

Mental Illness in Prison: Inmate Rehabilitation & Correctional Officers in Crisis

SpearIt†

INTRODUCTION

In July 2005, the state of California Department of Corrections (CDC) adopted “Rehabilitation” as a part of its official title, becoming the “California Department of Corrections and Rehabilitation” (CDCR).¹ This change in name, however, has not inspired a change in substance, and there is much doubt as to whether rehabilitation can be realized in any meaningful sense. Since the word “Corrections” was already extant in the title, the symbolic change of name must signify that “Rehabilitation” has a different meaning than “Corrections.” From the outset, then, we must understand rehabilitation as something that moves beyond mere punishment for corrective purposes. Exactly what rehabilitation means in the prison context remains a mystery, and as the following research suggests, the mental health crisis in California prisons poses a challenge to the CDCR in carrying out the additional task of rehabilitation. To be sure, the quest for rehabilitation may be aggravated by CDCR policy through its reliance on supermax units, prisons that achieve maximum control over inmates, which were not designed for rehabilitation and instead cripple the possibility of rehabilitation.²

Although the reentry of rehabilitation into the CDCR’s regime is official, it is not so evident what this practically entails. On the CDCR website, for

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1. Office of the Governor, *Governor Schwarzenegger Signs Legislation to Transform California’s Prison System*, press release (2005), <http://gov.ca.gov/index.php?press-release/1935/>.

2. SASHA ABRAMSKY, *AMERICAN FURIES: CRIME, PUNISHMENT, AND VENGEANCE IN THE AGE OF MASS IMPRISONMENT* 136 (2008).

example, “Adult Programs” is mentioned as the “heart of rehabilitation activity,” listing as its three primary goals:

- Provide effective evidence based programming to adult offenders
- Create strong partnerships with local government, community based providers, and the communities to which offenders return in order to provide services that are critical to offenders’ success on parole
- Establish and nurture collaborative partnerships linking Department facilities and communities in which they are located³

Beyond these bold statements, the website provides little additional detail explaining how any of the above is supposed to be carried out. For example, the notion of “evidence-based programming” has been described as the attempt to answer the question, “What works?”⁴ In terms of prison programming, “what works” would mean employing a program that “has been rigorously tested and has been shown to have a meaningful and statistically significant effect on the outcome for which the program was designed (e.g. reducing recidivism).”⁵ Yet in spite of the CDCR’s advocacy of tested programming and the CDCR’s other stated goals, it is difficult to imagine how the CDCR can successfully implement these programs in California’s gargantuan system, where resources are scarce and overcrowding is severe. When the very methods for achieving rehabilitation are either limited or unavailable, it is a challenge to see how rehabilitation is supposed to find success.

Although the CDCR’s plan for prisoner-rehabilitation is far from evident, there are other unanswered questions surrounding this plan. For example, is “rehabilitation” a self-evident concept? Does it have the same meaning to the prisoners and institution? Does every prisoner need rehabilitation? Or at an even more basic level, what is rehabilitation’s goal? These deceptively simple questions become complex and convoluted when one considers the role of the officers who tend to the twenty-four hour custody of inmates.⁶ Of all prison personnel, these officers spend the most time with prisoners, yet they often have a negligible role in the rehabilitation process. At the very least, one might wonder how correctional officer training techniques have responded to the growing menace of mental illness behind bars. It has long been noted that introduction of treatment goals, like rehabilitation, within prisons has resulted in conflicting role definitions for officers.⁷ The question of treatment versus

3. CAL. DEP’T OF CORR. & REHAB., DIVS. AND BDS.—ADULT PROGRAMS (2008), http://www.cdcr.ca.gov/Divisions_Boards/Adult_Programs/index.html.

4. Howard N. Snyder, *Research’s Two Modes for Discovering Evidence-Based Programming*, CORRECTIONS TODAY, April 2006, available at http://www.aca.org/research/pdf/researchnotes_april06.pdf.

5. *Id.*

6. “Line” officer is used somewhat interchangeably with “rank and file” and “peace” officer. As used throughout the rest of this study by different sources, these terms intend to indicate those who oversee to the day to day custodial care of inmates.

7. Eric D. Poole & Robert M. Regoli, *Alienation in Prison: An Examination of the Work*

security has also been called the “adversarial relationship between treatment facilitators and correctional officers,”⁸ which can often produce confused results. In the fusion of roles, officers must maintain discipline over prisoners with a heavy hand, the same hand that has to deliver food and medication.

Other questions surround the notion of rehabilitation and our basic understanding of the term. Yet despite uncertainties about rehabilitation, as a result of recent legislation,⁹ the law requires the CDCR to implement a plan to obtain additional rehabilitation and treatment services for prisoners.¹⁰ Etymologically, the word rehabilitate is composed of the latin *re* (again) and *habitare* (make “fit”); the notion of rehabilitate has therefore historically meant something like “to make fit again” or “to restore.”¹¹

Determining exactly what “fit” means is no easy task. One quantitative gauge for the success of rehabilitation is the rate of inmate recidivism.¹² Although this is not the sole indicator, attention to recidivism is one way of monitoring how effective prisons are at rehabilitating.¹³ Currently, as Joan Petersilia in *Understanding California Corrections* reports, “Only 21% of California parolees successfully complete parole—half the national average—and two out of three inmates returning to prison are parolees.”¹⁴ The most recent accounting by the CDCR puts the total number of parole returns at 93,279 of the total number that entered prison in 2007.¹⁵ These figures indicate that only a fraction of ex-prisoners are successfully restored to society, regardless of the underlying causes of recidivism;¹⁶ yet for prisoners with severe mental illness, approximately 80% recidivate.¹⁷

The quest for rehabilitation might be further complicated when correctional officers do not subscribe to a rehabilitation philosophy. In a recent

Relations of Prison Guards, 19 CRIMINOLOGY 251, 257 (1981).

