

The Role of Correctional Officers in Multidisciplinary Mental Health Care in Prisons

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Prisons have become the homes of thousands of inmates who have mental disorders. The stress of incarceration can cause morbidity among these individuals, resulting in more severe symptoms and more disruptive behavior. Effective treatment for such inmates often involves services provided by a multidisciplinary treatment team that includes correctional officers. Correctional officers can assist in observations and interventions, and they play a unique role on specialized housing units. Successful collaboration between correctional officers and treatment teams requires a foundation of mutual respect, shared training, and ongoing communication and cooperation. With these elements in place, correctional officers can assist the treatment team and make important and constructive contributions to the assessment and management of offenders who have mental disorders. (*Psychiatric Services* 52:1343–1347, 2001)

The need for comprehensive mental health services in correctional facilities has never been greater. During the 1990s the population of inmates under the jurisdiction of federal and state prisons increased at an average annual rate of 6.5 percent, reaching 1,366,721 by the end of 1999 (1). In mid-1998 the U.S. Department of Justice estimated that 283,800 incarcerated persons in the United States had a mental illness (2). A majority of these mentally ill offenders—about 179,200—resided in state prisons, and the remainder were in jails or federal prisons. The De-

partment of Justice based these figures on the responses to questionnaires administered to nationally representative samples of inmates. Respondents were considered to be mentally ill if they reported a current “mental or emotional condition” or an overnight stay in a mental hospital or treatment program. Sixteen percent of male prisoners and 24 percent of female prisoners met these criteria for mental illness.

The Department of Justice survey relied only on self-report to determine whether an inmate had a mental illness, but most studies have found

that 10 to 15 percent of state prisoners have serious mental disorders (3–5). However, these figures tell only part of the story. A literature review by Pinta (5) examined prevalence rates of mental disorders in U.S. prisons by looking at both a narrow and a broad definition of mental disorder. The narrow definition was a diagnosis of major depressive disorder, bipolar disorder, schizophrenia, or another psychotic disorder. The broad definition included other diagnoses associated with substantial impairment in daily life activities, excluding substance use disorders, paraphilias, and antisocial personality disorder. On the basis of his analysis of existing studies, Pinta estimated that 10 percent of male inmates and 18 percent of female inmates had a mental disorder according to the narrow definition, but 19 percent of males and 30 percent of females had a mental disorder according to the broad definition.

In Massachusetts, open mental health cases account for around 15 percent of the total male prison population of about 9,400 and for around 50 percent of the female prison and jail population of about 600. Including the 300 patients at Bridgewater State Hospital—the state’s maximum security forensic psychiatry hospital—the Massachusetts Department of Correction houses more than 2,000 persons who are receiving active treatment for mental disorders.

Regardless of the criteria used to define a mental disorder, prisons in the United States face serious problems in dealing with inmates who

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have mental disorders. Symptomatic inmates can impair the safe and efficient operation of a correctional facility, and the correctional environment can exacerbate symptoms of mental disorders (6). Incarcerated persons, even those who do not have a mental disorder, experience significant stress. Separation from family and social supports, significant limitations on privacy, fear of assault, and boredom are some of the common stressors in prison. Overcrowding, which occurs commonly in state and federal prisons (1), can exacerbate these problems. These challenges often overwhelm the limited coping skills of inmates who have mental disorders, resulting in functional deterioration.

The prison's management also experiences problems when inmates have difficulty functioning. The impaired ability of inmates who have mental disorders to cope with prison life leads to poorer adaptation than is seen among inmates who are not mentally ill (7,8). For example, individuals who have schizophrenia (8) or mental retardation (9) commit more rule infractions, spend more time in lockup, and are less likely to obtain parole. Acts of self-mutilation and attempted or completed suicides disrupt the operation of the prison and divert staff time and resources. Dysfunctional behavior by inmates who have mental disorders not only impairs the ability of officers and administrators to operate safe and orderly facilities but also results in stress for correctional employees at all levels.

