identity and value: “There is a huge disconnect between
purpose and utility. And when you hit that, again you’re forced as an individual
practitioner to think ‘what am I going to do with that? Do I personalize it? ... How do I
put that into my psyche? How do I put that into my professionalism?”
Agents in positions of formal authority at regional and national levels do not all have an appreciation of the mental health mandate of the prison-hospital and, therefore, place little or no emphasis on the ideas and values of those responsible for implementing that mandate: “I don’t know who to deal with on this because no one will make decisions on this... he will only talk about operations; he won’t talk about the mental health side.” Frustrations continue to grow among institutional managers and frontline staff who battle through these conflicts on a day-to-day basis. “We’ve got two masters, the mental health act provincially and the [ Corrections and Conditional Release Act] federally. And we operate, have to operate, differently.”

7.5 Displaying Ideologies in the Multiplicity of Perspectives and Ideologies

While the conflicts resulting from incongruent values and perspectives on mental health care remain unresolved, contextual factors within the prison-hospital environment have increasingly dominated decision making processes. Frontline staff and institutional managers face many organizational pressures that prioritize ‘custody’ over ‘care’ during decision making processes. Decision makers fail to carry out mental health policies based on ideologies related to providing ‘care’ because greater emphasis is placed on contextual factors related to ensuring ‘custody’, such as meeting operational requirements and managing resources.

As senior managers negotiate decisions about mental health care across the country, the battle for formal authority over the prison-hospital was driven less by ideological concerns than by the struggle for power: “I don’t think their position was that it is a correctional environment first and a hospital second. I think it was one of
“protecting their turf and having different agendas when they came to the table.”” IR3

Various proposals for formal lines of authority have had mental health staff under a line of authority separate from the correctional staff to protect decision making based on ideological concerns related to ‘care’. “I think having one person taking on the clinical professional role and direction as well as the administrative or correctional support creates an ethical dilemma and also creates conflictual decision making, which does not allow, sometimes, the health care to have its voice.”” IN2 Yet, opposing views on lines of formal authority within the prison-hospital were designed to ‘limit the power of others’ based on the desire for ‘collective agency’ and the need for ‘accountability’ in decision making processes related to ‘care’: “A two-headed model with no one in charge doesn’t work... You know, we want the nurses and security to work together, and if nurses don’t report... up through operations we can’t tell them what to do... You want to hold one person accountable.”” II2 The one thing that proponents of both perspectives have in common is a concern about how this, and other, policies and initiatives will be resourced.

When new policies and initiatives are put in place without any new resources attached, a practice that is increasingly common, the prison-hospital is required to adjust operations in order to assume related expenses. The specificity of correctional policies details operational requirements for a prison, which must be adhered to. In contrast, the ambiguity of mental health policies allows operational adjustments to the provision of ‘care’ in order to ensure provision of ‘custody’: “As a manager in the public service, I have no authority to over-extend my budget... but we do everything we can, delay staffing, don’t staff vacant positions, i.e.: [the occupational therapist] leaves and we don’t staff in behind her... two psychologists leave, we haven’t staffed behind them... and
we use the remaining salary dollars to help offset our financial difficulties." This practice of sacrificing ‘care’ responsibilities for ‘custody’ requirements is not only accepted but reinforced by personal financial incentives for managers. “Every manager has a performance agreement... and in that agreement it says, you know, live within your budget... and if you’re not meeting your accountability agreement, then that would determine if you’re going to get any kind of pay increase or... performance bonus.”

It is these types of contextual factors that place emphasis on the correctional mandate of the prison-hospital, while drawing emphasis away from the mental health mandate. In doing so, there is a growing imbalance in the philosophical dichotomy of ‘care’ and ‘custody’ experienced in the everyday work activities of the prison-hospital.

### 7.6 Summary

The ideological differences between ‘care’ and ‘custody’ are an ongoing subject of debate and source of conflict. “The [prison-hospitals] are the ones providing inpatient care and, as such, the challenge is: are they under an accommodation framework, that is a penitentiary framework, or is it a hospital framework? That’s where we need to reconcile that in terms of decision making.” Without a vision for mental health care, each agent forms her/his own perspective of what the prison-hospital should be and become intensely involved in conflicts to protect or enhance their own interests. The conflicts arising from these incongruent, deeply ingrained, attitudes and values toward mental health care are extended and amplified by the degree of clarity or ambiguity in the policy message and the perspective, priorities and concerns of the multiplicity of agents, and the use of resources within the prison-hospital. It is the policies for resource
allocation, and processes for utilization of these resources within the prison-hospital, that will be examined in Chapter 8.
CHAPTER 8
RESOURCES

8.1 Introduction

Section 8.2 begins this piece of the analysis by using policy literature to describe the fourth key element that shapes the policy implementation process: resources, which includes material, human and financial resources, that support or subvert implementation behaviour. The literature is analyzed to display how the provision of resources, and expectations for the impact of those resources, can support or subvert implementation behaviour. Tensions are identified in the resource allocation process where a power-dependence emerges between mental health care and correctional services (section 8.3). Connections between points of control for resource allocation and distribution at various levels of the organization are traced (section 8.4) and the ideological perspectives, the beliefs regarding the impact of available resources and the value placed on economic forces that shape the institutional discourse within the prison-hospital, are displayed (section 8.5). The chapter ends with a summary of tensions surrounding the allocation and utilization of resources in the implementation of mental health care (section 8.6). Analysis of this element shows how inconsistent policy structures for allocating resources create a power-dependence for achieving the goals and objectives of an institution.
8.2 Literature

It is generally understood that resources, including human, material, political, informational, technological, and financial resources, are critical to the policy implementation process (Hambleton, 1983; O’Toole, 1986; Thain, 1987). However, different approaches to the policy implementation process produce different expectations of the impact resources have on implementation activities. In a top-down policy approach, resources are expected to promote implementation activity that fits with the goals and priorities of the organization. Agents conform to the policy as it is laid out because, in doing so, they will receive a share of the resources. In a bottom-up approach, the availability of resources might distort implementation activity away from the goals and priorities of the organization because agents may be attracted to a policy because the attached resources can be used to further their own ends, rather than being in agreement with the goals and content of the policy (Hambleton).

Regardless of whether resources attract implementation behaviour that supports or subverts policy goals, frontline staff can only meet the objectives of an organization within the context of limited resources. Agents at various levels of an organization have resources with which to influence policy implementation but no one agent has sufficient resources to impose her/his own interests. They need to exchange resources in order to achieve their goals, creating a power dependence and inter-dependence among agents (Thain, 1987). As a result, the institutional discourse becomes focused on the more immediate concerns about the build-up of resource commitments to ongoing plans and priorities and the need to decide on allocation of available resources (Hambleton, 1983). An organization’s decisions about its use of resources alters the activities of managers,
frontline staff, and clients, affecting the provision of, and access to, services (Milio, 2001). Often policies are developed without attention to the way that economic forces, including the range of activities for producing, distributing and consuming services, will undermine them. It is important not to assume that an infusion of resources will, in itself, speed implementation (Hambleton).

Implementation can be understood as a series of actions and activities where value-laden choices are subject to pressures from a number of sources. “If policy is weak – on issues like the shifting of resources towards services for less privileged groups – this must be explained in terms of the built-in power of certain… interests within the system” (Barrett & Hill, 1984, p.224). Policies set priorities and guide decision making regarding amounts and allocations of resources. “The overall amount is a statement of commitment to certain areas of concern; the distribution of the amount shows the priorities of decision makers” (Milio, 2001, p. 622). Therefore, funding ‘shortfalls’ need to be understood, not just in relation to support for mental health policies, but also in relation to support for other policies (Barrett & Hill, 1984).

Federal systems, where policy making and implementation are divided by levels of government, provide opportunities for the spread of ‘symbolic policies’ – the extent to which decision makers want to be seen as being in favour of certain ideals and goals while actually having no intention of ensuring implementation. “We should not be surprised to find policies whose effective implementation is distinctly improbable, and to suggest that some of their ‘makers’ are perfectly aware of this fact” (Barrett & Hill, 1984, p.223). The challenge is to determine the limits of any attempt to gain or maintain influence over the local economy.
8.3 Identifying Points of Tension in the Resources

The built-in power of correctional interests, over mental health interests, within the organization is evident in resource policies that spell out desired levels of spending. Funding ‘shortfalls’ for mental health services can be understood, not only in terms of available funds, but in relation to the clarity or ambiguity of the policy message in communicating expectations to frontline staff, the complex chains of reciprocal interaction in determining a correct interpretation and accurate execution of that message, and the incompatibility of ideals and values on the provision of both care and custody in the prison-hospital. The combined influence of these factors has resulted in organizational resource policies that impede the provision of mental health services within the prison-hospital.

The dominance of correctional policy intentions, that has become evident through the content and communication of organizational policies (as discussed in Chapter 5), has also emerged in the creation of indicators for distributing resources throughout the organization. Just as the complexity and lack of familiarity with mental health care has made it difficult to identify clear performance indicators (also discussed in Chapter 5), these factors have also made it difficult to develop relevant resource indicators. Despite correctional resource indicators being developed and implemented in 2002 (including indicators for correctional resources in the prison-hospital), indicators for distributing mental health resources remain at the development stage:

“I don’t know why it should take so long. We had done our homework. We had compared the [prison-hospitals] to six community forensic facilities, compared the clinical staff-to-patient ratios... I think we had a really strong rationale. I think it’s probably an issue of will in the service, that you know there are many other priorities and this is going to cost to put this in place and I think it’s just a
lack of feeling like they needed to focus their attention in this particular area… Mental health is not seen as a huge priority.”

The multiplicity of agents involved in developing resource indicators for mental health care are torn between competing perspectives and priorities (discussed in Chapter 6) as they battle to determine an interpretation and execution of policies for resource allocation that will ensure provision of mental health care. “A couple of times we were ready to finalize and sent the documents out to [the prison-hospital executive directors] to look at, to approve it, as we had discussed at our last meeting. I just want them to endorse this copy before it goes ahead, and they’ve raised major issues at the eleventh hour. So, I think in all fairness they’re really busy people and they probably never attended to it until they absolutely had to.” The seemingly simple activity of endorsing a previously agreed upon document is revealed to be dependent on a complex chain of reciprocal interaction. Each link in the chain has the opportunity to act independent of the collective process as she/he approaches the activity with her/his own priorities and concerns. In doing so the discourse is reproduced rather than modified, leaving mental health care to continue operating under the existing main-estimate resource allocation process, rather than altering it to move forward with the rest of the organization.

The following description illustrates how everyday frontline nursing work in the prison-hospital is distorted away from mental health care within the context of limited resources. The potential conflict between providing mental health services that are ‘consistent with professional standards’ and working within the constraints of ‘operational adjustments’ arises from the priorities and decisions made regarding allocation of these limited resources:
The source of tension is directly related to the staff’s perspectives about what resources are needed for providing mental health services in the prison-hospital. Personal frustration arises from a decreasing number of mental health staff at the prison-hospital due to inconsistencies in the policies for allocating resources. Justification for human resources arising from existing correctional resource indicators are juxtaposed with a vague understanding of human resources necessary for “providing a continuum of essential care”. These conflicting perspectives create a power dependence among agents at the prison-hospital in order for them to achieve their goals.

This power dependence is represented in the exchange of resources between the correctional and mental health mandates in order to cover the more immediate resource needs of the prison-hospital: “Every time you don’t get salary dollars that impacts the whole institution because you’re looking at the bottom line. For instance, when we overrun in security overtime, as we do, it impacts on everything. How often we shut down and, as you know very well, we have to have operational adjustment plans. The latest operational adjustment plan is pretty severe.” The provision of, and access to, mental health services was significantly affected by operational adjustments that primarily altered the activities of frontline mental health staff.
The weakness of existing resource allocation policies allows salary dollars to be shifted away from the provision of mental health care and, indeed, over time the prison-hospital has felt the effects. There were a total of 60 full-time-equivalent nursing positions at the time that the second building was acquired in 1995. By the time a nursing services audit was conducted in 2005 there were only 44 full-time-equivalent positions. “That means that 16 fte’s have been lost to the overall funding levels to support health services operations.” The impact of this loss on mental health service provision was recognized in the 2004 health services accreditation survey report: “The lack of human resources, due to cutbacks and failures to replace when staff leave, has left the organization barely able to provide any services, let alone high quality services.”