8. DON A. JOSI & DALE K. SECHREST, THE CHANGING CAREER OF THE CORRECTIONAL OFFICER: POLICY IMPLICATIONS FOR THE 21ST CENTURY 123 (1998).

9. See generally DEP’T OF CORR. & REHAB., DIVS. AND BDS.—AB 900 JAIL CONSTRUCTION FUNDING (2007), http://www.cdcr.ca.gov/Divisions_Boards/CSA/CFC/AB900_Jail_Construction_Funding.html.

10. See CAL. PENAL CODE § 2062.

11. Online Etymology Dictionary, <http://www.etymonline.com/index.php?l=r&p=8>.

12. LISE MCKEAN & CHARLES RANSFORD, CURRENT STRATEGIES FOR REDUCING RECIDIVISM 8 (2004), <http://www.impactresearch.org/documents/recidivismfullreport.pdf>.

13. *Id.*

14. JOAN PETERSILIA, UNDERSTANDING CALIFORNIA CORRECTIONS 2 (2006). There are other complications which make these numbers inflationary. For example, in California, technical violations account for a significant percentage of entering prisoners; as the same report notes, California has a “catch-and-release crime policy that churns inmates back and forth between prison and community...” *Id.* at 75-76.

15. DEP’T OF CORR. AND REHAB., CALIFORNIA PRISONERS AND PAROLEES 2007 (2008).

16. Mark W. Lipsey & Francis T. Cullen, *The Effectiveness of Correctional Rehabilitation: A Review of Systematic Reviews*, ANN. REV. L. & SOC. SCI. 297 (2007) (offering meta-analysis of literature on recidivism and rehabilitation).

17. Council on Mentally Ill Offenders, *Incarcerated Mentally Ill: A Growing Issue in California*, <http://www.cdcr.ca.gov/COMIO/Legislation.html>.

study on California correctional officers' attitudes toward rehabilitation, one researcher found:

While about 46% agree that rehabilitation should be a central goal of incarceration, there is reasonable consensus that it should not be the only, or even the primary, purpose of a prison. Instead, a majority of correctional officers believe that *both* rehabilitation and punishment should be goals of a prison.¹⁸

These findings raise questions about how rehabilitation might function in an environment where a minority of correctional officers subscribe to the Department's philosophy. This data clearly conflicts with the CDCR's stated goals and mission. Whether the State and CDCR can construct a viable rehabilitation programs depends on how successfully they can deal with the problems outlined in this article.

Section I examines the shifts in health and criminal policies that have persisted in the incarceration of mentally ill offenders, which includes the practical and psychological influences of mentally ill prisoners in the lives of other inmates. Section II examines the training of correctional officers considers the additional stress of mentally ill prisoners and how this affects inmate rehabilitation. This work concludes with a final commentary on the study of mental illness and rehabilitation in California prisons.

I. THE PRISON AS ASYLUM AND DRAGNET OF THE MENTALLY ILL

Mental illness is prevalent in U.S. prisons.¹⁹ The Bureau of Justice Statistics reports that over half of all prison and jail inmates nationwide have mental health problems—totaling well over one million inmates.²⁰ In California, a report published on CDCR's website by the Council on Mentally Ill Offenders notes that “in 1998, people with severe mental illness accounted for 11% of [the] state prison population. In 2003, it was 16%. In 2006, it was estimated to be 20%.”²¹ Although there is no conclusive study that explains how this crisis came about, how the state's mentally ill population nearly

18. Amy E. Lerman, *Learning to Walk “the Toughest Beat”: Quasi-Experimental Evidence on the Role of Prison Context in Shaping Correctional Officer Attitudes towards Rehabilitation* (Nov. 18 2008) (Berkeley Center for Criminal Justice Roundtable); see also Francis T. Cullen et al., *The Correctional Orientation of Prison Guards: Do Officers Support Rehabilitation?*, 53 FED. PROBATION 33, 40 (1989).

19. See Pamela M. Diamond et al., *The Prevalence of Mental Illness in Prison*, 29 ADMIN. & POL'Y IN MENTAL HEALTH 21 (2001).

20. Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (2006), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>; in 2000, the American Psychiatric Association reported estimates that as many as one in five prisoners were seriously mentally ill. Am. Psychiatric Ass'n, *Psychiatric Services in Jails and Prisons*, at xix (2d ed. 2000); see also *Impact of Mentally Ill Offenders on the Criminal Justice System: Hearing Before the Subcomm. on Crime of the H. Comm. of the Judiciary*, 106th Cong. 10 (2000) (statement of Rep. Strickland).

21. Council, *supra* note 17.

doubled in eight years, it is a noteworthy transformation that demands further exploration.

Mental illness is an expansive term and can include milder forms of illness, such as anxiety or depression, as well as more severe forms of illness, including bi-polar disorder, schizophrenia, and full-blown decompensation. For prisoners, it is not uncommon to display comorbid disorders. Further complicating these considerations is the fact that a person's mental condition is not static; rather, it can be temporarily improved through treatment only to relapse later.

As a result of these institutional trends, the path to mental health treatment has changed. One study reports that by 2005, jails had become the "primary source" of treatment for Californians,²² and some scholars have even suggested that prisons are the primary mental health care provider for Americans.²³ This phenomenon has been articulated in *Ill Equipped: U.S. Prisons and Offenders with Mental Illness*, a decade-long study published in 2003 that explains the historical and sociological contours of mental health in prisons: "Fifty years ago, public mental health care was based almost exclusively on institutional care and over half a million mentally ill Americans lived in public mental health hospitals. Beginning in the early 1960s, states began to downsize and close their public mental health hospitals, a process called 'deinstitutionalization.'"²⁴

The closure of many state mental facilities without sufficient outpatient services may have led to the incarceration or homelessness of many of these former patients.²⁵ California's current overcrowded condition has stretched resources to the point of making correctional officers something of a new therapist, a role perhaps better left to trained psychologists. The likelihood of officers making medically-impacting decisions is especially acute during evening hours when mental health staff is not present.²⁶ In the face of psychotic, abnormal, or even violent behavior by an inmate, officers often lack the training to recognize the difference between genuine mental illness and an

22. CAL. BD. OF CORR., MENTALLY ILL OFFENDERS CRIME REDUCTION GRANT: ANNUAL REP. TO THE LEGISLATURE 2 (June 2004), available at http://www.bdcrr.ca.gov/cppd/miocrg/2004_annual_report/miocrg_2004_annual_report.doc.

