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ON THE ROLE OF CORRECTIONAL OFFICERS IN PRISON MENTAL HEALTH

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This article discusses the role of correctional line staff in treatment of prison inmates with serious mental illness. The authors assert that many roles and duties traditionally attributed to clinicians can and often should be performed not only by mental health professionals, but by line staff such as correctional officers and nurses. Moreover, the optimal climate for effective treatment is one in which mental health professionals and line staff work collaboratively, especially since line staff alone are in contact with inmates 24 hours per day. The specific activities which comprise mental health treatment in prison are described as: 1) counseling and psychotherapy—talking *with* inmates, 2) consultation—talking *about* inmates, 3) special housing, activities, and behavioral programs, and 4) medication. Case examples demonstrate how correctional officers, nurses, and other line staff perform each of these activities. Recognition and nurturance of these activities will improve the quality of services and reduce stress on staff

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and inmates alike. Consultation with line staff, joint training, and use of multidisciplinary treatment teams are advocated as methods of reaching these goals.

KEY WORDS: correctional officer(s); prison; jail; mental health.

Early in my career, I remember an especially embarrassing moment. While working as an inexperienced intern in a large state forensic hospital, I walked over to a unit in which I did not usually work. I asked a uniformed correctional sergeant if any of the "professional staff" were in the building. He looked at me as if I were a child and said, "You know, I get paid to be here too. It may surprise you doctors, but I consider myself to be a professional."—Joel Dvoskin

INTRODUCTION

The correctional system in the United States is charged with the mammoth task of supervising and caring for an ever-increasing number of inmates and detainees. The unremitting growth in corrections is illustrated by the fact that as of June 2002, the nation's jail and prison population exceeded two million inmates for the first time in history (1). Alternately stated, one out of every 142 residents of the United States was behind bars (1). At last report, twenty-two states and the Federal prison system report operating at or above their highest capacity (2).

As the incarcerated population continues to grow, so too does the number of inmates who suffer from mental illness. In 1998, the United States Department of Justice (3) estimated that over 283,000 mentally ill offenders were behind bars. In fact, depending upon the criteria employed, as many as 19% of male and 30% of female inmates can be identified as having a mental disorder (4). According to the American Psychiatric Association, approximately 20% of inmates are in need of mental health care (5), and in 2000, almost 10% of state prisoners were receiving some form of psychotropic medication (6). Despite the growing demand for treatment, correctional systems have been largely unable to keep pace with the burgeoning need for mental health care. While the overall number of mental health professionals employed by correctional settings has increased (7,8), the psychologist-to-inmate ratio is estimated to be half of what it was during the 1980's (9).

The general public tends to perceive the role of prisons and jails to be simply the secure housing of all offenders, including those who are mentally ill (10). However, the responsibilities of the correctional system extend far beyond the warehousing of offenders (11). Prisons and jails are legally mandated and ethically bound to provide appropriate and adequate care (12); indeed, it is unconstitutional for those who

incarcerate to be deliberately indifferent to the serious medical and psychiatric needs of inmates (12). Ultimately, correctional systems are expected to simultaneously serve punitive, protective, and rehabilitative functions. Like all multidimensional systems, departments of correction operate under a set of functional roles that govern the responsibilities and expected contributions of its employees. These functions, by their very nature, often conflict with one another, further complicating matters for correctional systems. Given the inherent demands of the correctional setting, a gap exists between these official role descriptions and what happens in the real world. In real prisons, a practical overlap or blurring of roles is the norm. Rather than disrupting productivity, however, if embraced and supported, this overlap can serve to improve the conditions and experience for all those who live and work in prison.

THE PRISON AS A COMMUNITY

Although not traditionally regarded as such, prisons are communities in every sense of the word. Each prison consists of groups of interdependent people, often divided along social and/or racial lines, who live and work in the same place, under the same conditions (11). Members of the correctional community include inmates, line staff, administrators, "professional" medical and clinical personnel, and any number of contractual employees. Beyond just the people who comprise the community, the day to day functioning of a correctional facility is also analogous to the "free world" insomuch as community members work collectively to provide the necessities of daily life, including food, cleaning, maintenance and operation of the physical plant. Some correctional facilities also provide a variety of services and industries (e.g., construction, farming, production of consumer goods) that are aimed at external consumers.

In order to truly appreciate the nature of this unusual setting it is necessary to understand the mutual dependence of staff and inmates. Inmates depend upon staff to maintain order, safety, and security. Staff depend on inmates (present in much larger numbers) to follow facility rules and in many cases to provide a labor force (11). Behavior, actions and reactions of both inmates and staff have significant and direct repercussions for the institution at large. Despite the inherent power differential, inmates and staff unequivocally rely upon one another in order to maintain the safe and effective functioning of their facility.

Similarities notwithstanding, the correctional setting presents a unique collection of environmental stressors, which strongly and

negatively affect the people who live and work there. Extremes of noise, temperature, filth, and fear are often inescapable realities of life inside an institution (13). Significant overcrowding in many state and federal facilities (14) only serves to exacerbate these ever-present stressors. The fundamental stressors of the correctional setting impact all who live and work behind bars.