While it is evident that power dependence exists between correctional and mental health resource priorities it is not inter-dependence, in that resources seem to flow in only one direction – from mental health to correctional or security priorities. The disparity between resource allocation policies for providing both ‘care’ and ‘custody’ has subverted mental health care and placed it in a position of weakness when requesting or advocating for necessary resources. An institutional manager expressed his personal frustration of working from this position of weakness: “You had no way of arguing or justifying or asking for additional resources. On the security side you could look at the post analysis and the indicators for that... The ones that were more difficult were the occupational therapists, were the program staff, were the nursing staff – how do we determine that we need this number of nurses? How do I argue for additional resources when I can’t defend it?”
8.4 Tracing Social Connections in the Resources

The power dependence evident in the shifting of resources away from mental health care within the prison-hospital is also evident within the formal authorities who control resource allocation to the prison-hospital. Throughout the 1990’s and early 2000’s, institutional managers had a good deal of control over the resources allocated annually to the prison-hospital and the Associate Wardens/Executive Directors had a great amount of flexibility in managing their budget. Funds could be shifted to cover immediate needs and changing priorities, and these adjustments could be sustained from year to year. With the introduction of the envelope system in 2003 a significant amount of that flexibility disappeared, particularly for resources located in regionally or nationally managed envelopes. The management of mental health funds were located within the regionally controlled health care envelope and, as such, fell under the control of the Regional Administrator, Health Care. However, without an organizational vision for mental health care, indicators for allocating mental health resources were not yet developed and the main-estimate process remained in effect for funding mental health services in all of the prison-hospitals.

While indicators for correctional resources are responsive to changes in the number of offenders housed in the facility, the size of the facility, and other cost measures, the main-estimate process for mental health care is dependent on expenditures in a previous year. It does not take into account any changes to demand for mental health services or operational adjustments that had been made in previous years in order to balance the budget:

“So, if 32 million was spent last year, that’s what we will recommend to be funded for the upcoming year, so it’s always based on the previous year. Because
we know that if you spent that much last year, chances are you’re going to be spending the same amount again. But it creates a problem because our base budget may not have been incremented by the same amount as what was spent... so if the cost is on more inmates requiring this type of service, we have to find the money inside.”

The correctional mandate of the prison-hospital has both resource indicators to justify the number of correctional positions it has and direct control of the security resource envelope to ensure that that number of correctional positions are maintained. However, without resource indicators, institutional managers do not have the same justification for maintaining specific mental health positions and feel a greater freedom to reduce expenditures for these positions to accommodate the over-extended security envelope in order to balance the overall budget for the prison-hospital.

“There were a bunch of things they didn’t fund us for and that really hurt. This year they will probably fund us the same way as in the past and we’re going to start off again in the hole. That’s why when [a psychologist] left we didn’t back fill behind her. That’s why when [another psychologist] left we didn’t back fill because we need, big time, those salary dollars. So when [an occupational therapist] left we didn’t fill in behind, because we needed those dollars to make up for the shortfall in salary.”

However, as these types of adjustments bring mental health expenditures down, they in turn create a false main-estimate for allocating mental health resources in the future. As a result, the budget for the prison-hospital has incrementally deteriorated to the point that, “this year’s budget is the same size that it was in 1998”.

Regardless of funds allocated through a resource indicator process or a main-estimate process, the organization still has to work within the funds made available from the legislative level. The way that institutional managers make use of resource indicators may not be consistent with how the indicators process was designed: “Not everyone is aware that this doesn’t tie into what the Treasury Board provides us. This is our own
method of distributing it. So, because they say this is the method to distribute it, doesn’t mean the Correctional Service of Canada was actually given that money in that ratio.” IR5

Managers appear to use resource indicators as leverage and justification for obtaining and maintaining a certain number of staff positions rather than using the actual resource amounts to maximize these funds. However, resource indicators do not dictate what positions need to exist within a particular facility, they just determine the amount of funds placed in a particular envelope. There is an expectation that resources allocated to the mental health envelope will promote implementation activity that fits with the mental health mandate. However, it is at the discretion of the agents managing the envelopes, how those resources are used: “A funding model is not an operational model… If they found a model that’s more efficient or works better at their facility, we’re not suggesting because of resource indictors, that’s what they should do. They can certainly operate different from that within the restriction of the number of dollars that they have.” IR5

There is also a power-dependence built into the organization’s operational model that places the focus of the institutional discourse on the more immediate correctional needs. A common operational model within the Correctional Service of Canada is that of ‘clustered sites’ where, typically, two facilities located in close proximity to one another share common services such as food services, facility maintenance, sentence management, admissions and discharge (correctional process for entering and leaving a prison), and financial services. When the prison-hospital gained administrative separation from the maximum security prison, the responsibility for over-seeing these shared services remained with the maximum security prison. It is common among clustered sites
for the smaller facility to be a lesser priority in the management of shared services and the prison-hospital was no exception: “The downside of a clustered service is that if you’re the smaller institution you tend to not get the attention you require and I saw that happen at [the prison-hospital] and it’s not [the maximum security prison’s] fault. If they were having incidents and their management services were busy fixing broken toilets that got smashed last night and we had a plugged toilet, our plugged toilet was going to wait.” IR2

Matters that fall within the purview of shared services include chairing the institutional joint occupational safety and health committee (IJOSH), responding to privacy requests, doing building repairs, and responding to inmate grievances. Control of the resources allocated to both facilities for these services is held by the maximum security prison creating a power-dependence that draws much of the prison-hospital’s time and attention away from mental health care and directs it, instead, to the management of ongoing needs for operating as a stand-alone facility:

“So, the services like food services or any of the maintenance shops, we had no control over any of that. We were kind of like the poor cousin. We’d have to beg for services. So if something broke down there was no guarantee that it would get fixed… the [maximum security prison] would have received the money, the per diem, for the number of inmates they were feeding, including [the prison-hospital] but we never saw that money and never had any control over that money.” IR1

Access to these resources needs to be continuously negotiated and often “depend[s] on the goodwill of the staff” II1. However, managers at the prison-hospital are hesitant to ask those who control shared services at the maximum security prison to take on these responsibilities: “The [Assistant Warden, Management Services] over there is so overwhelmed by the issues and problems over there, I can’t ask her to respond to something or deal with something.” II2
The prison-hospital’s power-dependence on the maximum security prison for resources required a distortion of implementation activity away from the provision of mental health services in order to secure their portion of shared services. The prison-hospital created a project officer position in the mid-2000’s to address concerns related to shared services. Much of the project officer’s role focused on opening relations between the two facilities to improve the flow of resources: “You have to really depend on facilitating relationships with the people who have those resources... You have to depend on the good graces of your neighbour. And if they’re trying to balance their budget, they wouldn’t be spending money on you next door unless they absolutely have to.”[IR1] This was a time-limited position, existing for a single year, that produced limited and unsustained improvements prompting managers at the prison-hospital to use alternative strategies for addressing immediate concerns:

“If you make enough noise high enough, you will get some attention. The problem when you do is that you run the risk of turning others against you. So you may win the battle but you lose the war. So you’ve got to be selective unless it’s a real issue, like when they switched food carts and we didn’t get heated food carts. I got nowhere with [the maximum security prison] and nowhere with region. So I went and told the commissioner and I did get it. However, I know there were a few people unhappy about that because I wasn’t following the chain of command. Except I had followed the chain of command and I got nowhere.”[II2]

Despite the implementation of resource envelopes and administrative separation from the maximum security prison, the everyday activities of institutional managers operating within the limits of available resources, and the operational structure of shared services among clustered sites, has perpetuated the dominance of correctional intentions (as discussed in Chapter 5). This power-dependence is largely attributed to the organization’s lack of vision for mental health care: “I think, our organization was still
grappling with what did it mean to treat mentally ill offenders and to have an institution for mentally ill offenders.”

8.5 Ideologies Displayed in the Resources

The power of resources to support or subvert policy implementation activities is grounded not only in the allocation and distribution of those resources, but also in how those resources are utilized by agents to either conform to policy intentions or to further their own interests. Under the current resource allocation policy structure, the effective implementation of mental health policies is improbable. The symbolic nature of policies for “providing a continuum of essential care” is evident through the infusion of resources to retrofit the main building of the prison-hospital and the subsequent acquisition of the second building.

It was assumed that this investment in the prison-hospital’s facility would increase and improve the provision of mental health services. However, the following description illustrates how this infusion of resources for the facility contributes to the subversion of implementation activities for mental health care:

“The space for staff on each unit is made up of a series of small rooms, nooks, crannies, and broken up space that prevent all team members from being in the same room at the same time. There is only space large enough to hold multi-disciplinary meetings on the unit on 2 of the 5 units, therefore nursing and correctional staff must be available to leave the unit in order to participate in multi-disciplinary meetings. In the main building, correctional officers and nurses work in close proximity, which affords opportunities for interaction/collaboration. In the second building, nurses and correctional officers are in separated spaces, not even within casual hearing distance of one another, which deters and limits interaction/collaboration.”

The organizational belief that the prison-hospital, in ‘receiving a share of the resources’, is better able to provide mental health services stands in direct contrast to the
value that frontline staff place on the economic force of ‘teamwork’ for producing and distributing those services. The closed units locate staff in their own space – whether in separate buildings, on separate floors, or in separate rooms – and coordinate their actions and activities to be done individually or in small groups of agents with similar values and perspectives. Frontline staff who are not located on the units, such as parole officers, programs officers, social workers, and occupational therapists, come to the units infrequently to interact with nursing and correctional staff, instead relying on email and telephone communications. The limits of ‘teamwork’ become evident when they do enter each other’s work space: “Other staff coming onto the units to work almost look uncomfortable being there and interacting with the nurses and correctional officers, even if they’ve worked at the prison-hospital for years. They behave like guests who aren’t quite sure if they should take their shoes off at the door and whether they should wait to be invited to sit down.”

Managers and frontline staff at the prison-hospital conformed to the decision to acquire a second building from the maximum security prison with the expectation that they would receive increased resources for providing care. However, as one frontline staff member noted, “the promise of resources that were supposed to come with [the second building] never came.” The institutional discourse was modified as economic forces – the range of activities for producing, distributing and consuming mental health services – adjusted to operating within this altered physical space.

The well-intentioned acquisition of a second building to increase and improve mental health care did not recognize how the facility structure would subvert implementation activities for producing and distributing mental health services. It created
a power-dependence between the two buildings that does not appear to be the result of mismanaged resources but rather is a consequence of operating within limited resources. The belief that the availability of the second building would increase and improve mental health services is disproved next to the actual distribution and utilization of those resources:

“Construction projects get started but not finished. Someone came and pulled all the trim off the hallway and the nursing station walls but didn’t ever come back to fix it. They started to build a doctor’s office on the second floor where the physician would come to do medical care for this building. They tore out a wall and put in new lights and then just stopped and they’ve never come back to finish. Now it’s a completely unusable space. ‘We have an old examination table in one of the cells – it’s a hand-me-down from [the main building]. We always get the old stuff when they get something new. They get a new exam table – we get the old one. They get a new blood spinner – we get the old one. They have a proper chair for doing bloodwork with arm support that angles the arm and we’re doing bloodwork at an old desk using books to prop the guys arm into a proper angle and we have to bend over rather than sit because otherwise we can’t reach his arm properly’. There is no privacy. The nurse does bloodwork in the hallway. That is also the only interview space – in the hallway – that’s where the psychiatrist does interviews. The correctional officers and others walk through the hallway to use the bathroom, which means they walk through the psychiatrist’s interviews with patients.”

The power-dependence between the need to operate within limited resources and the mandate to provide mental health care is often attributed to the structure and condition of this 175 year-old facility. “Great gobs of money have to go to maintaining these [facilities], but since the budget usually stays the same from year to year it’s affecting how they distribute money to the regions, because they’ve got to keep the infrastructure going, which is breaking down all over the place. Big facilities have huge problems and so, it’s affecting our ability to meet our mandate.” There is a general belief that, “this place isn’t built to provide care for these guys. I don’t know if they’ll ever do it but they’ve been talking about building a new [prison-hospital] as long as I’ve
been around. However, it is the relatively recent provision of these very facilities that, to date, has prevented support for constructing a new facility.