23. See e.g., Gerald E. Nora, *Prosecutor as "Nurse Ratched"?: Misusing Criminal Justice as Alternative Medicine*, 22 CRIM. JUST. 23 (2007) (discussing the transition from mental hospitals as primary caretaker for the mentally ill to the present, where prisons fulfill that function); Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 4 HARVARD C.R.-C.L. L. REV. 391, 391 (2006).

24. HUMAN RIGHTS WATCH, *ILL EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* (2003), available at <http://hrw.org/reports/2003/usa1003/usa1003.pdf> (last visited Nov. 6, 2008).

25. Stephen Allen, *Mental Health Treatment and the Criminal Justice System*, 4 J. OF HEALTH & BIOMED. L. 153, 157-58 (2008).

26. Jamie Fellner, *Prison Reform: Commission on Safety and Abuse in America's Prisons: A Conundrum for Corrections, A Tragedy for Prisoners: Prisons as Facilities for the Mentally Ill*, 22 WASH. U. J.L. & POL'Y 135, 143 (2006).

inmate who is purposefully breaking the rules or faking illness.²⁷

In the prison environment, having a mental illness predisposes prisoners to engage in the type of erratic, destructive behavior likely to lead to a disciplinary hearing or a trip to solitary confinement.²⁸ This situation is only inflamed when illness is left untreated. Yet even in the face of this glaring institutional malady, prisons are unrelenting in their approach toward punishment as the mentally ill are disproportionately represented among prisoners in segregation.²⁹ In addition, those with severe mental illnesses have more difficulty adapting to prison when compared to the rest of the population.³⁰ And among mentally ill prisoners, suicide is an extreme, yet prevalent, marker of poor adjustment to incarceration.³¹ These facts suggest that untreated mental illness is likely to result in abnormal behavior, behavior over which an inmate has limited control, and which is likely to illicit the most severe punishments from prison staff.

These vast shifts in social and prison policy have brought us to the present where “thousands of mentally ill persons across the country are being punished—not for being criminal, but for being sick.”³² On the street, untreated illnesses and related behaviors are likely to attract the attention of police, resulting in jail or imprisonment. This point was illustrated in a study revealing that 90% of mentally ill inmates in the Los Angeles County Jail were repeat offenders and that nearly 10% of those offenders had been previously incarcerated at least ten times.³³ With this county jail providing the main pipeline to California prisons, it is easy to see why the system is clogged with mentally ill prisoners—they are being funneled in from the jails, where rates of mental illness are even higher than in prison.³⁴

Still, understanding the socio-legal factors that have gone into the mental health problems in prison does not say anything about what happens inside the prison proper. As noted above, mental illness enters prisons via individuals with pre-existing mental conditions. Additionally, the punishment of solitary confinement has been shown to trigger and aggravate mania and other types of

27. *Id.* at 143.

28. Abramsky, *supra* note 2, at 143.

29. David W. Ball, *Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation: Strategies for Improving Treatment and Reducing Recidivism*, 24 J. CONTEMP. HEALTH & POL'Y 1, 17 (2007); Fellner *supra* note 26, at 402.

30. T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. OF CRIM. L. 283, 299 (1997); *see also* Terry Kupers, PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT, at xvi (1999).

31. Stone, *supra* note 30 at 299.

32. Allen, *supra* note 25, at 180.

33. *Mentally Ill Offender Treatment and Crime Reduction Act of 2003: Hearing on S.1194 Before the Subcomm. on Crime, Terrorism and Homeland Security of the H. Comm. on the Judiciary*, 108th Cong. (2004) (statement of Cheri Nolan, Deputy Assistant Att'y Gen., Office of J. Programs).

34. James, *supra* note 20.

psychological afflictions.³⁵ The general problem of mental illness is only exacerbated by neglect in treatment, which, in California's case, has forced federal authorities to take over the state's prison health services.³⁶ Perhaps now more than ever the state is learning that prisons were never intended to serve as mental health facilities.³⁷

A. *Ill by Punishment*

The empirical literature on solitary confinement has painted an ominous picture when describing its negative effects on inmates.³⁸ In many prisons, this confinement is typically twenty-two to twenty-three hours a day, with breaks every other day for exercise and showers. In the U.S. federal prison system, solitary prisoners are detained in a "Special Housing Unit" ("SHU"), whereas California's version is designated as "Security Housing Unit" (also "SHU"). Studies on California prisons have demonstrated how mental illness can be manufactured behind bars. In *Prison Madness*, a study that focused largely on California SHUs, the author asserts that harsh conditions in prison have a "particularly deleterious effect on the mental health of all prisoners."³⁹ In solitary confinement, "prisoners with preexisting psychiatric disorders are at even greater risk of suffering psychological deterioration while in segregation."⁴⁰ From the earliest days of Quaker penitentiaries to modern supermax facilities, research on solitary confinement has amounted to one long warning about the ill effects of prolonged isolation.⁴¹

As early as the 1830s, empirical evidence began to show an increased incidence of mortality and physical morbidity in prisoners exposed to rigid forms of solitary confinement.⁴² More recently, studies offered by plaintiffs in *Madrid v. Gomez* indicate that today even the healthiest of SHU inmates runs a significant risk of hyper-responsiveness and severe forms of anxiety.⁴³ The risk of hyper-response is critical in prison since a glance or accidental bump typically must be tolerated. However, for one prone to over-responding, such an innocuous event might be interpreted as being disrespected, a challenge, or any similarly imagined threat. Thus, although prison administrations have an

35. Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. PSYCHIATRY 1450, 1450 (1983).