> One way in which to understand some of the specific stressors of prison is an exercise I developed while training newly recruited correctional officers. I asked them, "What could make you become violent?" With surprising consistency, they related anger, fear, loss of autonomy (no choices), uncomfortable physical limitation ("feeling cornered"), and humiliation. I would then ask them to try to think of a place where all five of these factors are maximized. With smiles of discomfort, the prospective officers would say "prison."—Joel Dvoskin.

While this vignette highlights the relationship between five major environmental stressors and violent behavior, it also suggests the insidious way in which they impact the psychological well being of all members of the prison community. Yet, they are as much a part of American prisons as walls, bars, and fences. For the inmate, stressors are inevitable (15). It is simplistic to say that inmates "deserve what they get" or that "prison isn't supposed to be comfortable." Of course the very nature of the setting requires that inmates reap the consequences for their actions. However, the reality is that once inside, the complexity of interpersonal interactions and individual reactions have a tremendous impact on the entire correctional community. Many inmates come to prison angry. They are angry at the loss of their freedom, angry that they were caught, and angry at the length of their sentence. They are angry that they will be separated from loved ones, from romantic relationships, from privacy, from useful activity, and from the simple pleasures that most of us take for granted. Similarly, even the most hardened criminal brings to the reception gate often unexpressed but very real fears of more things than most of us fear in a lifetime—fear for his or her own life, fear of rape, and perhaps, a fear that he/she will never again be free. Loss of autonomy and uncomfortable physical limitation seem to have become accepted as the very definition of prisons, exemplified by the loud clanging of slamming gates and orders to wake up, to eat, to turn out the lights, or to exercise—all at the bidding of their keepers. Finally, we turn to the fifth stressor; humiliation. Inexperienced staff, dealing with their own fears, may belittle or embarrass inmates in order to exaggerate the difference in their respective stations. Inmates may humiliate each other in order to maintain their status in the inmate "pecking order," or out of shear boredom. Of the five stressors discussed, humiliation is perhaps the most destructive

and the least necessary part of life in American prisons. Despite this, it may well be the most pervasive.

That said, it is worth repeating that while the stressors described above are psychologically destructive and demoralizing to inmates, they are equally real to the line staff that spend forty hours each week in the same environment. Once again, the fundamental power differential is not sufficient to preclude correctional staff from suffering as a result of the environmental extremes of the setting. Work stress is a frequent reality for employees in virtually any capacity or discipline. For correctional staff, the "normal" stresses of work (e.g., systemic issues, supervisory difficulties, etc.) are coupled with daily exposure to a hostile and stressful environment. Not surprisingly, observers have noted physical illness, substance abuse, burnout, strained family relationships, and other negative results of stress among correctional officers (16). Additionally, officers routinely face these challenges while struggling with staff shortages, low pay, and long work hours (16,17). All of this is compounded by the fact that public perception of correctional officers is negatively skewed and few correctional personnel receive the respect or admiration that often accompanies other areas of law enforcement (18,17). Nevertheless, a tremendous amount of trust and power are invested in correctional officers every day. The decisions they make have a direct impact on the lives of everyone in the correctional community (18).

As noted by Dvoskin et al. (11), "Environment stressors lead to individual stress, which leads to interpersonal tension, which in turn creates a volatile atmosphere for inmates and staff alike." Clearly, anyone wishing to have a positive effect on the mental health of prison inmates and staff would do well to look toward reducing these and other stressors in the prison environment. While some of the stressors are, in fact, inevitable and perhaps even necessary, it is unproductive to write them off as "the way it is." Prison is intended to be punitive and by its very nature necessitates severe limitations in an inmate's autonomy. However, the decisions we make and the manner in which people are treated (inmates and staff) can have harsh consequences both for those within the "prison community" and ultimately for the rest of society outside of the gates.

CORRECTIONAL MENTAL HEALTH CARE

Historically, prisons have been described as "almost diabolically conceived to force the offender to experience the pangs of . . . mental

illness" (19). Given the magnitude of stressors that confront everyone in the correctional community, it is not difficult to recognize the potential for disruption of an individual's ability to function. The presence of a diagnosable mental illness is certainly not necessary for the weight of the setting to take its toll. However, for those inmates with preexisting mental conditions and/or limited coping mechanisms, the stress can prove overwhelming (15).

The operation of a correctional facility is highly dependent upon order and routine. Mental illness, especially in the absence of adequate treatment, often results in disruptive behavior (20). All inmates, even chronically disruptive inmates, in our experience fear generalized disorder within prisons. The functioning of a correctional system demands that all of those within the facility work to maintain a delicate balance between order and chaos. To that end, besides being legally mandated (21), psychiatric and psychological treatment of mentally ill inmates if often seen as contributing to prison security by decreasing (or at least segregating) unpredictable and violent actions by mentally ill inmates (22).

