MENTAL HEALTH WORK IN PRISONS AND JAILS

Inmate Adjustment and Indigenous Correctional Personnel

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Mental health efforts in prisons and jails most often ignore the mental illness prevention capabilities of main-line correctional personnel. By focusing on inmates with drug dependencies or severe psychiatric disorders, traditional mental health services have failed to come to grips with the problems created for "normal inmates" by the conditions of confinement. This article argues that indigenous correctional personnel might supplement the efforts of professional treatment staff by learning to assist inmates in coping with the stress produced by everyday institutional living conditions.

In recent years trends in scholarly research on prisons and jails, concerns of the medical and mental health establishment, and litigation in the area of prisoners' rights have begun to merge and focus on the quality of life in correctional institutions and what can be done to improve it. Hans Toch's *Living in Prison* (1977) and Johnson and Toch's *The Pains of Imprisonment* (1982) capsulize a shift in scholarly interest away from doing good (treatment, rehabilitation) to mitigating the physical and psychological harm caused by correctional institutions. Efforts of the American Medical Association to develop model health-care delivery systems (Anno, 1978) and reports by the General Accounting Office (Comptroller General, 1978, 1980) demonstrate medical and governmental interest in developing and implementing standards related to the mental and physical health of

CRIMINAL JUSTICE AND BEHAVIOR, Vol. 12 No. 1, March 1985 17-28

prisoners. In addition, the quantity and quality of health services and the debilitating effects of the conditions of confinement are increasingly being questioned in prisoners' rights cases (Winner, 1981) with many states now operating under court order regarding conditions of confinement.

These trends toward concern with the quality of inmate life merge with my interests in the character of working life in prisons and jails, and the exploration of the relationship of correctional staff to the quality of inmate life. Though history is replete with correctional staff contributions to the ill-health of inmates (for instance, Barnes, 1972: 150-200), the possibilities, shape, and extent of positive staff contributions have only recently been acknowledged and explored (see also Lombardo, 1981; Johnson, 1977, 1979; Johnson and Price, 1981; Klofas and Toch, 1982). This literature is beginning to show that correctional line personnel often desire to and do contribute to lessening the stress, pressures, and difficulties encountered by prisoners. Correctional personnel are often perceptive in reading signs of stress and interpreting those symbolic inmate gestures that reflect more underlying difficulties. Indigenous correctional staff are also capable of demonstrating inventiveness in employing scarce institutional resources to achieve a reduction of inmate stress. I see these findings as an indication that indigenous correctional personnel (the correctional officer, jail officer, deputy sheriff) are a resource that might be employed in helping to prevent and to reduce "mental illness" and in contributing to the overall mental health of prisoners.

DEFINING MENTAL HEALTH AND MENTAL ILLNESS

INDIGENOUS CORRECTIONAL STAFF

In speaking of the "mental health" and "mental illness" of prisoners, I am *not* using these terms in the clinical or medical

sense most frequently utilized in discussions of mental illness in prisons and jails. In the General Accounting Office report (Comptroller General, 1980: 1) "Jail Inmates' Mental Health Care Neglected," for example, the term mental health care "covers a broad spectrum of inmate problems, namely psychosis, neurosis, behavioral disorders, and alcohol and drug abuse and addiction." This emphasis on specific "medical/mental problems" usually leads to calls for the increased intervention of "professional" medical personnel and the establishment of "mental health units" (Clanon, 1981; Katsampes and Neil, 1981; McCarthy et al., 1982). By definition, the *medicalization* of mental health and illness in corrections bypasses indigenous correctional personnel when it comes to planning and delivering services to those suffering the effects of harsh prison and jail conditions. Medicalization also seems to dictate that we wait for the adequate funding of "professional mental health programs" before meaningful intervention can occur. In discussing the dilemmas of such professional mental health activities in prisons, Paul Wiehn (1982: 229-230) comments:

> Identifying and describing the mentally ill in prison is not difficult compared with the problem of finding ways to effectively intervene to help them. The fact that such variables as size and population of the facility, daily living condiitons, and access to jobs and training are normally beyond the control of prison mental health workers limits this treatment response and serves as an ever-present source of frustration for staff.

Wiehn seems to be saying that until the conditions of confinement are changed, the possibilities for meaningful mental health intervention will be severely limited. I would argue, however, that it is precisely the "conditions of confinement" impeding medicalized mental health treatment that should become the focus of indigenous correctional worker intervention.

I agree that those who come to our confinement institutions with *already-existing mental problems* and those suffering from substance abuse need specialized services, and I do not propose

that these problems be neglected. I would argue, however, that indigenous correctional personnel are uniquely situated to deal with many of the mental difficulties caused by "daily living conditions" referred to by Wiehn. By working to relieve conditions causing stress, indigenous correctional personnel supplement medicalized mental health programs by attempting to reduce the number of inmates needing "medical" services. Indigenous correctional personnel need to focus on *all inmates* (not just the mentally ill) and the effects on *all inmates* of the conditions of confinement.