Correctional officers face significant job-related pressure (10). In many states they must cope with understaffing, mandatory overtime, rotating shift work, and low pay. However, correctional officers identify the threat of violence by inmates as their most frequent source of stress (10). Nearly 218 incidents per 1,000 correctional officers were recorded between 1992 and 1996; only police officers have a higher rate of nonfatal violent incidents in the workplace (11). The strain of dealing with mentally disordered behavior can add to the considerable inherent stress of the job.

Effective treatment of inmates who have mental disorders can alleviate

the stress experienced by the mentally ill patients and by the correctional staff who supervise them. Such treatment often requires the involvement and skills of a multidisciplinary treatment team. As is the case in community mental health care settings, psychiatrists, psychologists, social workers, psychiatric rehabilitation professionals, and other mental health professionals all contribute to the assessment and treatment of patients. However, in a prison setting correctional officers also play a central role in the care of psychiatric patients. This article addresses issues that can enhance the contribution of correctional officers to the management of offenders who have mental disorders.

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Competing cultures or linked missions?

Although they must work together cooperatively, correctional (security) staff and mental health staff each have distinct professional cultures and missions that must be recognized and appreciated (12). The primary mission of the security staff is to serve society by confining inmates, whereas mental health providers and other health care staff serve primarily the individual patient by providing treatment. The correctional culture typically involves regimentation, universally applied rules, implicit authority

of security staff, and punitive sanctions for violations by inmates. The culture of the health professions, in contrast, is characterized by individualized treatment, informed consent, and negotiated compliance.

Many commentators have described how the disparity in ideologies between security staff and mental health staff often results in conflict between the two groups (13–18). For example, some correctional staff view mental health providers as excessively soft, gullible, and coddling of inmates. They perceive mental health problems as character flaws. Some officers resent the fact that inmates have access to free services that many citizens in the community lack, or view mental health care as an undeserved—if not unneeded—service for inmates. They also may perceive treatment as protecting inmates from the consequences of their behavior.

Correctional professionals do not have a monopoly on bias, however. Some mental health care providers view correctional staff as being unnecessarily harsh and punitive. They believe that the antisocial propensities of inmates, along with their mental health problems, are indications for treatment, not punishment.

The perceptions of members of both professional groups have some validity. Individual mental health care providers can be naive and prone to excusing inappropriate behaviors by inmates. Individual correctional officers can be inappropriately harsh. However, blanket characterizations of each other's professional group do everyone a disservice.

Profound differences certainly exist between correctional and mental health training, beliefs, methods, and purposes. Nevertheless, the two groups have much in common and often work well together (19). Enlightened administrators and professionals from each discipline seek to fulfill their functions humanely. For example, effective correctional officers are firm but fair. They understand that inmates' incarceration is their punishment, not a vehicle for further punishment.

Always outnumbered by the inmates they supervise, officers inside prison walls typically are armed with nothing more deadly than ballpoint

pens with which they can write tickets for rule infractions. Alertness, professionalism, and secure but humane treatment keep institutions safe and help avoid unnecessary applications of force. Skillful correctional officers, of whom there are many, embrace these qualities and appreciate the contributions made by a comprehensive mental health program. Similarly, effective mental health care providers generally regard correctional staff as allies, not adversaries. They too recognize that inmates and staff suffer if facilities lack either adequate security or health care services. Everyone benefits when the environment is characterized by mutual respect and reliance on the expertise of both security professionals and mental health professionals.

The role of the correctional officer in multidisciplinary care

Observation

Clinicians have only brief contact with inmates compared with the daily contact experienced by correctional officers, who essentially “live” with inmates 40 hours a week on the housing units. Officers are typically the first to observe significant changes in an inmate’s routine or mental status. In the structured prison environment, bizarre behavior suggestive of mental illness, deterioration in self-care, or an increase in aggressive or irritable behaviors tend to stand out. Mental health staff depend on correctional officers for this information, because patients can often “look good” in a clinician’s office once a week even though their overall functioning is in fact becoming impaired.

Information from officers can contribute to diagnostic assessments and ongoing monitoring of patients. Mental health staff might also alert security staff about patients who need special monitoring because of increased risk. For example, correctional officers might be asked to pay special attention to patients who become non-compliant with treatment or who face potentially upsetting personal or legal setbacks. Inmates who appear increasingly depressed or who exhibit warning signs of suicidality—for example, giving away possessions—can especially benefit from having an attentive officer who relays information

to clinical staff. These officers are often the first to respond to inmates’ psychological problems, and thus they have as much of a role in suicide prevention as the clinical staff, and possibly a greater one.