Elements of Treatment

A central function of correctional mental health staff is to assist in the maintenance of order and security. Therefore mental health treatment is not limited to those who are violent, unpredictable or in need of psychiatric intervention. Virtually any inmate can experience periodic episodes of emotional distress that, without intervention, could escalate to the level of acute crisis. The utility of extending treatment to depressed, anxious, or "quietly psychotic" inmates is twofold. First, it demonstrates that mental health professionals in prison, like their colleagues in the community, work toward the simple reduction of human suffering. Second, it serves a proactive protective function by intervening before a situation becomes a crisis, thereby not only alleviating pain in the individual, but also preventing unnecessary disruptive and costly drain on system resources. Traditional or rigidly defined "treatment" strategies are inadequate to address the complex needs of corrections. Truly effective correctional mental health care can only be accomplished by employing both formal and informal intervention strategies.

Simply put, there is no room for clinicians to hold a lofty sense of self-importance or to engage in turf wars around the provision of treatment. Although the agendas of correctional and clinical personnel appear in conflict at first glance, closer inspection reveals a false dichotomy. In fact, the overarching goals of custody and treatment staff are, and ought to be, remarkably similar: 1) keep everyone safe; 2) prevent escapes;

3) minimize human suffering (in and/or out of prison); 4) maximize morale; and 5) help to maintain systemic operations. Obviously, in some instances, specialized clinical mental health training is essential toward addressing inmate needs. However, far more often, intervention in corrections can be accomplished by any staff member interested in achieving the aforementioned objectives. For example, the correctional setting is laden with complex policies and procedures that can be exceedingly difficult to negotiate, regardless of mental status. Often, the simple provision of information, or simpler yet, *listening* to an inmate's concerns, can diffuse a potentially difficult situation. Ultimately, "treatment" in corrections takes many forms, perhaps the most important of which is basic human respect and concern.

The elements of "treatment" are remarkably straightforward when broken down into what exactly is done to or for mentally ill inmates. We talk and listen to them, we talk about them, we allow or force them to be in a special place, we provide or withdraw things and activities, and we can prescribe them medicine. Though these interventions often go by more formal titles such as psychotherapy, consultation, inpatient hospitalization or respite care, behavior therapy, activities therapy, and psychotropic medication, the activities themselves are actually quite routine. Who performs these activities for mentally ill inmates? The answer is easy. Line personnel, such as correctional officers, nurses, and case managers (i.e., correctional counselors) carry out the preponderance of mental health care for inmates.

The reasons for this provision of mental health services by line staff are equally simple. First and most importantly, they are *there*. While doctoral and masters level mental health professionals in prison typically work a business week, coverage by correctional officers, nurses, and other line staff is round the clock. Second, there are a great many more of them. Finally, to a large extent, inmate supervision consists primarily of informal intermittent verbal exchanges.

Psychotherapy: Talking with Inmates

Correctional officers are, without doubt, the staff members with the greatest amount of daily contact with inmates. In fact, a well-trained and conscientious correctional officer is more likely to be responsible for diffusing a potential problem than is any member of the mental health staff (23).

In talking with mentally ill inmates, both the mental health professional and the correctional professional line staff person are likely to have similar goals. In many cases, the goal is to resolve a crisis by

saying things to help the inmates to "calm down" (i.e., reduce certain disruptive behaviors, such as screaming, crying, hitting, banging, etc.). The response to a crisis might also include instruction in ways to avoid similar crises in the future (e.g., "stay away from him if he irritates you so much," or "maybe you should ask your mother not to visit quite so often if she upsets you so much."). Another goal might be to end the crisis in a way that would not cause the inmate to experience further loss of self-esteem or an increase in other symptoms, such as depression. Finally, it may be necessary to decide, at some point, that a verbal response is inadequate due to danger to the inmate or others, and that external physical controls must be utilized.

Each of the goals and attendant activities above are performed the majority of the time by line staff; if for no other reason, more than two-thirds of the time they are the only staff there. In order to resolve or respond to a crisis, you must be there when it occurs.

These interventions by correctional officers, however, constitute a double-edge sword. The potential for both positive and negative outcomes is clear (24). If, for example, an officer's first words to an acutely psychotic and panic stricken inmate are threats of physical harm, we would expect an increase in panic, an exacerbation of psychosis, reinforcement of unreasonable fears, and above all, an increase in the chances of injury to both the officer and the inmate.

To use another example, if an officer chose to respond to a suicidal gesture by assuming that it was merely an attempt to gain attention and mocks the inmate in front of his entire cellblock, it could cause both an increase in the inmate's depression and the chances of a future successful attempt. The officer's derision would convey a lack of respect, which could only further injure the poor self-esteem that may have led to the gesture. It could also be seen by the inmate as a challenge to prove that he is really depressed or suicidal, by killing himself. Again, this is not to suggest that in every case of a suicidal gesture the officer has only one option available in responding. Indeed, creativity born of experience with thousands of inmates can lead to innovative and effective interventions. Fortunately, it has been our experience that well-trained and experienced officers usually respond well to crises such as these, with patience, care, and common sense.