8.6 Summary

Organizational leaders want to be seen as supportive of ideals and goals of mental health care. Yet, after years of being left out of organizational changes to resource allocation processes, receiving resources that do not match the goals of the prison-hospital, and having available resources used to further the interests of other agents, it is evident that there has been little organizational commitment to mental health care. The lack of vision for mental health care has produced a power-dependence between the mental health mandate and the correctional mandate of the prison-hospital. In response, many agents have engaged in different forms of bargaining and negotiating in order to achieve their goals. It is this process of bargaining and negotiating, the politics of planning, that is examined in Chapter 9.
CHAPTER 9
POLITICS OF PLANNING

9.1 Introduction

Section 9.2 uses policy literature to describe the fifth and final key element that shapes the policy implementation process: the politics of planning, which views implementation as a bargaining process involving conflict, negotiation and compromise that overlaps and interacts with the four elements previous explicated (policy message, multiplicity of agents, multiplicity of perspectives and ideologies, and resources). The literature is analyzed to display how bargaining and negotiation processes are employed by agents actively pursuing their own goals and interests. Points of tension are identified where agents, or groups of agents, are in a position to influence or control the actions of others when conflicts arise (section 9.3). Connections between the bargaining and negotiation processes at various levels of the organization are traced (section 9.4) and the ideological processes and practices that coordinate the strategies and tactics agents use to gain and exert influence (section 9.5). The chapter ends with a summary of tensions surrounding the asymmetrical power relations at play when conflicts arise in the implementation of mental health care (section 9.6). Analysis of this element shows how asymmetrical power relations within an institution shape the bargaining and negotiation processes for determining outcomes in situations of conflict.
Policy can be seen as “a vehicle which promotes the values, understandings and ultimately the interests of a particular group” (Cheek & Gibson, 1997, p.669), bringing a political dimension to policy development including elements of power and control. ‘Political strategy’ is a plan to improve chances of advancing the values and interests of a particular group by influencing the direction and scope of implementation activities (Milio, 2001). When studying the implementation of policies, it is important to consider whose values are legitimated by the policy message and how this legitimization occurs. The political process of implementing policy can be seen as a bargaining process that involves conflict, negotiation and compromise (Hambleton, 1983). A game metaphor is useful for examining elements of the bargaining process including “the players, what they regard as the stakes, their resources for playing, the rules of play (which stipulate the conditions for winning), the rules of ‘fair’ play (which stipulate the boundaries beyond which lie fraud or illegitimacy), the nature of communications (or lack of them) among the players, and the degree of uncertainty surrounding the possible outcomes” (Hambleton, 1983, p.413).

A negotiated order, or agreements and rules between agents, is created through the implementation process including the degree to which one individual or group of agents is in a position of control over others; the degree to which they are in a position to coerce or influence the actions of others when conflict arises (Barrett & Hill, 1984). It is critical to illuminate asymmetric power relations within an institution by identifying the main interest groups involved, assessing whose interests are furthered and whose are obstructed or excluded (Hambleton, 1983). Individuals and groups of agents behave in
ways that will maximize their influence over others. These bargaining activities can be observed as agents continually make use of tactics to obtain or maintain control of real or symbolic resources (Bacharach & Lawlor, 1980).

In terms of organizational hierarchy, which approaches policy implementation from a top-down perspective, agents working on the frontline of service delivery should be operating in accordance with the rules and procedures defined by agents in positions of formal authority (Barrett & Hill, 1984). Alternately, from a bottom-up implementation perspective, the autonomy of agents on the frontline of service delivery in processing clients as consumers of services, affords them power in creating and re-creating the institutional discourse (Lipsky, 1980; Weatherly & Lipsky, 1977). From a bargaining perspective, the rules and routines created within the institutional discourse, and used by individual or groups of agents at various hierarchical levels of an organization, can be viewed as mechanisms for protecting functional and organizational autonomy (Barrett & Hill, 1984).

Bargaining is about gaining and maintaining influence that can be exerted when conflicts arise. If bargaining is seen as a positive-sum process, an exchange of real or symbolic resources does not necessarily mean that what is gained by one group of agents must be lost by another, but does require a shared recognition of inter-dependence for it to be effective (Barrett & Hill, 1984; Pressman & Wildavsky, 1973). Alternately, if bargaining is seen as zero-sum power games where strategies and tactics are aimed at achieving influence, a lack of goal consensus produces a struggle for influence where the gains of one group of agents mean another’s loss (Bardach, 1977; Barrett & Hill, 1984; Dunsire, 1978). However, most interactions between agents are ‘mixed-motive’ in that
agents are simultaneously presented with incentives to co-operate and incentives to compete (Bacharach & Lawler, 1980; Barrett & Hill, 1984).

It is important to distinguish ‘formal authority’ (legitimate power) from ‘influence’ (personal power) and the way that these forms of power can manifest within a bargaining process (Bacharach & Lawler, 1980; Barrett & Hill, 1984; Braveman, 2006). The conditions for determining who wins and who loses in a given situation “depends on either having sufficient power to force one’s will on the other participants or having sufficient resources to be able to bargain an agreement on means” (Matland, 1995, p.164). Inconsistent implementation behaviours are not necessarily a distortion of the original policy goals, but evidence of the value conflicts within which the policy was developed.

Bargaining in policy implementation focuses on “a particular range of interactions in which one set of actors is actively trying to influence or change the behaviour of others to get policy implemented; and other actors are responding according to whether the desired action fits in with or furthers their own interests” (Barrett & Hill, 1984, p.230). The nature of interactions within the implementation process, in consideration of the power-interest structures and relationships among the multiplicity of agents all pursuing their own goals and interests, might or might not be compatible with the goals of the policy mandate (Bardach, 1977; Barrett & Hill, 1984).

When conflicts exist, agents are forced to bargain and negotiate with each other in order to exchange resources to accomplish their goals and protect or enhance their own interests (Thain, 1987). One means of obtaining and exerting influence in the bargaining process is through workplace incivility and bullying, which includes “interpersonal
hostility that is deliberate, repeated and sufficiently severe as to harm the targeted person’s health or economic status” (Namie, 2003, p.1-2). Incivility and bullying are driven by agents’ need to control another individual or group of agents, often undermining legitimate business interests in the process. It is considered a zero-sum game involving a perceived power imbalance and creating a hostile work environment where personal gains are made at the expense of others (Namie, 2003; Salin, 2003).

Bargaining activities focus on achieving agreement on actions rather than agreement on goals, though are often unable to reach any agreement (Matland, 1995). Instead, the prominent factor in bargaining and negotiating is “the degree to which one group of actors is in a position to control, coerce or influence the behaviour of others, when conflict arises between them” (Barrett & Hill, 1984, p.226).

9.3 Identifying Points of Tension in the Politics of Planning

The process of bargaining and negotiating to advance the values and interests of mental health care is characterized by two forms of power: ‘influence’, as exercised by agents in positions of frontline service delivery and ‘authority’, as exercised by agents in positions of formal authority in the organizational hierarchy. The domination of values of agents in positions of formal authority (e.g.: hierarchical decision making) that are incongruent with the values and interests of frontline staff (e.g.: consultative teamwork) demonstrates the asymmetrical power relations at work within the prison-hospital (as discussed in Chapters 6 & 7). The negotiated order between individual and groups of agents, formed through implementation experiences, allows agents with ‘authority’ to have a greater degree of control over frontline agents when conflicts arise.
The following example demonstrates the degree to which agents with authority over correctional operations are in a position to influence the actions of frontline staff responsible for mental health services. The process of political bargaining that determines whose interests are furthered and whose interests are obstructed also unfolds:

“That whole imbalance started to grow more and more in the mid-90’s. And then we got hit with the whammo around staffing issues, with the correctional officers and the manning of posts… it started affecting the environment for me dramatically because it starting closing our area. It started with some planned closures where they said ‘we’re going to do it for these two or three months’, giving advance notice. We had a chance to voice our opinion but it didn’t matter, they were closing it anyway. But we had some notice, we planned a bit, everyone recognized that it’s hard… And then I see a major dip – a big fall: ‘Hey, you know what? Guess what you guys? We’re closing all the time now and we’re not going to tell you ahead of time’… Whenever we had department meetings one of us would raise it that, if we’re not being told, not being consulted, it’s a problem. And also ‘we’re closing all the time’ is a problem. So it gets raised at the department meetings except that there’s a sense that the department head… that person ends up giving you ‘I hear you. I feel bad. You’re right. But that’s the way it is.’ There’s not a sense that that person is in any position of power or influence to say ‘you know what? I’m going to go to a table and I’m going to keep fighting for you and we’re going to keep fighting until we resolve this’. No. We get an, ‘I’m sorry, you’re right, but that’s the way it is. Just do the best you can. And good job that you’re trying to do a good job’… We’ve signed some letters that we’ve submitted to the Executive Director and the Deputy Warden specifically saying that we had promises. I even kept a letter of agreement that we had about staffing a post from years ago… The problem with that is that it seemed to have an influence in the beginning. The group thing was actually a good strategy. It actually seemed to get a bit of attention from people. And now, it seems to be an annoyance. Now it seems to be ‘you know, we’ve got all these problems from these other ranks but they can have problems because we’ve been hitting them hard. So I wish you guys would just go away and do your job because you’re professionals and, you know, you don’t need to give us anymore problems either’. So when you make a letter or you bring it up privately... you get a much more short fuse feeling, as if you’re supposed to know to just back off and leave them alone because they can’t do anything about it. Or they’ve chosen not to do anything about it.”

The source of tension is directly related to the staff’s expectations for compromise in negotiating possible outcomes when balancing ‘operational requirements’ and ‘ensuring appropriate access’ to mental health services. Personal frustration arises from
operational adjustments that constrain the ability to carry out everyday activities for the provision of mental health care due to the dominance of correctional values in the asymmetrical power relations of the prison-hospital. The rules and procedures for access to facility resources as defined by agents with ‘authority’ are juxtaposed to the strategies and tactics of frontline staff protecting their functional autonomy for ‘providing a continuum of essential care’. Both the frontline staff and the institutional managers, in the example above, demonstrate a commitment to advancing the goals and interests of their position and role in the prison-hospital. However, incompatible values within the organizational policy structures create conflicts as they bargain and negotiate to further their own goals and interests.

This battle to determine whose interests will be furthered and whose will be obstructed does not appear to be a distortion of the original policy goals for the prison-hospital. Instead, it is evidence of the incompatible values and goals inherent within the correctional and mental health mandates. The positions of each agent affords each a form of power and their divergent responses to the situation reflect their location within the social relations of the institution. Mental health professionals on the frontline of service delivery hold ‘influence’ over the provision of mental health care in that they have the professional knowledge and contact with patients to ensure direct service delivery. The value they place on ‘consultative teamwork’ arises from their professional training and shapes the strategies and tactics they employ in trying to exert ‘influence’ to gain and maintain control over facility resources.

Managers, on the other hand, hold ‘authority’ over facility operations as a function of their position within the organizational hierarchy. Their responsibility to
operate ‘within limited resources’ necessitates the use of ‘operational adjustments’ as a strategy for exerting sufficient power to achieve their goals even while recognizing the impact on mental health service delivery: “The latest operational adjustment plan is pretty severe. Well, it is severe… We’ve gone from four days to three days in some areas although you can still see inmates on the units. We try to provide when we can.” This process of bargaining is a zero-sum power game, in that the gains of the agents in positions of formal authority for working ‘within limited resources’ means a loss for frontline mental health staff trying to ‘provide a continuum of essential care’. Without goal consensus, the strategies and tactics of both groups of agents are employed to coerce and control the behaviour of others to further their own interests. The specificity of correctional policies promotes the values and interests of the correctional mandate, allowing the obstruction of the values and interests that are more ambiguously communicated by the mental health mandate.

With the loss they experienced in bargaining and negotiating with agents in positions of formal authority, the frontline mental health staff in the example above, affected by the frequent closure of the activities areas, faced a new conflict among themselves:

“We were this group of people working our butts off doing substantive work, writing the reports, giving the treatment programs, interested in each other. We were all interested in each other’s problems. If something happened in Programs and they were taking away a staff member, we wanted to support them and we were vocal… When we started losing [correctional officers] in the activity areas it started up a little fight. Who should get the [correctional officer]? Who has the most vocal voice upstairs? Which manager can more strongly argue that we should keep an area open versus another area? Who gets the privilege of being open? Who is doing the most meaningful work? Who should get the better resources? And there started to be a sense of resentment.”
These two groups of agents found themselves in a ‘mixed-motive’ situation. They held compatible goals for mental health service provision, which provided incentive for them to cooperate with one another in achieving those goals. However, their physical location within different activity areas of the facility provided them with incentive to compete against one another. As these two groups of agents looked to their immediate supervisors to provide leadership in addressing this situation, the perceptions that managers do not have the leadership skills to achieve sustainable change was reinforced: “Management did not take the bull by the horns in that situation. [The supervisors] were very, very passive in that process... if there is in-fighting between departments, that’s something that is a very big sign of poor management.”

Left to their own devices, the nature of interactions between the two groups of agents became less and less compatible with the goals and priorities of mental health care:

“So, at this point, it was access to resources, it was the prioritization, it was the dog-eat-dog, the management distancing themselves and not really being involved. And when they were involved they were pretty lethargic about it. Well meaning, but lethargic. And then you get the order of the jungle because now, who’s going to get that pen? Who is going to get the paper? Who gets to go to that conference? And if you go to the conference, well, ‘damn them’ right? And so the law of the jungle happened – lack of structure, lack of direction.”

The range of interactions for actively trying to exert influence within ‘the law of the jungle’ began to include interpersonal hostilities as deliberate tactics to gain control over the limited resources. One staff member spoke about the lasting effects of these types of interactions: “There were some significant hurtful situations to myself in particular that remain unresolved. There were accusations made and I understand... but it was really unhealthy. Really unhealthy... I will not go to [that area] because the situations have not
been resolved and I do not want to be accused of something without an opportunity to resolve it.” The limited gains in holding onto the resources they still had were made at the expense of teamwork and created a hostile working environment for agents on both sides of the conflict.