36. See Summary, *2008 Developments in Juvenile Justice: Realignment, Proposition 6, and Changes to Competency Decisions*, 14 BERKELEY J. CRIM. L. 125.

37. Fellner, *supra* note 26, at 137.

38. See Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 508 (1997).

39. Kupers, *supra* note 30, at xvi.

40. Fellner, *supra* note 23, at 403.

41. See Grassian, *supra* note 35.

42. DAVID ROTHMAN, *THE DISCOVERY OF THE ASYLUM* 87 (Aldine Transaction) (1971).

43. Sally Mann Romano, *If the SHU Fits: Cruel and Unusual Punishment at California's Pelican Bay State Prison*, 45 EMORY L.J. 1089, 1130 (1996).

interest in minimizing environmental stressors in prison, the effects of solitary confinement will be against this possibility.

The maddening tendencies of California's SHUs have not gone unnoticed by mainstream media outlets. To illustrate, in a front-page article entitled "The Cruellest Prison," the *L.A. Times Magazine* reports that these units are "turning inmates into mental cases," the effects of which are "hallucination; hypersensitivity to external stimuli; paranoia; panic attacks; hostile fantasies involving revenge, torture, and mutilation. . . smearing oneself with feces or biting chunks of flesh from one's own body."⁴⁴ The report details case after case of prisoners who spent large blocks of time in solitary confinement, sometimes up to seven years, to be released to the public after a mere two weeks' time to readjust to light, conversation, and other stimulants.⁴⁵ In this environment, it has been asserted that the ultimate measure of the SHU's violence is the "intensity and prevalence of the insanity they create."⁴⁶ At the very least, this type of isolation intensifies the pains of prison with little concern for the long term psychological consequences to prisoners,⁴⁷ which directly inculcates the question of rehabilitation. Although there is no research focused specifically on the mental state of officers who work in solitary units, "there is reason to believe that the level of fear and uncertainty is higher among them than guards working in the general prison population."⁴⁸

Prisoners have also been widely known to hurt themselves under the stress and frustration of solitary confinement. The effects of an environment in which a prisoner typically spends nearly twenty-four hours a day locked in an eight-by-ten feet cell,⁴⁹ the effects of isolation can take their toll rapidly. This environment is known to induce intense rage and disorientation in prisoners.⁵⁰ As the report above soberly reminds us, the most pressing fact in these scenarios is that most of the prisoners in SHUs will one day be freed to return to society, albeit angrier, more impulsive, and more unbalanced than ever.⁵¹ Sometimes these individuals do not even make it back out—as one study on the CDCR shows, segregated inmates are prone to suicide; in 2003, 74% of all inmate suicides took place in administrative segregation.⁵² The various

44. Vince Beiser, *A Necessary Evil?*, L.A. TIMES MAG., Oct. 19, 2003.

45. *Id.*

46. CHRISTIAN PARENTI, LOCKDOWN AMERICA: POLICE AND PRISONS IN THE AGE OF CRISIS 207 (2000).

47. Haney, *supra* note 38, at 566.

48. Haney, *supra* note 38, at 528.

49. Scott N. Tachiki, *Indeterminate Sentences in Supermax Prisons Based upon Alleged Gang Affiliations: A Reexamination of Procedural Protection and a Proposal for Greater Procedural Requirements*, 83 CAL. L. REV. 1115, 1123 (1995).

50. Kupers, *supra* note 30, at XVIII.

51. Beiser, *supra* note 44.

52. Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999-2004*, 7 JAIL SUICIDE MENTAL HEALTH UPDATE 9 (2008), available at <http://www.ncianet.org/Fall%202008.pdf>.

negative effects of solitary confinement, beyond merely frustrating the goals of rehabilitation, can also inflict long-term psychological damage on inmates.

B. Deficiencies in Mental Health Care

In addition to the punishments described, the question of rehabilitation must confront the consequences of high rates of mentally ill offenders and the poor treatment, if any, they receive. At the national level, former-President George W. Bush's New Freedom Commission on Mental Health in 2002 reported that mental health in the United States was in "shambles."⁵³ In the prison environment, an entire body of jurisprudence addressing mental health has developed, and recent legislation has seen the passing of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004.⁵⁴

Yet despite such statements and legislation, deficiencies in mental health care in prison persist to the present. In 2005, the Commission on Safety and Abuse in America's Prisons described the effects of neglect in mental health care:

Without the necessary care mentally ill prisoners suffer painful symptoms and their conditions can deteriorate. They are afflicted with delusions and hallucinations, debilitating fears, and extreme and uncontrollable mood swings. They huddle silently in their cells and mumble incoherently or yell incessantly. They refuse to obey orders or lash out without provocation. They assault other prisoners or staff. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit suicide.⁵⁵

In spite of the real possibility of psychological damage from punishments, at the federal level, the Prisoner Litigation Reform act of 1995 (PLRA) and the Anti-terrorism and Effective Death Penalty Act of 1996 (AEDPA) present a nearly "impenetrable wall" against prisoners' legal redress for human rights violations.⁵⁶ For example, section 1197(e) of the PLRA provides that "no Federal civil action may be brought by a prisoner confined in a jail prison, or other correctional facility, for mental or emotional injury suffered while in custody without a prior showing of physical injury."⁵⁷ For the mentally ill in federal prisons, claims have been made even more difficult by courts that simultaneously disregard the fact that severe mental distress often has a physical substrate and deny that some kinds of mental suffering constitute

53. See RICHARD G. FRANK & SHERRY A. GLIED, *BETTER BUT NOT WELL 2* (2006).

54. See generally Ralph M. Rivera, *The Mentally Ill Offender: A Brighter Tomorrow Through the Eyes of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004*, 19 J.L. & HEALTH 107 (2004).