A case has been made for viewing the correctional officer as an important therapeutic agent in crisis intervention, but the officer's role is equally important in reaching the traditional goals of ongoing psychotherapy. Decades ago, Anthony & Carkhuff (25) summarized the literature on what they called the "functional professional," and their conclusions remain salient today. Defining the functional professional

in the mental health field as "a person who, lacking formal credentials, performs those functions usually reserved for credentialed mental health professionals," they found that **"regardless of the client outcome criteria studied, in all cases, the clients of functional professionals did as well or better than the clients of mental health professionals."** (Emphasis in original) (25).

It is important to note that Anthony & Carkhuff (25) did not suggest using functional professionals as "amateur psychotherapists." To the contrary, they recommended against such a role for two reasons. First, at least with what they then called the "chronically mentally ill," traditional "verbal therapies" of the time did not work very well, even when practiced by highly trained mental health professionals. Second, it was possible to get positive outcomes using a more sensible approach. They recommended two types of therapeutic activities as being especially appropriate for correctional officers. The first is as a supportive counselor and requires only general training in human relations skills. The second is as a skills trainer, which requires only that the officer receive training in the specific skills to be taught. Their wisdom has survived the intervening years, and today skills training, now often called psychosocial rehabilitation or cognitive behavioral therapy, has become a treatment of choice for people with serious mental illness, including psychotic illnesses (See, for example, 26, 27).

Unfortunately, as is the case with many interventions, here too lies a potential for harm as well as good. As an example, assume that an obese inmate was receiving psychotherapy for depression, and that the current focus of therapy was to ameliorate the inmate's negative image of himself as "fat and worthless." The psychologist in this case is trying to help the inmate explore other positive sides of himself as being important to others. Following an hour of such psychotherapy, however, the inmate must return to his cellblock. If the correctional officers, who are the authority figures there, are calling this inmate by a humiliating nickname, which refers to his weight, or are mocking him as "fat and worthless," the reinforcement of his negative self-image could well render the formal psychotherapy useless.

Beyond direct intervention on behalf of line staff, perhaps one of the most vital areas served by enhanced collaboration is that of referral. It is incumbent upon mental health professionals to create a climate conducive to the receipt of referrals from staff who have the opportunity to observe their inmate patients throughout the day and across contexts. A simple phone call from a work supervisor expressing concern about an inmate's demeanor or a brief consultation with unit staff about a change in an inmate's behavior can divert crises in the making. Clinicians must

be receptive and accepting of such information even given the possibility of time-consuming false positives. In reality, a brief review of the case will reveal whether a more thorough intervention is warranted. Mental health professionals can formally or informally advise staff of how and when to refer, thereby utilizing the "eyes and ears" of an entire institution. In fact, Toch and Adams (28) found that more often than not, correctional and mental health personnel concur about which incidents should elicit a mental health referral. Moreover, knowing that they have access to mental health staff may also be a relief to correctional officers faced with overwhelming or difficult mental health situations (29).

Ultimately, innovative therapeutic techniques and recommendations delivered by even the best psychotherapists are useless when they fail to consider the practical limits of the setting in which a patient lives. When working in corrections, clinicians must, almost above all, be pragmatic and creative. The integration of clinical expertise and practical experience and knowledge (e.g., mental health and correctional staff) is the only truly effective mechanism of positive change in prison.

Consultation: Talking About Inmates

The role of consultation has become a cornerstone of community mental health. As the mental health professions have come to realize the necessity of reaching great numbers of people who may be in need of their services, there has been an acknowledgement of the need to work "through" a variety of other types of volunteers, "paraprofessionals," and allied professionals. In prison, the stereotypical consultation is when a psychologist, for example, talks to a line staff member about how to better deal with a particular inmate. The goal is not only to resolve the immediate problem, but hopefully, to leave the line staff member with new skills or knowledge, which will be useful in preventing or resolving similar situations in the future. This type of consultation is extremely valuable and is enthusiastically recommended as a means of maximizing the value of line staff as therapeutic agents. That said, consultation must be viewed as interactive and mutually beneficial. In other words, the flow of information and assistance must be bi-directional. Both clinical and correctional disciplines bring unique and valuable information to the table which, when taken together, provide the optimal environment for the development of effective intervention strategies.

Unfortunately, mutual distrust between clinicians and correctional professionals has been cited as one of the predominant barriers to effective offender care (30). Stereotypes abound—officers are seen as punitive and harsh, while mental health professionals are thought to be

"bleeding-hearts" with no appreciation of inmate management. Historically, the seemingly competing demands of security and mental health served to solidify the polarization and undercurrent of competition. However, as correctional systems evolve, so too must those who work within them. Correctional staff members who learn to trust and respect mental health providers are more likely to value their advice and respond accordingly (11). However, mental health professionals must first take steps to *earn* the trust of correctional staff. Establishing open communication in an atmosphere of respect for the knowledge and expertise of correctional staff will go a long way toward developing a climate of mutual support and collaboration.