The use of incivility and bullying is not uncommon in health care workplaces (diMartino, 2003). This type of interaction for gaining and exerting influence in the bargaining process emerges in situations where power-interest structures and relationships are not compatible with policy goals. The following example demonstrates the use of interpersonal hostility by an agent with ‘authority’ to control and coerce the behaviours of an agent on the frontline of mental health service delivery:

“I had a group running and the groups were videotaped. I reviewed the tape at the end of the day just to sort of see how things went. At one point when I was not in the room two of the guys in the group were conversing, it sounded like they were making a drug deal. The terminology was not familiar to me but it was so odd. So I contacted the then Unit Manager who listened to the tape and said ‘Oh yes, they’re referring to heroine and they’re planning to get it from [the maximum security prison]. I said ‘Okay, well there’s your information, I’m passing this information on to you to deal with it’. I was told that I had to charge the offenders and I refused because the integrity of my group was at stake. I was providing security with information and I felt I was doing my job. You know, I’m not a security officer but I am very much responsible for the safety of others. Upon my refusal, the Deputy Warden at that time gave me a direct order to submit the charge. Well, I didn’t. I contacted the union to see where I stood and the recommendation was that I submit the charge because I had been given a direct order... I submitted the charge with this sort of disclaimer that I had been given a direct order to submit this charge but that was not satisfactory. I was given another direct order and was told how to write the report, which I did with one condition that the offence not be handed to the inmate until I had spoken to him. My wishes were not respected. It put me in a very, very unsafe position within my group... This individual, while in a social setting at a local bar, [he] threatened me, to make my life a living hell if I didn’t comply with it.”

Through this conflict, the nature of the interaction exhibited by the agent with ‘authority’ compromised, not only the legitimate activity of providing care, but also the
personal safety of the agent on the frontline of service delivery. With the correctional values of ‘hierarchical decision making’ dominating decisions regarding mental health care, the feeling among mental health staff of having limited influence in decision making is reinforced. The incompatibility of ideas and values for providing mental health care within these asymmetrical power relations leaves frontline mental health staff facing great uncertainty around the possible outcomes from their efforts to further the interests of the mental health mandate.

9.4 Tracing Social Connections in the Politics of Planning

The process of bargaining and negotiating to advance the values and interests of mental health care is seen at the managerial level of the prison-hospital. Throughout the 1990’s, much attention was paid to increasing and improving mental health care at the prison-hospital through investments in the facility to increase capacity for providing mental health services, the drive to achieve a stronger voice for mental health at the regional management table by becoming a stand-alone facility, and engaging in health services accreditation processes to ensure professional standards of care were being implemented. However, without an organizational vision for mental health care, the mental health mandate remains vulnerable to the dominant values and interests of the correctional mandate during bargaining and negotiation processes.

As policy is developed at higher organizational levels, the values and interests of the correctional mandate are built into the policy message. As a result, a political strategy is necessary to improve the chances of advancing the values and interests of mental health care before policy is implemented at the frontline. The everyday work activities of
the Executive Director of the prison-hospital have become primarily “dealing with kind of global issues. Whereas the director of operations, I let her basically run the institution and that allows me to fight with and to deal with the bigger picture things... because if I get mired in all the everyday nuts and bolts then I don’t have time to fight for the overall good of this [prison-hospital], for its future right” . These bargaining and negotiation processes are also characterized by asymmetrical power relations that give dominance to correctional values and priorities.

The actions and activities of institutional managers are concerted by translocal processes of governance. In this system of hierarchical decision making, institutional managers rely on regional and national managers, with higher levels of the authority, knowing how to respond to policies affecting the mental health mandate. Some regional and national managers choose not to deal with issues related to the mental health mandate of the prison-hospital, which vacates the negotiated order for gaining and exerting influence when conflicts arise. In the short term, this can leave institutional managers at a disadvantage in the bargaining process: “I don’t know who to deal with on this stuff because nobody will make decisions on this. It’s crazy! [The national manager] will talk to me about this, but he won’t talk to me about that. He will only talk about operations; he won’t talk about this mental health side.”

The social relations that extend between agents, at different hierarchical levels and located at different sites, are constituted primarily by email and telephone interactions. Email, in particular, is frequently used as a tool in the bargaining process. It provides opportunities for a multiplicity of agents at various sites to read and respond to the issues and concerns of others: “As soon as you get an email it generates a whole
bunch more. I proposed [this]... [he] came back to me... I respond to him... at that point I didn’t respond to [her]... I went back to him... based on this I responded to her... then I go back, back to her, and things like this, it goes and goes... it’s like the energizer bunny.” However, the distance afforded by technologies allows agents at other sites to use avoidance as a tool in the bargaining process: “I might as well be talking to a frigging wall. He’s had zero contact with the [prison-hospital] heads since he replaced [the director of mental health services] last December. He doesn’t even answer emails or phone calls, so that’s a lost cause... but, anyway, that’s the world of corrections and mental health.” Both of these tactics are used for exerting influence in the bargaining process to protect the functional autonomy of each of the agents involved.

When the commonly used strategies and tactics for exerting influence compromise the priorities of the prison-hospital, institutional managers recreate the negotiated order of the bargaining process to advance the values and interests of the mental health mandate of the prison-hospital: “So I went to see the [Deputy Commissioner] yesterday and I gave her that. I didn’t email it to her in advance because she would have sent it to some of her staff who don’t necessarily support my [proposal], (not to mention names).... I got her to support my [proposal] and she can go to EXCOM to fight for us, which she will.” Within this re-negotiated order there are changes to the nature of interactions considered legitimate for exerting influence also change. The following example illustrates how aggressive interactions were used to avoid experiencing a loss for mental health care in the bargaining process: “We put forth three options last fall, you know, Cadillac, Chevy, and status quo – which is the poverty option. Then they came back in December and said ‘Well, we don’t think those options will fly.
We have two options, which is status quo and cuts. So we all screamed bloody murder and never heard any more about it, so we don’t know what happened.”

However, these tactics appear to be chosen with greater consideration for the possible personal losses that agents could experience. “When you are closer to retirement, what the hell are they going to do to you? I’m not looking to climb the corporate ladder. A younger person wouldn’t do those kinds of things because their career would get chopped off at the knees. It’s hard to climb the corporate ladder when you don’t have legs to stand on.”

9.5 Displaying Ideologies in the Politics of Planning

Frontline staff attach value to the outcomes of bargaining and negotiation processes. The dominance of correctional values and interests resulted in significant losses to the mental health mandate at the prison-hospital that were experienced by frontline mental health staff as a de-valuing of, not just their day-to-day work, but of their professional identity and worth. They express a futility in not being able to produce the quality of work they would like to produce because of the ‘operational adjustments’ that limit their ability to ‘provide a continuum of essential care’: “I find the staff here, it’s very difficult for them to get involved in anything that might work towards their betterment. ‘Why should I? It’ll never happen.’ It’s a very defeatist attitude here.”

While some mental health staff respond to repeated losses by ‘giving up’, other staff respond by removing themselves from specific bargaining and negotiation processes in order to minimize their losses. “There’s a difference between scepticism and apathy, and an actual active decision to not continue to do something that’s going to be met with
considerable resistance and lack of any resolution... I do see a significant difference of making that very proactive decision not to take action on something to avoid that.”

The negotiated order of the bargaining and negotiation process establishes what constitutes ‘fair play’ and reflects the values within the institutional discourse. Within the timeframe of this study, a number of strategies and tactics for gaining and exerting influence, including inappropriate joking, snide comments and yelling, mobbing (a number of agents ‘ganging up’ on a particular individual), physical assaults (flicking, ‘purple-nurpling’, punching, and kicking), and sexual assault, were observed as acceptable or legitimate strategies and tactics for exerting influence over others despite national policies on harassment in the workplace that identify “any objectionable act, comment or display that demeans, belittles, or causes personal humiliation or embarrassment, and any act of intimidation or threat” as illegitimate. The following account is an extreme example of strategies used to gain influence that can be exerted when conflict arises at a later date, and demonstrates the staff’s uncertainty about the rules of ‘fair play’:

“Today in the nursing station, several frontline agents (both correctional and mental health) were engaged in inappropriate sexual joking. There was one mental health staff not engaged in the joking who was going about his work activities. Within the context of the sexual joking, a correctional officer grabbed the mental health staff who was not involved in the joking. The mental health staff clearly stated ‘do not touch me’ and moved away from the correctional officer, however the correctional officer followed the mental health staff and grabbed him again in a sexually explicit manner. All of the frontline agents in the nursing station continued laughing and joking. A few minutes later the mental health staff who had been targeted left the unit with me to attend a meeting elsewhere. Once we were alone, he asked me “Would that count as harassment?”

While the severity of the interaction is quite rare, the frontline agents in the example above demonstrated a lack of recognition or acknowledgement, or expressed
uncertainty, about the nature of the interaction qualifying as a form of interpersonal hostility or an illegitimate tactic for gaining or exerting influence. Yet legitimate strategies and tactics employed to exert influence in situations of conflict are readily counted as forms of harassment. The frequent turnover of managers at the prison-hospital and their inability to deal with long-standing issues have left frontline staff to determine the rules of ‘fair play’ on their own: “It’s not harassing to ask someone ‘would you do this admission please’. It’s not harassment to phone somebody about their sick time when they’ve booked off the last 30 days. There have been a lot of misconceptions around what constitutes harassment. So, that’s what the focus is right now, to make it very clear to everybody what the standard is, where the line is, and what will be tolerated and what won’t be.”

As the ‘rules of play’ were negotiated in favour of correctional values and interests, and illegitimate strategies and tactics became legitimized within the rules of ‘fair play’, mental health staff have been harmed at the core of their professional identity and have lost a sense of their own professional worth within the prison-hospital environment: “The people who have the ability to be real positive were making a real effort. And then you get another dip and you come back to ghost town. I was away for a few weeks… but I’ve come back to ghost town. I’ve come back to a place where I still see some of the nice people. Some people I’ve known for years, I say ‘hi’ and they look like ghosts – particularly the nurses.”

A number of mental health agents spoke of their own personal strategies for remaining professionally healthy. There are those agents who ‘give up’: “I’m going to be healthy by just not getting involved. I’ll do my work, I’ll go to meetings, but I’m not going
to put my heart and soul into anything anymore because I can’t do that and get out of here in a healthy way.” IM3 And there are those who renew their skills and energies in other work environments: “We have three of us who go to work at [the local psychiatric hospital] and we take advantage of the training there. That’s part of the reason I do it. Over there I get free training and access to those resources.” IM2

One idea that is catching the attention of more and more agents in the prison-hospital is the mantra “expect nothing”.

“It’s a kind of zen type expression, that if you expect nothing, and go through life expecting nothing then, it’s almost a paradox, then things will come to you... So if you have the idea to expect nothing, you do things because it’s the right thing to do. Because you want to do it. Because it helps other people. You have reasons but you don’t have an expectation that ‘I’m going to get this or I’m going to get that’. Then life just works out much, much better.” IM9

9.6 Summary

Political strategies to advance the mental health mandate of the prison-hospital have been constrained and defeated by the correctional values dominating organizational policy structures. Asymmetrical power relations within the prison-hospital have left mental health agents with little influence in bargaining and negotiation processes for day-to-day decision making. Without a vision for mental health care expectations for compromise in bargaining and negotiation processes in the prison-hospital have been thwarted as the mental health mandate, and the individual agents responsible for carrying it out, experienced repeated losses over a significant period of time.
CHAPTER 10
A ZERO-SUM GAME

10.1 Introduction

Chapters 5 through 9 analyzed the policy message, multiplicity of agents, multiplicity of perspectives and ideologies, resources, and politics of planning that are key elements of the process of implementing policies. Each chapter reveals how efforts to advance mental health care in the prison-hospital are continually subordinated to correctional and security priorities. This chapter presents a synthesis of the analysis from the view that the implementation of organizational policies within the prison-hospital is a ‘zero-sum game’. This ‘game’ illustrates the how gains for the dominant correctional mandate mean losses for the subordinate mental health mandate. This type of zero sum power game, where gains in one area mean losses in another, is not unique to the prison-hospital and its dual mandates for custody and care. It is also identified and described in other institutions in areas such as interventions for infectious diseases in developing countries where gains for wealthy nations and corporations have meant losses for developing nations (Folch, Hernandez, Barragan & Franco-Paredes, 2003), state funding for public education where budgetary gains for public school education has meant budgetary losses for public higher education (Rizzo, 2004), and cost and quality of health care services where gains for insurers and employers by shifting costs to patients have meant losses for patients from growing personal costs for services and decreased quality of care (Porter & Teisburg, 2004).
The zero sum game at the prison-hospital is mediated by the policy texts that connect frontline staff with policy makers and decision makers in other localities who all handle, interpret, and act upon these texts from their own social and historical location. The ‘rules of play’, or conditions that determine who wins and loses, are laid out and the rules of ‘fair play’, the boundaries for legitimate or illegitimate strategies and tactics within the game, are established. In the end, there is no uncertainty about the outcomes. As policy texts have concerted and coordinated the everyday activities of frontline staff in predictable ways, gains for the correctional and security priorities of the prison-hospital have meant significant and repeated losses for mental health care.