55. Fellner, *supra* note 26, at 137.

56. TARA HERIVEL & PAUL WRIGHT, *PRISON NATION: THE WAREHOUSING OF AMERICA'S POOR* 279 (2002).

57. 42 U.S.C. § 1997e(e)(2006).

physical injuries in their own right.⁵⁸ Thus for some who suffer psychological damage from incarceration, there may be little legal redress.

In California prisons, many medical conditions go untreated and those who do receive treatment likely receive such “poor mental health services” that many prisoners are left with inappropriate types or amounts of psychotropic medication that further impairs their ability to function.⁵⁹ As Judge Henderson found in *Plata*, “The Court does not believe that the Constitution can reasonably be construed to require the court to sit idly by while people are needlessly dying.”⁶⁰ Some of these problems are a direct result of poor prison policy and antiquated record keeping and computing. Often a simple matter like drug treatment is interrupted when prisoners are transferred between prisons or when lockdown procedures forbid the delivery of medication.⁶¹ In addition to lack of treatment, the prison experience itself has been shown to have generally negative effects on prisoners.⁶²

Widespread deficiencies in mental health care in California were first exposed in the massive *Madrid v. Gomez* class action suit.⁶³ Filed on behalf of some 3,600 Pelican Bay prisoners in 1993, the 1995 decision was decided in favor of prisoners. Judge Thelton Henderson held that prisoners had been subject to excessive violence, cruel and unusual punishment, and that mentally ill inmates could no longer be confined in the SHU.⁶⁴ Furthermore, the decision held that the “Eighth Amendment simply does not guarantee that inmates will not suffer some psychological effects from incarceration or segregation.”⁶⁵ But Judge Henderson was quick to temper its meaning:

However, if the particular conditions of segregation being challenged are such that they inflict a serious mental illness, greatly exacerbate mental illness, or deprive inmates of their sanity, then defendants have deprived inmates of a basic necessity of human existence—indeed, they have crossed into the realm of psychological torture.⁶⁶

It is telling that ten years after this decision, Henderson would end up ordering the prison over to a special master. This was a drastic move against the state since a special masters’ job is to ensure that court orders are carried out. With the federal judiciary micromanaging the State’s actions, the appointment of the special master was a sign that California’s mental health

58. *Developments in the Law - The Law of Mental Illness*, 121 HARV. L. REV. 1145, 1151 (2008).

59. Fellner, *supra* note 23, at 391.

60. *Plata v. Schwarzenegger*, No. C01-1351TEH, 2005 U.S. Dist. LEXIS 8878, at *23-24 (N.D. Cal. May 10, 2005).

61. Ball, *supra* note 29, at 11.

62. See generally Alison Liebling & Shadd Maruna, THE EFFECTS OF IMPRISONMENT 10-13 (Willan 2005).

63. *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

64. *Id.* at 1146.

65. *Id.* at 1264.

66. *Id.*

system, far from being able to provide effective treatment, was itself in need of rehabilitation.

In 1995 the court also decided *Coleman v. Wilson*, where it held the entire mental health system operated by the California Department of Corrections (CDC) as unconstitutional and that prison officials were deliberately indifferent to the needs of mentally ill inmates.⁶⁷ Today, all thirty-three institutions in the CDCR are in receivership to evaluate the CDCR's compliance with the court's order.⁶⁸ In this ongoing supervision, the department has not been able to fulfill its bare constitutional requirements in health care and as a result, the department has established a "decentralized system of mental health care."⁶⁹ The response of decentralizing care is evident in places like San Quentin State Prison, whose mental care facilities were practically non-existent before the appointment of the special master. Yet as of this writing, there is construction on a new medical facility for San Quentin that includes beds for mental health treatment.⁷⁰

Although California prisons have proven a failure in mental health, there are other, more effective models for providing effective mental health services for inmates⁷¹ the use of which could perhaps avert further entrenchment in the prison mental health crisis. For example, the Pace program in Boulder County, Colorado, prominently diverts the mentally ill from prison.⁷² The County Sheriff credited the Pace program with cutting down on clients' "cumulative jail time from roughly 10,800 days a year to only 800."⁷³ Although such a remarkable success is not dispositive of its ability to succeed in a state as troubled as California, it may point to the simple idea that actively trying to divert the seriously mentally ill from prison may alleviate many problems in the first place.

Taken wholly, the deficiencies in mental health care in California prisons are drastic, and existing mental illness is often exacerbated through lack of treatment. As the next section shows, mental illness does not simply linger in the untreated individual, rather, it negatively impacts the entire prison

67. *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995).

68. California Prison Health Services, Frequently Asked Questions, <http://www.cphcs.ca.gov/faq.aspx>.

69. REPORT OF THE CORRECTIONS INDEPENDENT REVIEW PANEL: REFORMING CORRECTIONS (2004), http://cpr.ca.gov/Review_Panel/ (follow "From Intro to 6" hyperlink or "From 7 to 11" hyperlink).

70. California Prison Health Care Receivership Corp., *San Quentin Medical Facility Plan Status*, June 14, 2007, available at http://www.cprinc.org/docs/projects/SQ_Medical_Facility_Plan_Status061407.pdf.

71. CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS, A JOINT REPORT OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL AND PUBLIC CITIZEN'S HEALTH RESEARCH GROUP 89 (E. Fuller Torrey, et al. eds., 2002).

72. Kris Hudson, *Boulder's PACE Program Diverts Mentally Ill from Prison*, DENV. POST, April 10, 2005, at C-06.

73. *Id.* For other developments in the de-institutionalization of mental illness, see Allen, *supra* note 25, at 171.

population, beginning with other prisoners.