Consultation in which the correctional professional is consultant and clinician the consultee is equally important in the treatment of mentally ill inmates. In prison, correctional staff, not clinicians, are the experts on the environment. Mental health professionals would be well served by soliciting the advice of seasoned correctional staff with a far greater appreciation of how to interact with inmates (11). Correctional officers frequently can provide information on the day-to-day realities of prison life, which are extrinsic to a given inmate, but can drastically affect their mental health. This information, however, does not always find its way to the mental health professional. Too often there has been no reason for the line staff to assume that their opinions or observations were welcomed or valued. It has been our observation that far too many mental health professionals do not regard correctional officers as having an area of expertise and consequently tend to treat patients in prison in isolation.

Special Housing, Activities, and Behavioral Programs

The use of special housing for mentally ill inmates in prison has a variety of both causes and effects. Often, prison officials place these inmates in separate cells "for their own protection," when mentally ill prisoners are seen as vulnerable to exploitation by more predatory inmates. In other cases, special housing is for the expressed purpose of concentrating supervision and treatment services by placing inmates who require such services in one location. The results are not always positive. Because of a lack of resources, these special housing areas sometimes receive a full complement of patients to serve with little or no additional staff or training to enable staff to treat patients effectively.

In some states, mentally ill inmates must live in forced association only with other severely disturbed inmates, but without adequate

security, observation, or mental health care. For our purposes, we will refer to such areas as "psychiatric cellblocks." Other mentally ill inmates are housed even more inappropriately in some states, where in some cases obviously psychotic inmates are transferred to administrative segregation settings where they receive what they experience as punishment for an inability to "get along" in the general prison population.

In both the housing units for the mentally ill ("psychiatric cellblocks"), as well as administrative segregation units, it is once again the line staff to which the tasks of treatment fall. That this treatment is often inadequate should not be blamed on line staff, for they often provide these services with little or no training or support from administrators or mental health professional staff. Often, assignments to units are seen as undesirable or based upon physical size alone.

Fortunately, there are glowing exceptions to this dismal picture. Many Departments of Corrections, such as those in New York and Ohio, have created "satellite units" or "prison mental health centers," which apply the principles of community mental health to prisons. These units may provide brief respite care, quickly returning inmates whenever possible back to the mainstream of prison life where they can take part in normal prison programming.

Even in administrative segregation units, correctional officers can effectively use their training and experience to realize positive therapeutic outcomes with very difficult inmates. These outcomes are even more noteworthy since, in administrative segregation, the officers must deal not only with mentally ill inmates in need of treatment, but with chronically violent, angry, exploitive, and predatory inmates for whom extreme security measures are a constant necessity. By placing psychotic inmates in such settings, we are asking officers to behave in a sensitive and caring manner as therapeutic change agents for the mentally ill, while concurrently requiring them to follow extremely rigid security procedures, which allow them virtually no freedom of choice in relating to inmates.

In some administrative segregation units, principals outlined in this paper have long been put to use with significant success. To cite one example, in response to a very disrupted and dangerous segregation unit, the authors had the privilege of participating in the design and implementation a new behavioral program within the segregation unit of a large state prison. A behavioral treatment system was adopted which allowed inmates, even within strict security requirements, to earn or lose certain privileges. More importantly, for the vast majority of segregation inmates, it allowed them to earn their way toward return

to the general population. Thanks to good communication between the prison psychologist(s), the warden, and uniformed staff, inmates were responded to with consistency and respect. Rather than using officers to implement the programs designed by the psychologist, it was largely the officers themselves who identified reinforcers, developed schedules, and assessed progress. Incident rates, upon implementation of the program, dropped dramatically.

In the following case, officers in yet another Department of Corrections were able to use this model to solve a problem, which had frustrated mental health professionals for years:

> Byron Grant (fictitious) was a thirty-four-year-old inmate who had been living in various special housing situations within the prison for several years. He was a source of conflict among staff for a number of reasons. At times, he was quite lucid and insightful, and would even imply to staff that he "really knew what (he) was doing." At other times, he would fly into unreasonable rages with apparently psychotic ramblings of paranoid delusions. For the past several years, Mr. Grant had been eating, throwing, and smearing himself with his own feces, and on several occasions, had painfully assaulted himself. Various psychologists and psychiatrists had disagreed greatly on diagnoses ranging from "Non-Psychotic Management Problem" to "Borderline Personality" to "Manic-Depressive Illness" to "Paranoid Schizophrenia." To further complicate matters, it was sometimes possible to stop a psychotic rage by loudly ordering Mr. Grant to stop being psychotic.
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> Uniformed staff finally decided that it was not important for the "shrinks" to resolve their diagnostic dilemma, and suggested a very simple behavioral intervention. They had observed that Mr. Grant seemed to care most about three things. First, he was a chain smoker. Second, he would do almost anything for attention from authority figures, which included the psychologist, the warden, and anyone in uniform. Finally, the officers felt that Mr. Grant wanted to stay in isolation because he was, despite his threats, scared to death of other inmates. The implications of this last observation were profound. For years, mental health staff had been "rewarding" him for any sign of improvement by "allowing" him access to other inmates. To Mr. Grant, it followed that he had been "punished" for improvement by allowing other inmate's access to him. The officers suggested a program with four components:
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> 1. It was explained to Mr. Grant that no one was to be allowed to talk to him while he was engaging in self-destructive or psychotic behaviors, except to state necessary instructions. In fact, on at least two occasions, when it was necessary to place Mr. Grant in restraints (due to self-destructive behavior), staff did so without speaking.
> 2. One staff member was designated per shift to visit with Mr. Grant at least once per half-hour of appropriate behavior and to offer to join him for a cigarette at least once per hour of appropriate behavior.
> 3. Psychotherapy sessions with the psychologist were to be earned or lost based upon behavior during the week, to a maximum of three forty-five minute sessions per week. Significantly, it was Mr. Grant and a correctional officer who kept score.
> 4. Mr. Grant was told explicitly that he could decide when and to what extent he would mingle with other inmates.