10.2 The Mediating Power of Policy Texts

Language carries the power to inform, know and understand various perspectives and ideologies. “Far more than ‘jargon’, these are conceptual systems, forms of knowledge that carry institutional purposes and reflect a standpoint in the relations of ruling” (McCoy, 2006, p.118). Correctional policy texts provide a conceptual system of knowledge that produces power in the social relations that move the correctional mandate along so inevitably. The dominance of this correctional conceptual system is amplified by the lack of a comparable conceptual system of vision for the mental health mandate within the organization’s policy structure. Policies are understood to be a central part of the social organization of the prison-hospital and, as such, they exert a power generated through the concerting and mobilization of agents’ work. As agents in different locations of the Correctional Service of Canada handle, interpret, and act on the same policy texts,
those policies have the power to coordinate and arrange how agents interact with one another in pre-determined ways.

The specificity of correctional policy structures that provides clear directions regarding the goals of the policies and actions for meeting those goals removes the potential for autonomous decision making in conflict situations. Everyday activities show how the process of implementing these highly prescriptive correctional policies undermines interpretive processes that might enhance mental health service delivery within the prison-hospital. Interpretation of policies in determining appropriate access to mental health services is undermined by the operational requirements for controlling inmate movement. Although mental health staff may assess patients’ mental health status and determine their level of access to services throughout the institution, it is the correctional processes for controlling inmate movement that activate actual participation in mental health services.

Asymmetrical power relations produced by the dominance of correctional values and interest within the organizational policy structures subordinates the mental health mandate and coordinates the activities of mental health staff in ways beyond their own motivations and control. Mental health staff find themselves doing clerical duties when human resources are insufficient, extending the duration of programs beyond professional standards in response to operational adjustments, and choosing not to get involved in bargaining processes that directly affect mental health service delivery in order to protect their functional autonomy and minimize losses to the mental health mandate. The degree of specificity in correctional policies legitimizes the ideas and values of the correctional
mandate while the ambiguity of mental health policies prevents a clear direction for enacting the mental health mandate.

10.3 Strategies and Tactics for Exerting Influence

Understanding that policy is an authoritative allocation of values, questions arise about whose values are being legitimized, as well as what values are absent from existing policies and through what processes. Specific accountabilities for meeting the operational requirements of a prison-hospital promote the ideas and values inherent in these requirements. Organizational pressures to meet these requirements create a sense of urgency and adjustments are made to ensure that these requirements are met. Without a comparable set of operational requirements for a prison-hospital, a similar sense of urgency does not arise and operational adjustments are made at the expense of mental health care.

A range of interactions within bargaining and negotiation processes are used by all staff to influence the actions of others in order further their own goals and interests. Interactions for furthering the goals and interests of the correctional mandate are supported by hierarchical decision making processes, which allow managers to direct frontline staff to participate in particular actions and activities. The manner in which those in positions of authority wield the power that ‘authority’ affords them weakens links in the complex chains of reciprocal interaction required to carry out the mental health mandate of the prison-hospital. The nature of these interactions exercised by
institutional managers, while consistent with the values of hierarchical authority within the correctional mandate, are not consistent with the values of multi-disciplinary teamwork and collaboration within the mental health mandate. Subordination of mental health care occurs when those who hold authority ‘limit the power’ of mental health staff to interpret policies and make decisions about the delivery of mental health services and affords those in positions of authority a significant degree of control over the behaviours of mental health staff.

The legitimization of values that emphasize operational requirements over care responsibilities make mental health resources vulnerable to the operational requirements for working within limited resources. The authority held by managers to make operational adjustments is sufficient to achieve their goals for remaining within the allocated budget of the prison-hospital. However, this gain for correctional operations means significant losses for mental health care since the adjustments result in decreased access to and provision of services as well as losses in human resources when departing mental health staff are not replaced. The dominant correctional perspectives on what resources are needed to operate the prison-hospital are inconsistent with subordinate perspectives on what resources are needed to provide mental health care. The resulting power dependence creates a flow of resources from mental health care to meet the more immediate needs of the prison-hospital.

The use of formal authority to meet the valued correctional goals makes mental health care vulnerable to the pressures and priorities of the correctional mandate. Mental health staff are compelled to use strategies and tactics to protect their functional and
organizational autonomy. When mental health staff view the nature of interactions by those in positions of authority as illegitimate, or outside the parameters of ‘fair play’, frontline mental health staff ‘give up’ or actively decide to not get involved in implementation processes outside of their usual everyday activities. These strategies are employed by mental health staff to minimize the losses to the mental health mandate when the inevitability of a correctional ‘win’ is clear.

10.4 Outcomes for Mental Health Care

If policy implementation is viewed as a zero-sum game, determining who wins and who loses in any given situation, then the analysis presented in chapters 5 through 9 demonstrates that, between the mental health and correctional mandates of the prison-hospital, mental health loses almost every time. Repeated losses over the period of the decline have reinforced the dominance of the correctional mandate and subordination of the mental health mandate. These losses include:

Workplace environment: A sense has developed among mental health staff about the value placed on mental health work. Those that receive the resources to do their job are seen as more valued, that the work in correctional operations is considered more meaningful because resources are found to ensure that their work carries on. As resources have increasingly gone to correctional and security priorities while resources diminish for mental health care, mental health staff have experienced loss at the core of their professional identity. Rather than feeling interested and invested in their work, they feel
helpless, hopeless, apathetic, sceptical, and demoralized. Interactions between staff that convey disrespect, devaluation, intimidation, and hostility have become accepted as an inevitable part of the environmental context.

**Deterioration of resources:** The loss of nursing management positions, not replacing mental health staff who leave their positions at the prison-hospital, and not having sufficient and consistent support staff for clerical and administrative work are felt most profoundly. There is less direct patient contact resulting from decreased mental health staff, closure of activity areas that limit access to many remaining mental health staff and services, and the dominance of correctional operations that constrain the everyday work activities of mental health staff. The common view is that the prison-hospital has now deteriorated to being just housing rather than a place of treatment.

Many mental health staff have chosen to limit their participation in the advancement of mental health care in order to minimize their losses. In doing so, the prison-hospital has lost the valuable source of knowledge about mental health care and service delivery that only staff with mental health training can bring. In this fashion, the dominance of correctional values and interests has coerced mental health staff to recreate the asymmetrical power relations of the correctional mandate beyond their own motivations and intentions.

**Decreased quality of care:** Without an appreciation for the ideas and values that drive delivery of mental health services and a clearly formulated plan that communicates the mental health mandate the focus remains on the ‘crisis of the moment’. The losses sustained to the mental health mandate by the focus on immediate correctional concerns,
are evident in the limited access to mental health services and the associated deteriorating quality of services. Insufficient human resources, closure of activity areas where many mental health services are delivered, and lack of training opportunities for mental health staff create a lack of capacity to provide basic standards of care, never mind current evidence-informed practices.

**Lack of quality improvement:** Losses for mental health care are also evident in the limited quality improvement processes and the many recommendations for improving mental health care that never seem to be implemented. There are some formal efforts to identify areas for improvement in the provision of services at the prison-hospital; however, the same recommendations are made over and over again in accreditation survey reports, health services audits, prison-hospital reviews, etc. while managers focus on more immediate contextual factors.

### 10.5 Summary

The dominance of correctional values and interests over those of mental health care within the organizing policy structures of the prison-hospital demonstrates both a lack of appreciation for the breadth and complexity of mental health care and a lack of commitment to it. Throughout the period of decline, mental health care has sustained numerous losses that has limited the provision of mental health services and compromised the quality of those services. The dominance of the correctional mandate has placed the mental health mandate in an ongoing position of vulnerability where
mental health staff act to minimize their losses rather than to advance the interests of mental health care.
CHAPTER 11
THE STARS ARE ALIGNING FOR MENTAL HEALTH:
WINDOWS OF OPPORTUNITY

11.1 Introduction

I use this final chapter, first, to reflect on my experience of conducting the study. Then I take a brief look at where mental health care is headed within the Correctional Service of Canada and summarize opportunities for advancing mental health care at the prison-hospital in relation to new organizational policy structures. Finally, I consider opportunities for future research that will build upon the current study and examine the implementation of subsequent organizational changes.

11.2 Reflecting on the Study

This has been a challenging study but one that has been intriguing and stimulating throughout the five years it has taken, from the first introduction of the premise to prison-hospital staff to completion of the written analysis. The challenge has been in finding a structure for writing the analysis. When I first learned about institutional ethnography, its standpoint in the material world of everyday experience seemed a natural fit with my desire to examine the day-to-day implementation of policies within the prison-hospital. Institutional ethnography, like policy implementation, focuses on how the actualities of everyday work are systematically put together. Both analyze the ways that texts (policies) coordinate and arrange actions and activities at various levels or localities of an institution.
However, having knowledge of the theory and method of institutional ethnography has not made it easy to write. Part of the challenge was my personal experience and connection with the institution I was studying. My familiarity with the prison-hospital, and the Correctional Service of Canada, as an ordinary participant in the provision of mental health care required that I conscientiously attend to the complexity and disorder of everyday life that had become so second nature to me. Fieldnotes were filled with conversation and action that seemed disconnected or incoherent such as a nurse counting the pieces of fruit on the meal cart. It took a great deal of time reading and reflecting on the data before I began to see how counting the pieces of fruit on the meal cart displays connections between diverse work processes. In checking the meal carts, frontline staff are displaying how everyday activities are connected to the institutional process of sharing services as part of a clustered site: frontline staff check that the prison-hospital is ‘getting the attention it requires’ from a service over which they ‘have no control’. Other staff negotiating with the same service ‘depend on the goodwill’ of staff who have control over those resources, while others employ strategies and tactics for ‘exerting influence’ to acquire related resources (heated meal carts) in order to protect the functional and organizational autonomy of the prison-hospital. On reflection, I realized that these seemingly independent actions of individuals in different locations are concerted and coordinated purposefully to share services as part of a clustered site. I also began to realize that counting the pieces of fruit on the meal cart provided a concrete example of a real, material practice in which the work of frontline staff is shaped by linkages between everyday life and the translocal processes of administration and governance.
I had developed the general argument of the thesis after a few months of analysis, but struggled to find a sense of the kind of analysis required. I worked through writing several convoluted drafts during the first year of analysis until I read the dissertation of Elizabeth Townsend (1994). Dr. Townsend’s strategy of creating a conceptual framework for analyzing the mental health work of occupational therapists prompted me to consider using an extant policy implementation framework for organizing my own analysis of the work of frontline staff at the prison-hospital. Once this structure was incorporated, the analytical work of writing and re-writing was rigorous but materialized more smoothly. The challenge over the last two years has been in separating various aspects of the analysis into separate chapters while explicating their interaction.

Another challenge was to keep out any sense of personal responsibility or ‘blame’ for outcomes that could be defined as ‘implementation failure’. Writing about tensions was balanced with the perspective that unfavourable outcomes are not the result of ‘difficult people behaving badly’ or ‘people not knowing or understanding their work’. Instead, they are the product of organizational policy structures that produce a generalized way of doing things regardless of individual or circumstantial differences. Some staff of the Correctional Service of Canada, both frontline staff and managers, will be uncomfortable with, and possibly resistant to, the analysis but most of those I have talked with say that it accurately depicts their own experiences.

This study offers an analysis which, hopefully, presents a direction for practical change in the provision of mental health care within Canada’s federal correctional system. The theory and method of institutional ethnography, as well as the theory of policy implementation, points to the ways that everyday activities are connected into the
extended social relations of ruling and economy and their intersections. This study illuminates the lack of vision for mental health care and its impact on the social organization of mental health care at the prison-hospital. However, I am optimistic about the potential for change. My sense of hope comes, in part, from the organizational changes to mental health care that are on the horizon for the Correctional Service of Canada. Primarily though, my sense of hope is rooted in the level of commitment demonstrated by the frontline staff of the prison-hospital and the energy and passion they have for advancing mental health practice that continues to roil just below the surface.