Although alerting security staff to an inmate’s risk involves sharing confidential clinical information with correctional officers, effective management of inmates who have mental disorders supports this practice “whenever such sharing would facilitate the treatment or safety of an inmate” (unpublished report to the Massachusetts Department of Correction, Appelbaum K, Dvoskin J, Geller J, et

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Intervention

Correctional officers can also play an important role in interventions involving inmates who have mental disorders. A concerned and knowledgeable officer can assist a functionally impaired inmate with prompts or supports that help the inmate meet the demands of the correctional environment. Officers can also enforce inmates’ attendance at mental health appointments, encourage compliance

with treatment, and alert staff when inmates refuse to take their medications. Outpatients in community settings often have concerned family and friends to assist them, but inmates may have only a supportive officer.

Specialized programs

In Massachusetts and elsewhere, specialized units in prisons, often known as residential treatment units, have been developed to house and treat functionally impaired inmates (20, 21). These more structured units have a low ratio of inmates to clinicians and use a group and occupational therapy model to work on behavioral change. Correctional officers who are stationed on the residential treatment unit have an important and unique role, functioning as part of the treatment team. Regular discussions and meetings between officers and clinicians can help ensure coordinated and consistent care of inmates.

The officers’ authority to provide discipline and apply sanctions is an important tool in managing and curbing the maladaptive behaviors of inmates on the residential treatment unit. Although correctional officers are not therapists, the most therapeutic intervention that officers provide for inmates is often in the form of clear boundaries and consequences. This role can be difficult for officers, who are trained in security matters but are introduced daily to mental health constructs such as “borderline personality disorder,” “splitting,” “acting out,” and “secondary gain.” Officers can become impatient with what they view as the tendency of clinicians to rationalize bad behavior in the name of mental illness. In choosing which officers to assign to a residential treatment unit, it is important to select those who have achieved a balance between firmness and sensitivity. Although policies sometimes limit flexibility in officers’ work assignments, a residential treatment unit will work best if officers with suitable dispositions are selected and retained.

Elements of success

The elements of successful collaboration between security staff and mental health staff can be broken down into

the categories of shared core values and respect, appropriate orientation and training, and ongoing communication and cooperation. Each category builds on and potentiates the others. Neglect of any one category means that the contribution of correctional officers to the multidisciplinary care and treatment of inmates who have mental disorders will be diminished.

Shared core values and respect

Foremost among the elements of successful collaboration between correctional officers and mental health professionals are jointly held values and mutual professional respect. Shared values and respect provide the foundation on which training and communication can be built. The ability of professionals from each discipline to work well together rests on their innate temperaments and dispositions.

Correctional officers maximize their contribution to multidisciplinary mental health care in prisons when they have a basic understanding of mental illness, remain alert to the signs and symptoms of mental illness, show a willingness to refer cases to mental health staff, and use appropriate flexibility in managing mentally ill inmates. Officers will meet all these criteria only if they value the services provided by mental health staff. Mental health staff, for their part, must approach security staff with a fundamental respect for the important and difficult job that they do. Cross-training can plant the seeds for this knowledge and appreciation, but those seeds will take root most effectively among individuals who are innately receptive to the message.

Orientation and training

For institutional safety and their own protection, correctional officers tend to view inmates in simple terms as potential security threats. Clinicians, on the other hand, look for complexity and ambiguity. They seek to develop a therapeutic alliance by finding attributes with which they can identify. Inmates are seen as clients or patients, not just criminals. The division between security staff and clinicians can be narrowed by exposing clinicians to matters of security and exposing officers to clinical matters.