> The program had three very positive effects. First, there was a marked decrease in self-destructive or violent behavior. At one point, Mr. Grant went nine months without an incident of this type. Second, Mr. Grant quickly learned the principles of the program he was on and was able to articulate its terms. He began to "bargain" for privileges and became a contributing member of his own treatment team. The third benefit was largely unintended. The uniformed staff took enormous pride in having made progress where the "shrinks" had failed. Moreover, they began to expand their creative use of behavioral programming to other inmates, often successfully.

The concepts outlined above are not new. Smith and his associates in Alabama incorporated these then novel strategies as early as the 1970's (31). They trained correctional officers as behavior technicians in a maximum-security state prison, with positive results. The training also resulted in an increase in number and percentage of positive interactions with inmates, and inmate perceptions that the trained officers had improved in general caliber, become less punitive and more concerned with the welfare of the inmates. Finally, the officers themselves felt that the techniques helped them in their work with inmates (31). It is hoped that by calling renewed attention to the successes of innovative facilities and practices around the country, others will follow suit and work toward implementing proactive strategies of their own.

Psychotropic Medication

On the surface, it may seem counterintuitive to consider advocating collaboration with correctional officers when it comes to medication, especially since the law generally allows only physicians to generally prescribe psychotropic medication, and in many states only nurses to dispense them. Before discounting the role of correctional officers in this area, however, we must look at the sources of information that are available to doctors in assessing symptoms before prescribing medication. Information about the patient comes primarily from four sources: 1) medical records, 2) self-report by the patient, 3) the Doctor's own observations of the patient, and 4) observations from other reliable persons of the patient's behavior/symptoms. In prison, the patient's self-report is highly suspect for several reasons. If psychotic, the patient's perceptions might be grossly distorted, as in any setting. When the patient is not psychotic, he or she may feign illness in order to obtain drugs for sale or personal abuse, or in an effort to move to a more comfortable setting. Inmates also may feign illness in order to avoid responsibility for rule violations.

The psychiatrist's own observations are often quite limited. As has been pointed out elsewhere in this paper, psychiatrists usually have very little opportunity to make these observations. Both authors have observed psychiatrists prescribe medications for as many as twenty inmates during a three-hour period. What is available to prison psychiatrists are the documented and verbal reports of observations by correctional officers who supervise their patients, and the nurses and medics who dispense the medication. The skillful prison psychiatrist will maximize this source of information by asking good questions, teaching staff specific behaviors to look for, and **above all**, listening to them. In many cases, as in the following example, their reports may be based on years of observed responses to different prescriptions and different doctors:

> An inmate, age forty-two-years, presented himself at sick call, describing symptoms of depression including early morning awakening, fatigue, poor appetite, and feelings of helplessness and hopelessness. A review of medical records documented a history of recurrent severe depressions, which had unaccountably not been treated with medication. The psychiatrist decided to begin treatment with Elavil (an antidepressant medication).
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> A correctional officer who had escorted the inmate to sick call asked the doctor what color the pills were. When told, he related to the doctor that, "someone gave him those five or six years ago the first time he was here, and he went crazy." The psychiatrist then asked for a second check of medical records, which turned up an additional prior record. This record verified a history of Manic-Depressive Illness, which had been successfully treated with Lithium Carbonate (a mood-stabilizing medication). Thanks to the unsolicited recollection of an officer, a possible manic episode was avoided. The patient was successfully treated with Lithium.

To further illustrate, we will look at so-called "medication compliance," or the willingness and ability of a patient to take prescribed medication, a common problem in prison psychiatry. Often, a psychiatrist may use an entire bag of tricks, including patient education, adjustment of doses, and medication to counteract side effects to enhance a patient's willingness to take medications, all to no avail. In desperation, a psychiatrist may turn to a correctional officer, a correctional medical assistant (medic), or the registered or licensed practical nurse who gives out the medication, who informs the doctor that the patient never takes his 8:00pm dose because he usually goes to bed at 7:00pm. The psychiatrist changes the hour of administration and the problem is solved. In this case, the area of expertise was not psychopharmacology, but the day-to-day behavior of one inmate, which the psychiatrist had never had the opportunity to observe. While this example may seem trivial or obvious at first glance, in the authors' experience, such obvious solutions

are missed with alarming frequency, particularly when treatment and security roles become polarized in the correctional setting.