C. Collateral Impacts on Prisoners: Spread and Inflammation

This section looks at the collateral effects of mixing mentally ill prisoners with the general prison population. As mentioned above, such mixing is largely due to overcrowding in prison, which effectively stretches resources to their minimum. Kupers' study showed that prisoners "who have never suffered a significant psychiatric disturbance in the past report worrisome psychiatric symptoms for the first time."⁷⁴ How much of this is causally connected to mentally ill prisoners or imprisonment itself is speculative at best. But as the following hopes to show, prisoners with untreated mental illnesses tend to compromise the mental health of others with whom they share living space, meals, and recreation time; or as one study on California prisons describes, "With little or no meaningful health care, the mentally ill free-fall in an ever increasing maelstrom of madness. For those prisoners forced to live with and around the mentally ill, subsequent damage to their own mental health is inevitable."⁷⁵

The CDCR's management of one of the largest incarceration operations in the world makes the issue of overcrowding even more complicated. Currently, the state's thirty-three adult prison facilities are organized into four security levels ranging from Level I (least restrictive) to Level IV (most restrictive). In California, prisons operate at nearly double capacity and overcrowding has interfered with the current responsibilities of the special master.⁷⁶ In this constrained environment, mentally ill prisoners affect other prisoners in substantial ways, and as one study concluded, "Just being locked up in the same dorm or same cell with someone suffering from mental illness heaps added stress on the already full plates of prisoners without emotional problems. For those not afflicted with psychiatric problems, life in prison is enough in itself to wear away one's mental health."⁷⁷

Having a cellmate who suffers from psychosis, paranoia, or a host of other conditions is not an appealing prospect. As one researcher puts it, "[O]thers don't realize how current prison policies are traumatizing formerly 'normal' prisoners and making them angry, violent and vulnerable to severe emotional problems."⁷⁸ The same may perhaps hold true for correctional officers, but there is little if any research in this area. It might be natural to suspect, however, that beyond merely complicating or frustrating the daily chores of

74. Kupers, *supra* note 30, at 48.

75. Herivel, *supra* note 56, at 170.

76. See generally California State Senate Republican Caucus, *Briefing Report: Receivership/Overcrowding Crisis Aggravation ("ROCA")*, <http://cssrc.us/publications.aspx?id=2992>.

77. Herivel, *supra* note 56, at 169.

78. Kupers, *supra* note 30, at xv.

correctional officers, mentally ill prisoners may also compromise the emotional well being of other inmates. Although this issue awaits further academic attention, there is little doubt that mentally ill patients negatively impact inmate's lives. As the next section shows, correctional officers receive little training that focuses on mentally ill prisoners, despite their massive numbers in prison.

II. DOWN BY LAW: TRAINING FOR CORRECTIONAL OFFICERS

The Section explores California law and the CDCR training materials to see what, if any, training is devoted to preparing officers on how to interact with mentally ill prisoners. It also examines the additional stressors placed on correctional staff as a result of the massive increase of mentally ill inmates; this part includes analysis of the psychological and emotional burdens that attend prison work in general, and how these are complicated by the ever growing presence of mental illness in prison. In this scenario, over-burdened correctional officers are ill equipped to ward over mentally ill prisoners or sometimes themselves, trends that negatively impact inmate rehabilitation as well as the emotional well being of officers.

The statutory training requirements for correctional officers have been mandated by California Penal Code § 6035(a), which charges the State with raising a competent force of corrections officers.⁷⁹ According to the statute, the training of correctional officers is set by the standards of the board (Board of Corrections), which as of July 1, 2005 was renamed the Corrections Standard Authority (CSA).⁸⁰ Revisions are made at the discretion of the CSA.⁸¹ Section 6036 spells out the CSA's power to approve or certify training and certification of courses at institutions for officers, among other responsibilities.⁸² Under state law, then, the CSA is responsible for developing and presenting training courses that prepare prison personnel for their employment by the state. This task, in turn, has been left largely to the auspices of the CDCR's Correctional Training Center.⁸³ As will be shown, although there are hundreds of hours dedicated to training officers, hardly any of this time is allocated on training officers how to interact with mentally ill inmates or even how to maintain their own mental health.

The CDCR's training program has been criticized in the media repeatedly, and in 2005 it was reported that on the job training "credit" was being given to

79. CAL. PENAL CODE § 6035(a) (West 2008).

80. DEP'T OF CORR. & REHAB., DIVS. AND BDS.—CSA—MAJOR DUTIES AND RESPONSIBILITIES (2008), available at http://www.cdcr.ca.gov/Divisions_Boards/CSA/Admin/About_us/CSA_Major_Duties_And_Responsibilities.html.

81. *Id.*

82. CAL. PENAL CODE § 6036.

83. DEP'T OF CORR. & REHAB., DIVS. AND BDS.—CSA—MAJOR DUTIES AND RESPONSIBILITIES (2008), available at http://www.cdcr.ca.gov/Divisions_Boards/CSA/Admin/About_us/CSA_Major_Duties_And_Responsibilities.html.

officers for completing crossword puzzles.⁸⁴ From such training activities, it is difficult to understand how such training contributes to the “Vision” statement on page 1A of the Cadet Handbook. In this statement the CDCR states it “will end the causes and tragic effects of crime, violence, and victimization,” yet in the pages therein, there is little to indicate exactly *how* the new cadet will contribute to this purpose.⁸⁵

A. *Deficiencies in Mental Health Training*

Over the last half century in California, prison work has shifted towards appearing more professionalized and paramilitary in image. The CDCR’s website has featured cadets-in-training wearing military uniforms, gas masks, and brandishing firearms. The historical transition from “guard” to “correctional officer” is a shift in perception that has been largely guided by the California Correctional Peace Officers Association (CCPOA), a union established in 1957.⁸⁶ The union has since ballooned in size and in 2008 there were nearly 30,000 “rank and file” members, representing one out of every seven people employed by the State.⁸⁷ The union has typically shunned the use of the term “guard” in favor of “correctional officer,” perhaps to propagate an authoritative alignment with police officers; in fact, the CCPOA’s current slogan is “CCPOA: Representing the men and women who walk the toughest beat in the state,”⁸⁸ perhaps an attempt to liken their rounds behind bars to the “beat” of a police officer on the street. In California, “cadets” must graduate from the Basic Correctional Officer Academy in order to become a full-fledged correctional officer.⁸⁹

The union’s goal of reimagining its work as something more than merely guarding, however, may be mostly in name. Noting this semantic affinity, one scholar has noted, “Correctional personnel tend to prefer ‘correctional officer’. . . a kind of ‘white wash’ which signifies no real change in the work and responsibilities.”⁹⁰ Criminologist Hans Toch has raised further doubts as to whether a name change has any meaning in prison.⁹¹ From such attitudes it is

84. John Gittelsohn, *Prison Guard Training Criticized*, ORANGE COUNTY REGISTER, April 16, 2005, available at http://www.ocregister.com/ocr/sections/news/news/article_484076.php.