I believe that Thomas Szasz's (1961) views of psychiatry and mental illness serve as a conceptual link between inmate mental health difficulties resulting from conditions of confinement and indigenous correctional workers. Szasz moves us from the medical model of mental illness and psychiatric treatment to a more *immediate problems in living* perspective very much applicable to difficulties encountered by people living in correctional settings. In discussing psychiatry as a theoretical science Szasz (1962: 7) writes:

> From the point of view presented here, *psychiatry consists of the study of personal conduct*—of clarifying and "explaining" the kinds of games that people play with each other; how they learned these games; why they like to play them; and so forth. Actual behavior is the raw data from which the rules of the game are inferred. From the many kinds of behavior, the verbal form—or communication by means of conventional language—constitutes one of the central forms.

Later, Szasz (1962:L 255) describes the relationship between the mentally ill and the professional therapist as "sick":

> Although ostensibly he [the patient] is requesting and receiving help, what is called "help" might be forthcoming only if he accepts the sick role and all that it may imply for his therapist. The principal alternative to this dilemma lies, as suggested before, in abolishing categories of ill or healthy behavior, and the prerequisite of mental sickness for so called psychotherapy. This

> implies candid recognition that we "treat" people by psychoanalysis or psychotherapy not because they are "sick" but rather because: (1) They desire this type of assistance; (2) They have problems in living for which they seek mastery through understanding of the kinds of games which they, and those around them, have been in the habit of playing; and (3) We want and are able to participate in their " education" because this is our professional role.

Extending Szasz's position to the relationship between prisoner mental difficulties and efforts of indigenous personnel to help prisoners cope with their problems, it is apparent that mental health services that wait for a troubled inmate to be defined as "sick" (for example, psychotic or neurotic) before mental health services are provided make little sense. This is especially true for those coping problems generated by the conditions of confinement. The main area of contribution of indigenous correctional staff to prisoner mental health is in the prevention of sickness by mitigating the sickness-producing conditions of our institutions. Indigenous correctional staff should recognize that inmates experience problems related to living in prisons and jails, and that inmates often communicate their desire for assistance through their behavior. Correctional staff, who through experience learn to interpret and manipulate the rules of "institutional games," should participate in the "educating of inmates" in the playing of such games. This education should help inmates to cope with the problems of living in confinement in a less destructive, if not more constructive, manner. *This task should be part of every correctional worker's professional role.* "Destructive" games played by correctional officers are all too common in the literature (Haney et al., 1977; Holt v. Sarver, 1970; Lombardo, 1981: 164-168). In many institutions these destructive games often become the norm around which a correctional officer subculture forms. However, the positive use of games envisioned here provides an alternative normative support system around which indigenous personnel might structure their roles. As Klofas and Toch (1982) have shown, this positive normative system often lies underneath a negative subculture that rests on "pluralistic ignorance."

MENTAL HEALTH WORK AND THE ROLE OF INDIGENOUS CORRECTIONAL PERSONNEL

Elsewhere I have tried to distinguish the kinds of services I am discussing here from what is traditionally thought of as mental health treatment (Lombardo, 1982). This distinction is important to understand if the relationship of correctional workers to inmate mental health difficulties is to become clear.

First, mental health services provided by indigenous correctional staff are generally *reactive* in nature. The decision to intervene and the choice of intervention strategies are responsive to the inmate involved in a specific situation or pattern of situations. It is the inmate who communicates his desire for help, and correctional personnel need to be alert for cues that express this need. Correctional workers responding to inmate needs do so with no set solution in mind, and no predetermined criteria for success. In this context success is judged by the inmate who learns to cope with his or her problems of living in a more effective manner. As prisoner mental health treatment is usually discussed, it is generally *proactive.* Mental health professionals seek out those in need of treatment through diagnostic processes, and attach the sick label to those who will receive treatment. The treatment strategy is then determined by the specific sick label attached. The treater, not the client, judges when successful treatment has been achieved (Steadman and Ribner, 1980; Clanon, 1981).

Second, providing mental health services in the context of problems generated by conditions of confinement is an activity aimed at the inmate's here and now, present state of affairs. Whether the inmate overcomes some deep-seated psychological condition, becomes a "better person" when released, or changes his or her way of life, is largely irrelevant. What matters is that the inmate's relationship to problematic conditions of confinement is adjusted in such a way that the particular condition no longer causes a level of stress that goes beyond the inmate's ability to cope successfully.

IMPLICATIONS OF A "MENTAL HEALTH" PERSPECTIVE

The proposed mental health component of the indigenous correctional worker's role is not intended to detract from the role's traditional association with security, order maintenance, rule enforcement, and supervision. Rather, a mental health perspective allows those traditional functions to be observed through a lens that transforms the *ground* against which they are viewed from "institutional control" to inmate mental health.