In Massachusetts all new clinicians attend a mandatory weeklong Department of Correction orientation conducted primarily by correctional officers. This training introduces clinicians to the prison setting and emphasizes safety, security, and the importance of following established procedures. During orientation, new staff begin to learn about the realities—and potential frustrations—of correctional work. Prisons are not mental health clinics. Along with the stark institutional environment, staff must comply with paramilitary-like rules and security procedures. They may be searched on entering and

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leaving a facility. Items such as cell phones, binder clips, medication, chewing gum, aluminum foil wrappers, and other common objects can be considered contraband. The typical workday includes periods during which access to inmate patients is limited because of controlled movement, periodic counts of the facility's population, and occasional lock-downs.

Orientation helps prepare mental health staff comply with these rules and accept their status as guests. The training also provides clinicians with a glimpse into the mind-set of security staff, particularly the focus on maintaining a structured and orderly environment. Clinicians quickly understand that without security, meaning-

ful clinical work is impossible. For their part, the correctional officers conducting the training convey the value that security staff places on the work of clinicians and the role that clinicians play in helping maintain a calm prison environment.

A particularly valuable cross-training program in Massachusetts is a series of collaborative training sessions for correctional officers about suicide prevention and mental illness. These sessions cover recognition of mental illness; identification of suicide risk factors, such as depressive symptoms, denial of parole, and previous suicidal behaviors; high-risk times and places, such as segregation cells at night or on weekends; and procedures for referring inmates to mental health care.

The training sessions also cover the policies of the Department of Correction, emphasizing the importance of sound documentation and the legal concepts of negligence and deliberate indifference. The teaming of a clinician with Department of Correction staff has heightened the overall credibility of the training in the eyes of the correctional officers, as evidenced by improvements in attention and participation during the sessions and more positive feedback from officers who complete program evaluation forms. Some particularly moving moments have occurred when officers have shared their firsthand experiences of the emotional impact of dealing with suicides of inmates, as well as suicides of fellow officers.

Communication and cooperation

Shared values and training bear fruit when security staff and mental health staff engage in ongoing communication and cooperation, both formally and informally and at the level of both line staff and administrators. Regular but informal interactions can help both groups move beyond preconceived notions and create an atmosphere of trust and communication. These casual interactions provide opportunities for mental health staff to become more sensitive to the concerns and perspective of security staff while they further inform officers about the nature and impact of mental disorders on inmate patients (22).

Discussions with security staff can also help mental health clinicians respond to mentally ill prisoners' requests for special privileges (23). Such discussions can sensitize mental health staff to the security implications of granting special privileges and can sensitize correctional staff to the treatment needs of patients. Security staff also may share their insights into the true motives behind some requests by inmates.

Formal and informal interactions between clinical and correctional administrators help model and complement effective contacts at the line-staff level. Cooperation and flexibility, rather than domination, allow for a constructive response to the inherent tension between custody and health care needs. For example, clinicians may have less downtime and more access to their patients in facilities that allow "out counts" for inmates who are being seen by health care staff during institutional count times (24). In addition, inmates may function better if the rules are flexible enough to allow them to be assigned to facilities or housing units, such as residential treatment units, that best suit their mental health needs.

Most important, however, is a commitment on the part of the correctional administration to provide the mental health program with access to adequate resources, including a modern formulary. Mental health administrators, for their part, must show similar flexibility and sensitivity to security and fiscal issues. For example, a commitment to cost-efficient practices might include educational initiatives that encourage prescribing psychiatrists to use the least expensive medication regimens.

Regularly scheduled meetings between custodial and clinical administrators can address many of these issues, but ad hoc meetings are also necessary for responding to specific issues, including challenging cases. Ad hoc case conferences help provide a system response for challenging patients, such as inmates with character disorders who engage in severely disruptive behavior. Such conferences, along with regularly scheduled administrative meetings, provide the framework for ongoing cooperation

that fosters the involvement of correctional officers in the multidisciplinary mental health treatment team.

Conclusions

Correctional officers can play a valuable role in the delivery of multidisciplinary mental health services in jails and prisons. Despite differences in their training, culture, and mission, correctional and clinical staff have some common goals. When correctional officers share appropriate information with clinicians and assist in the management of inmates who have mental disorders, both the quality of treatment and the safety of the correctional environment improve. Mutual respect, proper orientation and training, and ongoing communication and cooperation provide the foundation for meaningful contributions to mental health care by correctional officers. ♦

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