85. Basic Corr. Officer Academy, *supra* note 95, at 1A.

86. California Correctional Peace Officers Association – About Us, <http://www.ccpoa.org/aboutus.shtml>.

87. Elizabeth Hill, *Correctional Officer Pay, Benefits, and Labor Relations* (2008), available at http://www.lao.ca.gov/2008/stadm/ccpoa_pay_020708/ccpoa_pay_020708.pdf. In addition to correctional officers this number includes other classifications such as youth correctional officers, parole agents, and corrections counselors. *Id.* at 5.

88. See <http://www.ccpoa.org/>.

89. CAL. DEP’T OF CORR. & REHAB., PAY & BENEFITS, available at <http://www.cdcr.ca.gov/CareerOpportunities/POR/JobPostings/payandbenefits.pdf>.

90. PRISON GUARD, CORRECTIONAL OFFICER: THE USE AND ABUSE OF THE HUMAN RESOURCES OF PRISONS 83 (Robert R. Ross, ed., 1981).

91. See generally Hans Toch, *Is a “Correctional Officer,” by any Other Name, a “Screw?”*,

not evident that adopting the title “officer” made much of a difference in the job itself, except perhaps in the perception of officers.

In California, candidates seeking to become a Correctional Officer must attend a sixteen-week Training Academy and a two-year Apprenticeship Program.⁹² CDCR Peace Officers are trained at the Basic Peace Officer Academy in Galt, California.⁹³ The curriculum consists of training in the areas of firearms, chemical agents, non-lethal impact weapons, and arrest and control techniques. Cadets must also successfully complete the Peace Officer Standards and Training courses (POST).⁹⁴ Upon graduation from the academy, cadets are sworn in as State Peace Officers at a graduation ceremony. Due to the physical and mental aspects of the job and the institutional environment, candidates are expected to be mature, physically fit and emotionally stable.⁹⁵ The primary text used beyond cadet training is called the *Adult Corrections Officer Core Training Course Manual*, whose “primary purpose” is to present the core curriculum and design specifications for the Adult Corrections Officer Core Course.⁹⁶ This “essential” training information is also meant to offer “significant benefit to local corrections departments in the training of new adult corrections officers.”⁹⁷

“STC” refers to the “Standards and Training for Corrections,” which is a trainee’s gateway to becoming a line officer. The STC manual embodies 176 hours of instruction that is broken up into units and modules. Of particular concern is the *Monitoring Psychological and Physical Health* unit, which affords fifteen hours of instruction to cover six modules: Legal Issues, Mental Health Issues, Suicide Issues, Indicators of Substance Abuse, Indicators of Physical/Mental Problems, and Assisting Medical Personnel in the Distribution of Medication.⁹⁸ Of these hours, about half are devoted to leaning how to identify the potential signs of mental health issues in inmates

In an accompanying training manual, *Adult Corrections Officer Knowledge and Skills Maps*, the section on “Crisis Intervention” continues the theme that officers should be competent in identifying mental conditions.⁹⁹

3 CRIM. JUST. REV. 19 (1978).

92. Dep’t of Corr. & Rehab., Divs. and Bds.—Peace Officer Careers, http://www.cdcr.ca.gov/Career_Opportunities/POR/COTraining.html.

93. *Id.*

94. *Id.*

95. STATE OF CAL., BD. OF CORR., ADULT CORR. OFFICER CORE TRAINING COURSE MANUAL at i, available at http://www.cdcr.ca.gov/Divisions_Boards/CSA/STC/Publications/ACO_Core_Training_Manual.pdf.

96. STATE OF CALIFORNIA—BOARD OF CORRECTIONS, *Adult Corrections Officer Core Training Course Manual*, available at http://www.cdcr.ca.gov/Divisions_Boards/CSA/STC/Publications/ACO_Core_Training_Manual.pdf.

97. *Id.*

98. *Id.*

99. STATE OF CAL.—BD. OF CORRECTIONS, *Adult Knowledge and Skills Map*, available at http://www.cdcr.ca.gov/Divisions_Boards/CSA/STC/Publications/ACO_Knowledge_and_Skills_Maps.pdf.

Yet this section explicitly mentions that under “Rules & Concepts” officers are to report behaviors, not opinions regarding inmate behavior.¹⁰⁰ Even more definitive is the statement that a “corrections officer is not a mental health professional.”¹⁰¹ The bent of training and instruction is clear: officers must be able to recognize mentally ill prisoners, report them, and be aware of the correct protocol for interactions. Correctional Officers are limited as to what medical assistance they can offer to inmates, and their role in rehabilitation is relegated mostly to alerting medical staff to problems and to administering medication.¹⁰² This limited training session is the only instruction correctional officers formally receive on the topic.

Although correctional officers have limited training in mental illness or the rehabilitation of prisoners, they are better trained and assessed in other areas seen as important to their job. As the Minimum Academic Standards outlines, cadets are required to pass the Penal Code (PC) 832 Examination, a four-pronged test that includes an arrest and firearm component.¹⁰³ There is an additional firearms training component that acquaints cadets with the weapons found specifically in California prisons. Penultimately, there is a major physical training requirement, from which no cadet is excused and which must be attended.¹⁰⁴ The fourth and final requirement is proficiency in Tactical Skills, which is specific training in expandable baton, arrest and control, and alarm response.¹⁰⁵ Overall, the Cadet Academy dedicates a tremendous amount of time and resources to teaching cadets how to interact physically with prisoners—yet skimps on one of the most important aspects, namely assistance and supervision of mentally ill inmates.