When correctional officers "keep inmates from killing one another," and "keep stealing, gambling, and homosexuality to a minimum" they are imposing institutional control. More important, from the perspective of mental health they are demonstrating an awareness of the positive aspects of controlling behavior. They are providing safety and security to inmates who may fear and be troubled by an inherently violent environment. When correctional personnel enforce rules, they are upholding the institution's authority over inmates. When they strive to do so with consistency and fairness and employ rule violation situations as a mechanism for communicating useful information to inmates (Lombardo, 1981: 88-89) they are helping to provide structure and predictability in an environment that often appears chaotic and uncontrollable. What is important is not the content of the correctional worker's role, but rather that role performance be viewed as having an effect on the manner in which inmates experience the conditions of confinement.

In addition to providing new perspectives on the correctional workers' role the "mental health" approach implies that correctional officers gain a new appreciation for the environment in which they work. The jail or prison environment obviously is structured to achieve institutional needs for security and efficiency in control and movement. But from a mental health perspective the structured environment contributes to the stress of confinement. In addition, it contains people, places, and resources capable of reducing stress.

In *The New Red Barn* (1973: 40) William Nagel describes a young architect's assessment of prison structures:

> There are two major problems there—overdetermination and the removal of referents. Overdetermination he said is the condition in which everything—decisions, space, movements, and responsibility is clearly and narrowly defined. Removal of referents means the inducing of uncertainty by cutting off ties with the past, by grossly reducing contact with people, places and activities. In time, both overdetermination and removal of referents result in constriction and atrophy. The person subjected to them stops growing, learning, feeling. In short, confinement with its overdetermination and removal of referents prepares one only for confinement.

Though correctional workers can do little to reconstruct the physical jail or prison environment, an awareness that the environment contributes to stress and mental illness (from a problem of living perspective) alerts correctional personnel to the possibility that the problematic behavior of inmates may be a reflection of the context in which it occurs and not simply a reflection of an "unstable personality" or a psychotic personality.

This possibility can lead correctional workers to help inmates adjust to the environment in ways that reduce stress. In *Living in Prison*, Toch (1977) dramatically explores the relationships between prisoners and their environments. Seymour (1977: 179-180) pointed out that all institutions contain a variety of settings that may serve as "niches" for specific inmates:

> While some inmates show surprising resiliance to stress, we have considerable evidence that a more vulnerable group exists. These men become salient when they inflict self-injury or are transferred to a clinical setting. We are aware that they exist when we see a novice demanding protection, watch an older inmate explode with frustration, or see a man continuously limiting himself to mandated group activities. We are aware of such inmates, but they are labelled as weak, intransigent, or loners, and their behavior is diagnosed as an idiosyncratic emotion reaction of no generic importance. . . . We take a broader view of the vulnerable inmate, by exploring the process whereby he ameliorates his stress. We shall see that inmates in prison settings accommodate a larger number of worlds.

For the correctional worker concerned with a mental health perspective, this awareness of environment-inmate relations implies a constant need to inventory the institutional environment to assess its possibilities for stress amelioration. As Toch (1977) has shown, "niches" often provide inmates with refuges from the overall harmful effects of prison and jail life.

The mental health perspective described here also has important implications for staff training and research. Though staff training has continually been addressed as an area in need of improvement (Comptroller General, 1980; 14), one difficulty has been defining the substance of that training. The mental health role for indigenous correctional personnel calls for training efforts related to a positive assessment of correctional staff task—helping inmates cope with living in correctional institutions. To perform this task correctional workers need to develop skills in the following areas: (1) reading behavioral cues that express inmate distress; (2) assessing the institutional environment for factors that contribute to stress; (3) assessing the environment for resources that might help alleviate stress and (4) developing strategies for getting troubled inmates and resources together. Such training focuses on activities many officers perform informally (Lombardo, 1981, 1982; Johnson, 1977, 1979). It also provides opportunities for job enrichment often desired by many correctional workers (Brief et al., 1976; Toch and Klofas, 1982).

In addition, the development of training techniques aimed at such skills calls for more research into the practices of jail and prison personnel and the impact of such practices on inmates. This need is particularly acute in jails where indigenous personnel have all but been forgotten (Gibbs, 1982: 111).

CONCLUSION

The contributions of indigenous correctional workers to the mental health of inmates is an area with vast potential. For this resource to be developed, correctional officers must first be thought of as having the potential to contribute to stress

alleviation and mental illness prevention. In addition, the problems of mental illness in institutions must be reconceived as being related to problems of living in a stress-inducing environment. In this way, one group of potentially mentally ill offenders—those reacting to the conditions of confinement—can be reduced in size. This may not increase the good our institutions do, but it will certainly aid in minimizing their harm.

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