HOW DO WE GET THERE FROM HERE?

Our society has placed the correctional line staff member in a very threatening and stressful environment, often without adequate training, and does not even acknowledge the extent to which he/she performs the very difficult role of therapeutic agent, which is often exclusively ascribed to mental health professionals. This article is not about creating a new role for line personnel—correctional officers have been supervising inmates since prisons began. We advocate rather an acknowledgement of what is already being done so that we might do it better. It is in this regard that mental health professionals might better serve the prisons in which they work.

The first way to acknowledge and foster this role in line staff is through consultation. Consultation between correctional and clinical staff is often informal, and based simply on the development of mutual trust and respect. Just as any other behavior can be extinguished, when we do not actively listen to line staff members who are willing to share their observations, they will eventually stop talking to us. Moreover, ignoring the input of line staff will not only result in diminished communication, but also serves to fortify polarization and mistrust across disciplines. Conversely, we can reinforce, often through a simple "thank you," those communications which are especially helpful while demonstrating a healthy respect for line staff. In return, they will share with us years of experience in corrections and hours of supervision of individual inmates. Bidirectional communication is, therefore, both a means and an end toward improving system function.

A second method of improving these relationships is the creation of treatment teams within the prison, which would consist of various different types of staff, always including correctional officers. Such treatment teams can be conceptualized as a more formal type of cross-disciplinary consultation. Often called unit team management, this tool has been used successfully by the Federal Bureau of Prisons and a number of state correctional training centers, and is gaining increasing support in the literature (32). Treatment teams can contribute to a feeling of cooperative effort among staff or various disciplines and inmates. By allowing the correctional officer to make "treatment" decisions and the "treatment staff" to contribute to security decisions, the inmate can be

helped to integrate the nurturing and the limit-setting parts of his or her world. Perhaps even more important are the changes in the officers, who may move from cynicism to finding fresh meaning in their work.

A third method of improving the relationship between line staff and mental health professionals is the most obvious—training. In the absence of collaborative cross-disciplinary training, conflicting approaches will reign. By design, line staff may be more likely to punish disruptive behaviors than to reward positive behaviors (33). Moreover, management difficulties are likely to arise when correctional officers are left unequipped to deal with mentally ill offenders (34). However, research indicates that many correctional officers are highly motivated to obtain additional training in working with mentally ill offenders (35). Moreover, training programs can serve not only to increase the effectiveness of service delivery across disciplines, but also to reinforce the similarities between correctional and clinical staff (36). It is imperative that mental health professionals take part in training academies for new staff, as well as in-service training programs for veteran staff. This allows a chance to create a positive attitude toward treatment services early, before biases have developed, and to break down some of those biases where they already exist. Further, it allows the mental health professional to demonstrate sensitivity to security concerns and a forum for demonstrating that treatment is indeed a necessity for good security rather than an impediment to it.

Anthony & Carkhuff (25) long ago demonstrated the value of training correctional officers in specific areas which relate to mental health outcome, such as interpersonal skills and program development skills. Of course, training, like consultation, is a two-way street. If mental health professionals are to be trusted, we must not only be willing to train, but to be trained. It is pompous to believe that a doctoral degree renders us unable to learn from someone else's thirty years of experience in prison. By taking part in basic training activities as a trainee, the mental health professional can learn a great deal about the realities of daily prison life and the special stresses which affect officers and inmates alike. We can also demonstrate an honest respect for the skills of experienced uniformed staff and humility about our roles in prison, which has been conspicuously absent from the experience of most uniformed staff with mental health professionals. It is only by allowing ourselves to become part of the prison that we can have our fullest impact on the prison and the individuals who must live and work within its walls or fences.