11.3 The Stars are Aligning for Mental Health

Once again, the prison-hospital has reached a critical turning point that is generating a new sense of hope for mental health care among frontline staff and managers at all levels of the organization. The growing potential for advancing the mental health mandate of the prison-hospital is readily acknowledged by many staff: “I think you’ve always got windows of opportunity and I think the stars are aligning for mental health.” The prison-hospital is facing significant policy changes that will again have a profound impact on the day-to-day work practices of the frontline staff at the prison-hospital. The shortcomings of the unit management model have been recognized and it is being replaced with a new organizational governance structure that includes a sub-structure specific to the prison-hospitals. This governance structure rebuilds the nursing middle management positions to be comparable with the correctional management structure, ensures a permanent position for a continuous quality improvement coordinator who will focus on mental health service delivery and the recommendations from health
services accreditation surveys, and aims to draw frontline correctional staff into a more collaborative relationship with frontline mental health staff. There is a new organizational mental health strategy with funds dedicated to both institutional and community initiatives, which will create mental health services in regular prisons and community parole offices. These services are designed to facilitate transitions for offenders being admitted to and discharged from the prison-hospitals. There is also a proposal to build a new facility for the prison-hospital is going forward as an organizational priority. While such a proposal takes years to come to completion, it demonstrates a significant commitment within the organization to investing in the prison-hospital and mental health care regionally. These organizational policy changes will affect each of the Correctional Service of Canada’s five prison-hospitals differently based on the unique history and characteristics of the individual institutions. However, just changing policy does not necessarily make change happen.

The unpublished internal review of the organization’s five prison-hospitals, completed in 2004, continues to drive the process for establishing consistency in the organizational structure of the prison-hospitals that emphasizes clinical operations as their primary function. This review provides a framework for a collective understanding of the role of the prison-hospitals in the provision of services to offenders and in providing leadership within the regional and national levels of the organization. However, it is primarily practical in nature, outlining the roles and responsibilities of key groups of agents in mental health service delivery without attention to the day-to-day conflicts that result from trying to balance the mental health and correctional mandates. The incompatible values of these two mandates, and the asymmetrical power relations
that perpetuate the dominance of correctional values and interests, will continue to require the sacrifice of ‘care’ responsibilities for ‘custody’ requirements of the prison-hospital unless both correctional and mental health staff better define the problems they face and work together to develop creative solutions.

This study goes a long way to making clear the challenges faced by the prison-hospital under study, as well as providing insights that may be shared (and taken up) by other prison-hospitals. The issues and concerns explicated in the analysis provide a starting point for discussions between correctional and mental health staff, as well as between frontline staff and managers at all levels of the Correctional Service of Canada. By making clear the current social relations that work to subordinate mental health care, this study creates ‘windows of opportunities’ for all staff recreate the institutional discourse in ways that will better balance the correctional and mental health mandates.

11.4 Opportunities for Advancing Mental Health Care

This empirical analysis provides a kind of ‘map’ for understanding how policy texts organize what is said and done in everyday work processes. By revealing how policy texts shape the implementation processes that have produced the subordination of mental health care, possible opportunities for change can be identified. The five elements of policy implementation, as displayed in chapters 5 through 9, illuminate ‘windows of opportunity’ for advancing the mental health mandate of the prison-hospital by transforming this ‘zero sum game’, where gains in one area mean losses in another, to a ‘positive sum game’, or a ‘win-win’ situation where there is a shared recognition of inter-dependence between the two mandates in order for both to be most effective. It will be
crucial for all staff within the prison-hospital, and at all levels of the organization, to recognize that, if losses are occurring through the subordination of mental health care, there are gains to be had by taking steps to balance power relations by advancing the interests and priorities of mental health care. The suggestions here describe actual activities required to advance the interests and priorities of mental health care in the prison-hospital. Frontline staff will recognize these suggestions for change as ideas that they have discussed among themselves for years. However, the losses that the mental health mandate and mental health staff have sustained over time have led many frontline mental health staff to experience a sense of ‘helplessness’ and ‘hopelessness’ and they have given up on the possibility of bringing about positive change in their workplace. The changes suggested here require that frontline staff regain a sense of personal power for taking a central role in the policy choices and activities that affect them.

There is no single ‘best strategy’ for implementing change; it can be shaped by the unique environmental context of this prison-hospital and drawn from evidence on the most effective means for addressing the policy issues they currently face. The suggested changes propose an action plan, led by frontline staff, directed at changing policy activities that govern mental health care. Implied in these suggestions is a call for frontline staff to motivate one another, to initiate new forms of communication and bargaining that will (re)establish a sense of teamwork and ‘collective agency’. These actions would coordinate and control multiple policy activities so that power is shared between the dual mandates of the prison-hospital rather than being dominated by the correctional mandate. Recently, a series of policy dialogue tools have been presented in the literature to support those who make decisions about health policies and programs
(Lavis, Oxman, Lewin & Fretheim, 2009). While these tools are designed for senior level policy makers, many of them can be also be useful to frontline staff who wish to participate in the policy process.

The SUPPORT tools are relevant to health system stakeholders who want to influence decisions made by policy makers (Lavis, Oxman, Lewin & Fretheim, 2009). In particular, tools for clarifying a problem, framing options to address a problem, and how an option can be implemented are relevant to the opportunities for frontline staff to advance mental health care in the prison-hospital (Fretheim, Munabi-Babigumira, Oxman, Lavis & Lewin, 2009; Lavis, Wilson, Oxman, Grimshaw, Lewin & Fretheim, 2009; Lavis, Wilson, Oxman, Lewin & Fretheim, 2009). These tools consist of a series of questions to guide staff through the policy making process. For example, questions for clarifying a problem include: “What indicators can be used or collected to establish the magnitude of the problem and to measure progress in achieving it?” and “How can a problem be framed (or described) in a way that will motivate different groups?” (Lavis, Wilson, Oxman, Lewin & Fretheim, 2009, p.4). While, this study has made clear a number of challenges, or problems, faced by the frontline staff at the prison-hospital, these clarifying questions are designed to focus discussions on the need for and use of research evidence.

Subsequent tools present questions to guide the identification of options for addressing the problem, identifying both the benefits and harms important to those engaged who will need to carryout the option, as well as related costs and cost effectiveness (Lavis, Wilson, Oxman, Grimshaw, Lewin & Fretheim, 2009). This is followed by questions that consider potential barriers to implementing the options,
strategies to facilitate change among clients, frontline staff, and organizational managers (Fretheim, Munabi-Babigumira, Oxman, Lavis & Lewin, 2009). However, these tools are only useful if staff are willing to sit together and thoughtfully consider the problems they face and work together to consider options and make strategic plans for addressing these problems.

Opportunities are identified for mental health staff to participate in the policy process in ways that will bring about positive change in their own work environment. These opportunities manifest in a) the knowledge frontline staff have of how to use and respond to the use of policies in ways that will advance mental health care, b) the use of ethical standards to identify and employ legitimate strategies and tactics in bargaining and negotiation processes, and c) the renegotiation of conditions that determine ‘wins’ or ‘losses’ for mental health care within the correctional context.

11.4.1 Using and Responding to the Use of Policies

The Correctional Service of Canada’s mission statement (CSC, 2004) states that correctional control should work in support of reintegration efforts – efforts which can be interpreted to include the provision of mental health services. An ambiguous mental health policy message leaves enormous scope for individuals to advance the values and interests of mental health care as they maneuver and negotiate to interpret policy goals and make decisions about how to carry out that interpretation. There is the potential to be flexible and adapt to changes in the mental health professions and the field of knowledge, leaving room for mental health staff to learn what practices will be most effective within the prison-hospital environment through implementation. This process of interpretation is
dependent on staff’s knowledge of how to use the ambiguous mental health policy
structure in conjunction with the more specific correctional policies. Implementation
activities develop and evolve based on this knowledge.

Advancements for mental health care can occur when frontline staff interpret the
more detailed correctional policies as opportunities for delivery of mental health services.
As staff interpret policies in ways that will advance mental health care in the prison-
hospital, they will be able to balance their own goals and priorities with those of
correctional staff. The complexity of the Correctional Service of Canada’s mission and
strategic objectives needs to be openly acknowledged and overtly addressed in bargaining
and negotiation processes. It is when mental health and correctional staff try to
understand each other’s perspectives and support each other in their decisions that the
values and interests of mental health care can be advanced and power relations between
the two mandates can become more balanced. Disparate views on the goals of a policy do
not prevent agreement on actions in specific situations but may require a different
approach to decision making. The flexibility that comes with an ambiguous policy
message enables groups of staff with different professional training and backgrounds to
consider each other’s perspectives on what ‘should’ be done and to exercise discretion in
determining what ‘could’ be done to shift the balance of power in favour of mental health
care.

Opportunities for advancing mental health care emerge when mental health staff
and correctional staff work together to interpret policy and determine the best means of
carrying out policy goals. There needs to be time and opportunity for all staff involved to
consider how they might respond to various strategies for implementing policies in a way
that will ensure integration of correctional and mental health activities. Individual roles within such a plan of action can be understood as ‘links’ in a chain of reciprocal interaction all bent to a particular purpose that is consistent with the mental health mandate (Hambleton, 1983). Consistent with Lin’s (2000) work on policy implementation and prison reform, organizational policy structures and the prison-hospital environment can be shaped by both correctional and mental health staff, frontline staff and managers, participating in a series of related tasks all bent toward to the purpose of providing mental health care.

The use of resources is a critical area of focus for advancing the mental health mandate of the prison-hospital. The responsibilities for allocating and distributing resources lie with those in positions of formal authority, thereby becoming a critical link in the chains of reciprocal interaction. Opportunities exist for managers to facilitate the development of an operational model that will maximize the effective and efficient use of available resources, and to use the parameters of the envelope system to reflect where the actual budget pressures are. Funds allocated to mental health care need to be protected so that mental health expenditures will not be allowed to wane in order to balance the rising costs for correctional over-time and correctional costs can be balanced within the appropriate envelopes.

Opportunities to advance the mental health mandate of the prison-hospital would include bringing forward the language and conceptual system of mental health care and information on the values, interests and priorities of mental health care in training materials for new staff.
11.4.2 Accountability for Ethical Conduct

Efforts to balance the dual mandates of the prison-hospital will be dependent on a willingness to shape the local institutional context to share power, rather than exerting control by gaining and wielding power over one another. This is done “through collaboration, the process of working with others in interdependent relations characterized by reciprocity and mutuality; giving and taking, helping and receiving help” (Townsend, 1998, p.68). This will transform decision making processes at the prison-hospital to be horizontal rather than hierarchical, and allow the establishment of ‘collective agency’ among and between different professional groups.

While mental health staff do not typically hold sufficient power to advance mental health care through legitimate bargaining strategies, they do use legitimate tactics to minimize the losses for the mental health mandate such as ‘picking your battles’, which can include avoiding certain areas of the facility, actively choosing to not engage in a particular bargaining process, or expecting nothing in return for your good efforts. Mental health staff also hold the power to employ legitimate strategies to advance mental health care at the prison-hospital. With a growing emphasis on the need for training to increase knowledge about mental health care among correctional staff, there are opportunities for mental health staff to share their knowledge by providing in-service training for all frontline staff and managers on topics related to current policy issues being faced at the prison-hospital.

The range of interactions that staff consider legitimate or acceptable for gaining and exerting influence has developed over time to include incivilities (gossip, social isolation, interruptions) and hostilities (yelling, demeaning, harassment, physical and
sexual assault). However, the losses associated with such behaviours (discussed in section 10.4) emphasize asymmetrical power relations rather than achieving balance through legitimate interactions according to ethical standards that are consistent with the values and goals of the mental health mandate of the prison-hospital (Bardach, 1977; Barrett & Hill, 1984; diMartino, 2003; Namie, 2003). Opportunities to shape interactions according to ethical standards include having a reliable structure for preventing and addressing conflicts at the lowest level possible – training in interpersonal and communication skills (e.g.: conflict resolution, giving and receiving constructive feedback), avenues for seeking and receiving advice (ethics committee), and the building of trust among all staff (including managers) through constructive and timely responses to expressed concerns about unethical practices and interactions.

Personal responsibility for all staff to behave in an ethical manner in all aspects of their work is clearly recognized in a 2005 internal report on ethical standards and practices at the prison-hospital: “The challenge for all staff is to begin the process of change at the individual level; [staff] readily acknowledged that there is a personal responsibility... this is not to say however that people are not looking to the wider organization... and to local managers to respond to their concerns and set a very clear example of behaviours and practices, that by any objective standard, can be considered right”.116

11.4.3 Changing Priorities: Improving Outcomes

One of the best examples of interactions that challenge the established focus on immediate concerns for correctional outcomes is the ‘Thot of the Week’. Each week, the
pastoral care service at the prison-hospital sends out a quote from a published work or notable person by email. The very first ‘thot’ sent out April 25, 1999 came from C. S. Lewis’ ‘God in the Dock’ – “You can’t get second things by putting them first; you can get second things only by putting first things first.” D26

As the new process of organizational change takes place, mental health staff have the opportunity to modify the institutional discourse by integrating the conceptual system of mental health care learned through their professional training. Clearly defining the values that provide a basis for policies and programs specific to the prison-hospital will be an important first step in reducing the negative effects of conflicts that arise from trying to balance two very disparate ideological frameworks into a single environment. A key area of uncertainty is in the definition (or lack of definition) regarding what constitutes ‘non-essential’ mental health services. Staff at the prison-hospital, while not necessarily submitting revisions for the national mental health services policy, have the opportunity to take a leadership role in their region to (re)define this area of policy using mental health language and concepts as a tool for communicating the values and interests of mental health care.

When staff from different professional groups begin to appreciate each other’s professional ideas and values, there are opportunities to be creative in determining the best use of available resources for advancing mental health care. Frontline staff and managers can develop operational models unique to the environmental context of the prison-hospital that use the available resources in the most efficient and effective way.

A sense of responsibility and ownership comes with the recognition that different groups of staff, by means of their professional training and knowledge of the mental
health field, have better information about the best ways to meet policy goals and opportunities are created to apply that knowledge.

11.5 Limitations of the Study

This study does not examine all aspects of policy implementation at the prison-hospital, nor does it examine all of the texts that mediate the social organization of mental health care within the prison-hospital or throughout the Correctional Service of Canada. It is not the intention of institutional ethnography to exhaustively map out a particular institution, rather it is to trace a single thread through analytic processes that show how work activities are coordinated, typically through texts and discourses of various sorts (Devault, 2006). While this study focuses quite specifically on how mental health work of frontline staff are coordinated by policy texts, there remains a great number of other ‘threads’ left unexamined that could enrich our understanding of discourses within the prison-hospital and, indeed, throughout the Correctional Service of Canada. The core tension between custody and care actually has a broader impact than just the provision of mental health care. Within the data collected for this study were a number of examples of physical health care also being subverted by operational priorities and adjustments. Of particular note were a few patients who had been waiting so long to see a dentist that they started pulling their own teeth to ease the pain, a patient with broken teeth whose face swelled up and turned purple and still had to wait two weeks for a security escort to a dentist appointment, and a patient who developed cellulitis after a security escort was not available to take him to the community hospital to have a leg injury examined.
This study, while not allowing for absolute generalizability of the findings, does provide insights that other prison-hospitals and forensic psychiatric units may recognize and relate to their own experiences of balancing both care and custody for incarcerated offenders with mental health disorders or hospitalized patients in secure forensic psychiatric units. More broadly, lessons learned in this study about the elements of policy implementation— the impact of specificity and ambiguity in a policy message, interpretation of policies by a multiplicity of agents in different social locations within an institution, values and ideals embedded in policy structures, power dependence and interdependence between resource priorities, and the processes of bargaining and negotiation that are part of an everyday way of living and working – explicate the production of tensions, as well as experiences of power and oppression, that frontline staff in variety of contexts can identify with.

Finally, the opportunities for advancing mental health care are specific to the prison-hospital under study and may not be readily applied within a different environmental context. However, it is hoped that this study has raised our consciousness about forms of oppression within prison-hospitals and provided a method for others to gain insight into the social organization that shapes their everyday world.

### 11.6 Future Directions

This study has presented a critical analysis of the subordination of mental health care as it has developed over a period of about 15 years. With significant organizational policy changes on the horizon once again, questions arise about how these changes will impact the provision of mental health services throughout the Correctional Service of
Canada. Of particular concern are the dynamics of power and oppression arising within the unique environmental context of the prison-hospital.

11.6.1 Dissemination of Findings

While dissemination of findings from this study will be done through professional presentations and peer-reviewed publications, the findings will first be presented to the frontline staff of the prison-hospital whose standpoint is presented herein. Other opportunities to present the findings to key groups within the Correctional Service of Canada, including the Executive Directors of all five prison-hospitals, will be sought. These opportunities for knowledge exchange will focus on illuminating the experiences of frontline staff and the interaction of all organizational policy structures that influence the day-to-day actions and activities of frontline staff in providing mental health care.

These findings will be taken to broader criminal justice communities of practice through mental health training sessions for new police recruits, special interest groups on mental health courts that include judges, lawyers, and mental health professionals, as well as special interest groups of mental health professionals who provide forensic services in psychiatric facilities. These groups will be engaged in discussions about specific aspects of the findings in order to provoke and promote thoughtful reflection and consideration of the tensions evident when attempting to merge or balance criminal justice perspectives with mental health needs.
11.6.2 Opportunities for Future Research

A single study can typically only trace a specific thread through institutional processes. Separate research projects can, in a sense, chart different regions of the same terrain. While this study focused on the organizing power of policy texts, there are many other forms of texts used in the day-to-day activities of frontline staff at this, and other prison-hospitals – e-mails, clinical documentation, correctional reports, kardex systems, pick-up lists, team meeting and committee minutes, and the list goes on. These, too, play a significant role in constructing the institutional discourse and are worthy of examination and explication. Clusters of related studies examining other means of social organizing mental health care in the prison-hospital, and parallel studies of different institutional complexes such ‘correctional rehabilitation’ or ‘sentence management’, would reveal the meta-discourses that reach across mandates and arenas.

As the Correctional Service of Canada implements a new era of organizational change, this time including mental health at the outset, the kinds of activities that bring changes in ‘consensus discourses’ from one era to the next are of particular interest. Surveying and collecting opinions and perspectives about the impact of organizational changes on the provision of mental health services from staff in many different social locations within the Correctional Service of Canada would allow groups of individuals, as a collective, to address the complex issues inherent in trying to balance correctional and mental health mandates.
11.7 Final Comments

Often, tensions experienced by frontline staff are assumed to be the result of ‘difficult people behaving badly’ or ‘not knowing or understanding their job’. This study supports the premise that, in fact, these tensions reflect systematically organized ways of doing things within the organizational context. Without the values and objectives of mental health care being integrated into organizing policy structures, the social relations of everyday life are systematically organized to carry out purposes that do not fit with their own vision for mental health care.

It is important to consider that failures of the prison-hospital’s mental health mandate are not necessarily the result of the structure of mental health policies but result from the interaction of all organizational policy structures that operate within and influence the day-to-day activities of the prison-hospital. Lessons learned from this study include the conclusion that the causes of decline lay outside the relatively small areas upon which mental health policies are focused.

There is recognition that the recent gains made for health care, including mental health care, throughout the organization resulted from the efforts of health care professionals in positions of formal authority. Frontline mental health staff, if they are willing to step forward, also have opportunities to influence the shape of things to come at the prison-hospital: “[The Director General of Health Care] has raised the bar within corrections in regards to health care, including mental health care... and the executive committee has worked hard in addressing the organizational issues in regards to both physical and mental health care. So, we’ve got a window of opportunity. What we’re going to do with it is up to us.”jr4
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APPENDIX A

INFORMATION LETTER
FOR RESEARCH SITE
MENTAL HEALTH CARE DECISION MAKING IN A DUAL PRISON-HOSPITAL

As part of the requirements for a Ph.D. in Rehabilitation Science at Queen’s University, Crystal Grass is conducting the following study at (XXXX) over the next few months. Approval to conduct this study has been granted by the Research Ethics Board at Queen’s University and by the (XXXXX) Deputy Commissioner under the recommendation of the (XXXXX) Regional Research Committee. While approval to conduct this study has been granted by the (XXXXX) Deputy Commissioner and support for the study has been expressed by senior managers at the (XXXX), this project is being conducted independent of the Correctional Service of Canada’s research and evaluation activities. It is not part of the (XXXXX)’s quality improvement processes or the Correctional Service of Canada’s research plan.

The purpose of this study is to describe and explain how mental health care decisions are made in relation to the dual prison-hospital mandate within the (XXXX). The focus of the study is on policy implementation and the integration of mental health and correctional processes and policies within an institution that is both a hospital and a prison regardless of individual and circumstantial differences. It is the aspects of the institution relevant to people’s experiences, not the people themselves, that are the object of inquiry. How do the teams apply the mental health and correctional legislation and policies directing their work? How do the teams negotiate mental health decisions when these legislation and policies conflict? This study will enable the (XXXX) to better define the challenges faced in merging the mental health and correctional systems in the day-to-day process of providing care and identify strategies for working together within those systems to find solutions.

Data collection will begin with observing the actual work experiences of the frontline staff at (XXXX) as they demonstrate implementation of policies and protocols through their daily activities. It is the perspective and experiences of these individuals and teams applying policies to everyday situations that will organize the direction of the research to explore the institutional system that they participate in. From these original observations, policy implementation issues will be identified and further explored through individual interviews and examination of relevant documents. Each next step of investigation learns more from you of how your everyday work brings into being the institutional processes that are the focus of the investigation.

For example:

_During the course of observing work practices on unit (XX), staff are observed negotiating a conflict between mental health policy and correctional policy. One staff member comments that “they just weren’t thinking about this place when they wrote that_
requirement”. I would request an interview with the speaker to gain a greater understanding of what he/she meant and seek other examples from that person’s experiences reflecting the same concern. I would then request an interview from the person responsible for developing such policies (at RHQ or NHQ) to find out what is ‘thought about’ or considered when drafting and revising such a policy. Are there guidelines for policy development that must be followed? Who is involved in the policy development process? What type of cross-referencing with other policies is done?

Each next step in the data collection process builds from what has been discovered and branches from the original site (XXXX) to include and make visible the larger organization of the CSC that enters into and shapes (XXXX). The following are examples of situations where the larger organization impacts activities and decision making at (XXXX). One local example is the admission and discharge decisions regarding which referrals from other institutions will be admitted within different time frames when there limited beds available – what determines if someone gets admitted a.s.a.p., what determines if someone else will wait to be admitted until next week or placed on a wait list? A regional example is the negotiation of bed space when direction is received from the regional level to make room within our mental health beds for a number of administrative admissions while the regional accommodations team problem-solves a bed shortage situation at (XX). A national example is the changing of federal governments - as happened recently in Ottawa – which puts funding for projects and initiatives on hold and, at times, requires the CSC to begin again in promoting particular issues with the sitting government.

The result is a sort of ‘map’ that connects the daily experiences of applying and implementing policies at various local sites to understand how they relate to and influence one another. Using the above examples – the A&D team decides to wait list a larger number of referrals in a particular month because the bed space usually reserved for transferring (XXXX) patients between units has been temporarily filled with administrative admissions from (XX). Alternative options for accommodating these high needs offenders from (XX) are not available because the institutional mental health strategy had not been signed by the Liberal government before the election that placed a new Conservative government in power.

The study aims at discovering the different kinds of work in different settings and how they are coordinated to create the institutional processes that guide and direct decision making for mental health care at (XXXX).

I aim to be open and transparent in all my data collection activities. All observations and interviews will be pre-arranged with the persons directly involved in the work experiences to be observed. At various points in the data analysis process, I will meet informally with some individuals who were previously observed and/or interviewed to gain further clarification on the policy implementation issues identified to that point.

Your participation in this study is voluntary and confidential. All interviews will take place at a time and location most convenient to the individual being interviewed. All
information obtained during the course of this study is strictly confidential and your anonymity will be protected at all times. For the purpose of managing the data, you will be identified within the data using an alphabetical code. Data will be stored in locked files outside of the (XXXX) and will be available only to Crystal Grass. Electronic data will be double password protected. You will not be identified in any reports or publications. After the project is complete, both electronic and hard copy data will be destroyed.

There are no risks to you as employees of the institution under study. There are also no direct benefits. However, through your participation, this study will provide you with an opportunity to identify policy issues relevant to your own experiences, to promote a greater understanding of your work experiences, and to bring about change in your own workplace. From the findings of this study, recommendations will be made on how the institution, and the broader organization, can better integrate mental health and correctional policies and how special purpose institutions, such as (XXXX), can participate in the policy development process.

If you have any questions or concerns about this study you may contact Crystal Grass directly at (902) 494-1982 or via e-mail (crystal.grass@dal.ca) to express any questions or concerns.

If at any time you have concerns about the implementation of this project, you can contact Dr. Sandra Olney, Chair of the School of Rehabilitation Therapy, Queen’s University, (613) 533-6102.

If at any time you have concerns about the ethics of this project, you can contact Dr. Albert Clark, Chair of the Research Ethics Board, Queen’s University, (613) 533-6081.

Thank you

Crystal Grass
PhD candidate (Rehabilitation Science)
Queen’s University
APPENDIX B

OBSERVATION CONSENT FORM
OBSERVATION CONSENT FORM

Mental Health Services in a Dual Prison-Hospital: Implementing Healthy Public Policy

You are being invited to participate in a research study conducted by Crystal Grass to understand how decisions about mental health care at the (XXXX) are made. This study is being carried out as part of the requirements for a Ph.D. in Rehabilitation Science at Queen’s University. Approval to conduct this study has been granted by the Research Ethics Board at Queen’s University and by the (XXXXX) Deputy Commissioner under the recommendation of the Ontario Regional Research Committee.