REFERENCES

1. United States Department of Justice: Prison and jail inmates at midyear 2002. Bureau of Justice Statistics, NJC 198877, April 2003.
2. United States Department of Justice: Prisoners in 2001. Bureau of Justice Statistics, NJC 195189, July 2002.
3. United States Department of Justice: Mental health and treatment of inmates and probationers. Bureau of Justice Statistics, NJC 174463, July 1999.
4. Pinta ER: Evaluating privilege requests from mentally ill prisoners. Journal of the American Academy of Psychiatry and the Law 26:259–265, 1998.
5. American Psychiatric Association: Psychiatric Services in Jails and Prisons, 2nd ed. Washington, DC, American Psychiatric Association, 2000.
6. United States Department of Justice: Mental health treatment in state prisons, 2000. Bureau of Justice Statistics, NJC 188215, July 2001.
7. Ferrell W, Morgan RD, Winterowd CL: Job satisfaction of mental health professionals providing group therapy in state correctional facilities. International Journal of Offender Therapy and Comparative Criminology 44:232–241, 2000.
8. Clements CB: Psychology, attitude shifts, and prison growth. American Psychologist 54:785–786, 1999.
9. Boothby JL, Clements C: A national survey of correctional psychologists. Criminal Justice and Behavior, 27:716–732, 2000.
10. Dvoskin JA, Patterson RF: Administration of treatment programs for offenders with mental disorders, in Treatment of Offenders with Mental Disorders. Edited by Wettstein RM. New York, Guilford, 1998.
11. Dvoskin, JA, Spiers, EM, Pitt, SE: Mental health professionals as institutional consultants and problem solvers, in Correctional Mental Health Handbook. Edited by Fagan T, Ax B, Lanham MD, American Correctional Association, 2002.
12. Metzner JL, Cohen F, Grossman LS, et al: Treatment in jails and prisons, in Treatment of Offenders with Mental Disorders. Edited by Wettstein RM. New York, Guilford, 1998.
13. Dvoskin, JA: Jail-based mental health services, in Effectively Addressing the Mental Health Needs of Jail Detainees. Edited by Steadman, HJ. Boulder, CO, National Institute of Corrections, 1990.
14. United States Department of Justice: Prisoners in 1999. Bureau of Justice Statistics, NJC 183476, August 2000.
15. Applebaum KL, Hickey JM, Packer I: The role of correctional officers in multidisciplinary mental health care in prisons. Psychiatric Services 52(10):1343–1347, 2001.
16. Gillan T: The correctional officer: one of law enforcement's toughest positions. Corrections Today 63:112–115, 2001.
17. Finn P. Addressing Correctional Officer Stress: Programs and Strategies. National Institute of Justice in cooperation with the Corrections Program Office, Washington DC, 2000.
18. Collins M: Traditional warrior ethics in modern correctional training. Corrections Today 64(5):16–20, 2002.
19. Thurrel RJ, Halleck SL, Johnson AF: Psychosis in prison. Journal of Criminal Law, Criminology, and Police Science 56:271–276, 1965.
20. Dvoskin JA, Spiers EM, Metzner JL, et al: The Structure of Correctional Mental Health Services. 2003.
21. Cohen F: The Mentally Disordered Inmate and the Law. Kingston, NJ, Civic Research Institute, 1998.

22. Morris SM, Steadman HJ, Veysey BM: Mental health services in United States jails: A survey of innovative practices. Criminal Justice and Behavior 24:3–19, 1997.
23. Armstrong JJ: Causes of institutional unrest, in Prison and Jail Administration: Practice and Theory. Edited by Carlson PM, Garrett JS. Gaithersburg, MD, Aspen, 1999.
24. Lambert MJ, Bergin, AE, Collins, JL: Therapist-Induced Deterioration in Psychotherapy in Effective Psychotherapy. Edited by Gurman AS, Razin AM. Oxford, Pergamon, 1977.
25. Anthony WA, Carkhuff RR: The functional professional therapeutic agent, in Effective Psychotherapy. Edited by Gurman AS, Razin AM. Oxford, Pergamon, 1977.
26. Lieberman, RP: Requirements for multidisciplinary teamwork in psychiatric rehabilitation. Psychiatric Services 52(10):1331–1342, 2001.
27. Lieberman RP, Glynn S, Blair KE, Ross D, Marder SR: In vivo amplified skills training: Promoting generalization of independent living skills for clients with schizophrenia. Psychiatry 65(2):137–155, 2002
28. Toch H, Adams K. Punishment, treatment, and prison infractions. Journal of Offender Counseling, Services, and Rehabilitation 12(2):5–18, 1988.
29. Muzekari LH, Lonigan CJ, Hatton AY, Rowe C: Mental health services in the county jail: A critical partnership. Psychological Reports 84:1099–1104, 1999.
30. Roskes E, Feldman R: A collaborative community-based treatment program for offenders with mental illness. Psychiatric Services 50, 1614–1619, 1999.
31. Smith RR, Milan MA, Wood LF, McKee JM: The correctional officer as a behavioral technician. Criminal Justice and Behavior 4(3), 1976.
32. Holt C: The Correctional officer's role in mental health treatment of youthful offenders. Issues in Mental Health Nursing 22(2):173–180, 2001.
33. Rice ME, Harris GT: The treatment of mentally disordered offenders. Psychology, Public Policy, and Law 3:126–183, 1997.
34. Versey BM, Steadman HJ, Morrissey JP, Johnsen MJ: In search of missing linkages: Continuity of care in U.S. jails. Behavioral Sciences and the Law 15:383–397, 1997.
35. Kropp PR, Cox DN, Roesch R, Eaves D: The perceptions of correctional officers toward mentally disordered offenders. International Journal of Law and Psychiatry 12(23):181–188, 1989.
36. Coleman C: The clinical effectiveness of correctional staff in prison health units. Psychiatric Annals 18(12):684–687, 1988.