You are being invited to participate through observation of your daily activities. Observations will be conducted during your usual course of business. Observations will be recorded as fieldnotes for analysis. Your participation in this study is voluntary. If you choose not to consent to being observed, the investigator will not engage in observation in your work area. Choosing to not participate through observation will not affect your employment with the Correctional Service of Canada.

All information obtained during the course of this study is strictly confidential and your anonymity will be protected at all times. For the purpose of managing the data, you will be identified within the data using an alphabetical code. Data will be stored in locked files outside of the (XXXX) and will be available only to Crystal Grass. Electronic data will be double password protected. You will not be identified in any reports or publications. After the project is complete, both electronic and hard copy data will be destroyed.

There are no risks to informants as employees of the institution under study. There are also no direct benefits. However, in choosing to participate, informants will be contributing to an increased understanding of the policy implementation process as it applies to mental health care. It is hoped that the knowledge generated will enable mental health professionals, correctional administrators, and future research to begin to inform the ruling apparatus of the (XXXX) in ways that can affect positive change.

If at any time I have further questions, problems or adverse events, I can contact

Crystal Grass (613) 384-6525
Principle Investigator

or

Sandra Olney (613) 533-6102
Department Chair, School of Rehabilitation Therapy
Queen’s University

If I have questions regarding my rights as a research informant I can contact

Dr. Albert Clark (613) 533-6081
Chair, Research Ethics Board (Health Sciences)
Queen’s University
I have read and understand the information and consent form for this study. I have had the purposes, procedures and technical language of this study explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form.

By signing this form, I am indicating that I agree to participate in this study.

Signatures of participants… Date

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STATEMENT OF INVESTIGATOR

I have carefully explained to the subject the nature of the above research study. I certify that, to the best of my knowledge, the participants understand clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

____________________________________  ________________________
Signature of Principle Investigator    Date
APPENDIX C

INTERVIEW CONSENT FORM
You are being invited to participate in a research study conducted by Crystal Grass to understand how decisions about mental health care at the (XXXX) are made. This study is being carried out as part of the requirements for a Ph.D. in Rehabilitation Science at Queen’s University. Approval to conduct this study has been granted by the Research Ethics Board at Queen’s University and by the (XXXXX) Deputy Commissioner under the recommendation of the Ontario Regional Research Committee. While approval to conduct this study has been granted by the (XXXXX) Deputy Commissioner and support for the study has been expressed by senior managers at the (XXXX), this project is being conducted independent of the Correctional Service of Canada’s research and evaluation activities. It is not part of the (XXXX)’s quality improvement processes or the Correctional Service of Canada’s research schedule, nor is it funded by the Correctional Service of Canada.

The purpose of this study is to describe and explain how mental health care decisions are made in relation to the dual prison-hospital mandate of the (XXXX) and to use this knowledge to further understand how policy implementation is approached and experienced in that setting. It is hoped that the knowledge generated will enable mental health professionals, correctional administrators, and future research to inform the way the (XXXX) is organized and governed in a manner that can affect positive change.

You are being invited to participate in an individual interview. Interviews will be conducted at a time and location most convenient to you to ensure your comfort and confidentiality. Interviews will be recorded and later transcribed for analysis. Your participation in this study is voluntary. You may withdraw from this study at any time and your withdrawal will not affect your employment at the (XXXX).

All information obtained during the course of this study is strictly confidential and your anonymity will be protected at all times. For the purpose of managing the data, you will be identified within the data using an alphabetical code. Data will be stored in locked files outside of the (XXXX) and will be available only to Crystal Grass. Electronic data will be double password protected. You will not be identified in any reports or publications. After the project is complete, both electronic and hard copy data will be destroyed.

There are no risks to informants as employees of the institution under study. There are also no direct benefits. However, in choosing to participate, informants will be contributing to an increased understanding of the policy implementation process as it applies to mental health care. It is hoped that the knowledge generated will enable mental health professionals, correctional administrators, and future research to begin to inform the ruling apparatus of the (XXXX) in ways that can affect positive change.
I have read and understand the consent form for this study. I have had the purposes, procedures and technical language of this study explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.

If at any time I have further questions, problems or adverse events, I can contact

**Crystal Grass**  (902) 494-1982  
Principle Investigator

or

**Sandra Olney**  (613) 533-6102  
Department Chair, School of Rehabilitation Therapy  
Queen’s University

If I have questions regarding my rights as a research informant I can contact

**Dr. Albert Clark**  (613) 533-6081  
Chair, Research Ethics Board (Health Sciences)  
Queen’s University

By signing this form, I am indicating that I agree to participate in this study.

____________________________________  ________________________
Signature of Participant     Date

STATEMENT OF INVESTIGATOR

I have carefully explained to the subject the nature of the above research study. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to participants in this study.

____________________________________  ________________________
Signature of Principle Investigator     Date
APPENDIX D

APPROVAL FROM

RESEARCH ETHICS BOARD
QUEEN'S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

Queen's University, in accordance with the "Tri-Council Policy Statement, 1998" prepared by the Medical Research Council, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada requires that research projects involving human subjects be reviewed annually to determine their acceptability on ethical grounds.

A Research Ethics Board composed of:
Dr. A.F. Clark  Emeritus Professor, Department of Biochemistry, Faculty of Health Sciences, Queen's University (Chair)
Dr. S. Burke  Emeritus Professor, School of Nursing, Queen's University
Rev. T. Deline  Community Member
Dr. M. Evans  Community Member
Dr. M. Green  Assistant Professor, Department of Family Medicine, Queen's University
Ms. T.C. Knott  Research & Evaluation, Southeastern Regional Geriatric Program, Providence Continuing Care Centre – St. Mary's of the Lake Hospital Site
Dr. J. Low  Emeritus Professor, Department of Obstetrics and Gynaecology, Queen's University and Kingston General Hospital
Dr. H. Murray  Assistant Professor, Department of Emergency Medicine, Queen's University
Dr. W. Racz  Emeritus Professor, Department of Pharmacology & Toxicology, Queen's University
Dr. H. Richardson  Assistant Professor, Department of Community Health & Epidemiology Project Coordinator, NCIC CTG, Queen's University
Dr. B. Simchison  Assistant Professor, Department of Anesthesiology, Queen's University
Dr. A.N. Singh  WHO Professor in Psychosomatic Medicine and Psychopharmacology Professor of Psychiatry and Pharmacology Chair and Head, Division of Psychopharmacology, Queen's University
Dr. S. Taylor  Director, Office of Bioethics, Queen's University and Kingston General Hospital; Associate Professor, Department of Medicine, Queen's University
Ms. K. Weisbaum  L.L.B. and Adjunct Instructor, Department of Family Medicine (Bioethics)

has examined the protocol and consent form for the project entitled "Mental Health Services in a Dual Prison-Hospital: Implementing Healthy Public Policy" as proposed by Ms. Crystal Grass and Dr. Terry Krupa of the School of Rehabilitation Therapy at Queen's University and considers it to be ethically acceptable. This approval is valid for one year. If there are any amendments or changes to the protocol affecting the subjects in this study, it is the responsibility of the principal investigator to notify the Research Ethics Board. Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information."

Chair, Research Ethics Board
Date
REH-282-05

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APPENDIX E

APPROVAL FROM
RESEARCH SITE
RESEARCH APPLICATION AND UNDERTAKING

RESEARCH PROJECT - PROJET DE RECHERCHE

PROJECT TITLE: Mental Health Services in a Dual Prison/Hospital - Implementing a Healthy Public Policy

PROJECT DESCRIPTION: Purpose: To make clear how mental health care decisions are made in relation to the dual prison/hospital mandate of the Regional Treatment Centre (Ontario) and to use this knowledge to further explicate how policy implementation is approached and experienced in that setting.

Participants: Frontline staff at the Regional Treatment Centre - Ontario

TYPE/CLASS OF INFORMATION REQUESTED: Voluntary - Informed consent to participate

a) Contribution to the achievement of the Mission and the priorities of CSC
b) Compliance with the Tri-council Policy Statement on Ethical Conduct for Research Involving humans
c) Level of disruption to the implementation of correctional objectives from an operational perspective
d) Quality of the methodology
f) Qualifications of the researchers
h) Anticipated benefit to corrected offenders

PRIMARY RESEARCHER - CHEQUE SUR PRINCIPAL

Crystal Grass, Ph.D. Candidate
School of Rehabilitation Therapy
Queen's University

Address - Adress

OPERATIONAL UNIT - UNITE
Also an Occupational Therapist at the RTC Ont, since 1996.

OTHER RESEARCHERS - AUTRES RECHERCHEURS

Faculty Advisor - Dr. Terry Knapp, Associate Professor, School of Rehabilitation Therapy, Dept of Psychiatry and Dept of Nursing.

Name and Affiliation - Nom et affiliation

APPROVAL - APPROBATION

Date: 7/6/07

Signature

DISTRIBUTION
APPENDIX F

ALPHA-NUMERIC CODES

FOR DATA SOURCES
# DATA SOURCES

<table>
<thead>
<tr>
<th>Alpha-numeric Code</th>
<th>Data Source</th>
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<tr>
<td>FN</td>
<td>Fieldnotes from observations and informal interviews</td>
</tr>
<tr>
<td>IM# (1-9)</td>
<td>Interviews with frontline mental health staff – including nurses, occupational therapists, social workers, behavioural science technologists, and program officers</td>
</tr>
<tr>
<td>IC# (1-4)</td>
<td>Interviews with frontline correctional staff – including correctional officers in both CX1 and CX2 classifications, and parole officers</td>
</tr>
<tr>
<td>II# (1-4)</td>
<td>Interviews with institutional managers – including mental health managers, correctional managers, and unit managers</td>
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<tr>
<td>IR# (1-9)</td>
<td>Interviews with regional managers</td>
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<tr>
<td>IN# (1-4)</td>
<td>Interviews with national managers</td>
</tr>
<tr>
<td>D# (1-25) (listed below)</td>
<td>Documents including policies, organizational reports, external reports, emails, and internal memos (this is not an exhaustive number of documents reviewed for the project – rather it is the number of documents directly quoted within the text of thesis)</td>
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<tr>
<td>D1</td>
<td>CCHSA Accreditation survey, 1995</td>
</tr>
<tr>
<td>D2</td>
<td>CCHSA Accreditation survey, 1998</td>
</tr>
<tr>
<td>D3</td>
<td>CCHSA Accreditation survey, 2001</td>
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<tr>
<td>D4</td>
<td>CCHSA Accreditation survey, 2004</td>
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<tr>
<td>D5</td>
<td>National Review of Treatment Centres, 2004</td>
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<tr>
<td>D7</td>
<td>Correctional Service of Canada Mission Statement, 2003-09-23</td>
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<td>D8</td>
<td>Operational Review 415-8905.3, 1989</td>
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<td>D9</td>
<td>Operational Master Plan, 1989</td>
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<td>D10</td>
<td>Commissioner’s Directive 005, Unit Management, 1990-07-01</td>
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<tr>
<td>D11</td>
<td>Commissioner’s Directive 850, Mental Health Care, 2002-05-02</td>
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<td>D12</td>
<td>Canada’s Big House, © 1999</td>
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<td>D13</td>
<td>[Prison-hospital] Role Statement, (extracted from internal info-net 2005-12-13)</td>
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<td>D14</td>
<td>Guideline for yard movement, 2002-08-12</td>
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<td>D15</td>
<td>Standing Order 562, Inmate Movement, 2000-03-01</td>
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<td>D16</td>
<td>Report on the Ethical Issues Seminars… with Staff of the [prison-hospital] (the Jones Report), June 2005</td>
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<td>Report on the Follow-up [prison-hospital] Meeting (the Jones</td>
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<td>D18</td>
<td>Report on the Final Meeting with Staff of the [prison-hospital] (the Jones Report), 2005-09-01</td>
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<td>D19</td>
<td>Admission, Discharge, and Transfer Process [prison-hospital], 2004-September</td>
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<td>D20</td>
<td>Commissioner’s Directive 726, Correctional Programs, 2003-11-19</td>
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<td>D21</td>
<td>Standards for Correctional Programs, 726-1, 2003-11-19</td>
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<td>D22</td>
<td>Operational Adjustment Strategy [prison-hospital], undated</td>
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<td>D23</td>
<td>Memo, operational adjustments [prison-hospital], 2006-09-26</td>
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<td>D24</td>
<td>Commissioner’s Directive 005, Unit Management, 1990-07-01</td>
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<td>D25</td>
<td>Policy on Prevention and Resolution of Harassment in the Workplace, Treasury Board of Canada Secretariat, 2001-06-01</td>
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**NOTE:** Data are not attributed more specifically to professions or position titles to protect the confidentiality of participants.