The rules that govern a correctional officer’s behavior are the Director’s Rules.¹⁰⁶ According to Rule 3391, prison employees must be “alert, courteous, and professional in their dealings with inmates, parolees, fellow employees, visitors, and members of the public. Employees shall not use indecent, abusive, profane, or otherwise improper language while on duty.”¹⁰⁷ Later the Handbook defines “alertness”: “Employees must not sleep or be less than alert and in full possession of all faculties while on duty.”¹⁰⁸ Although these rules may reflect the priority of duties for the prison, it is difficult to fathom that they are always adhered to—during many trips to California prisons, this author has witnessed these rules repeatedly violated.¹⁰⁹

100. *Id.*

101. *Id.*

102. *Id.* at 81.

103. *Id.*

104. *Id.* at 29.

105. *Id.*

106. *Id.* at 39.

107. *Id.*

108. *Id.*

109. The author has researched in Lancaster State Prison and has taught courses at San

There is no reason a correctional officer's role in rehabilitation needs to be minimized, as it is in California. One psychologist has described ways in which line officers can be used to greater effect since they are with inmates twenty-four hours a day.¹¹⁰ This system envisions a fuller use of correctional staff within a system of mental health treatment comprising of "1) counseling and psychotherapy—talking *with* inmates, 2) consultation—talking *about* inmates, 3) special housing, activities, and behavioral programs, and 4) medication."¹¹¹ Within this framework, line officers play a much greater role than simply delivering medication and pointing out illness for reporting purposes—instead they play an active role in the rehabilitation process. In California, officers are not able to participate in such rehabilitative efforts, and worse, their lack of training in interacting with mentally ill inmates may hurt rehabilitative potential and contribute to a negative work environment. As the next section shows, there is also lack of training for officers' own emotional and psychological well being, which all too often get sacrificed for the job; high stress combined with few coping skill can impact not just officers who suffer high levels of stress, but the prisoners they guard as well.

B. Stress and Emotion at Work

The mental health crisis in prison adds to the many layers of stress that entails the work of a correctional officer. Whether told by academics, the media, or officers themselves, prison work is stressful and emotionally draining. One comparative study has shown that occupational stressors do not differ significantly between police officers and correctional officers.¹¹² Like the dangers faced by police on the street, threats in prison are ever-looming for correctional officers; significantly, a portion of this violence originates from mentally ill prisoners.¹¹³ Research is unified in showing that fear of danger is the prominent stressor for prison staff.¹¹⁴ Given the threatening atmosphere, mental endurance and stability are critical for correctional officers wishing to achieve professional longevity in an environment of high turnover rates.¹¹⁵

Quentin State Prison.

110. Joel A. Dvoskin & Erin M. Spiers, *On the Role of Correctional Officers in Prison Mental Health*, 75 PSYCH. Q. 1 (2004).

111. *Id.*

112. Risdon N. Slate, et al., *Police Stress: A Structural Model*, 22 J. POLICE & CRIM. PSYCH. 102, 109 (2007).

113. See e.g., AMERICAN PSYCHIATRIC ASS'N, VIOLENT BEHAVIOR AND MENTAL ILLNESS: A COMPENDIUM OF ARTICLES FROM PSYCHIATRIC SERVICES AND COMMUNITY PSYCHIATRY (1997).

114. See Susan Philliber, *Thy Brother's Keeper: A Review of the Literature on Correctional Officers*, 4 JUST. Q. 9, 17 (1987).

115. *Id.* at 15. In California, turnover is not solely attributable to unbearable work conditions. There are other factors at play, including that corrections work may simply be temporary work for many on the way to some other job, especially police work. Thus, turnover in California is in part due to employees' strategic job-searching.

Although these sobering conditions for officers warrant serious attention, prison scholarship has tended to focus on prisoners, and by comparison correctional officers have largely been forgotten.¹¹⁶

Generally speaking, the intense emotional strains of prison work were recognized as early as 1833, when Alexis de Tocqueville and Gustave de Beaumont carried out their famous study on American prisons.¹¹⁷ In this pioneering study, their praise for American prisons is tempered by their description of conditions for guards in Sing Sing Prison in New York State: “The safety of the keepers is constantly menaced. In the presence of such dangers, avoided with such skill but with difficulty, it seems to us impossible not to fear some sort of catastrophe in the future.”¹¹⁸ A century and a half later, the *Encyclopedia of American Prisons* (1996) traced modern signs of trouble to the 1920s, when psychologists had begun raising red flags due to the “social distance” between the prison staff and administration.¹¹⁹

There are other indications of the high stress associated with prison work. The website of the CCPOA notes that several studies have estimated life expectancy of correctional officers at 59 years.¹²⁰ Police officers in the “United States have an estimated life-expectancy ranging from fifty-three to sixty-six years.”¹²¹ By comparison, the Police Policy Studies Council reports that in the United States, non-police males have a life-expectancy of seventy-three years. In addition to shortened lives, the divorce rate for correctional officers is purportedly twice the national average,¹²² and high rates of alcoholism and suicide are found among line officers.¹²³ One of the most comprehensive studies on correctional officer stress concluded that illnesses related to stress at work, including hypertension, ulcers, and heart disease were abnormally high among correctional officers.¹²⁴

116. LUCIEN X. LOMBARDO, *GUARDS IMPRISONED: CORRECTIONAL OFFICERS AT WORK* 1 (Elsevier 1981).

117. GUSTAVE DE BEAUMONT AND ALEXIS DE TOCQUEVILLE, *ON THE PENITENTIARY SYSTEM IN THE UNITED STATES AND ITS APPLICATION TO FRANCE* (Francis Lieber trans., Carey, Lea & Blanchard 1970) (1833).

118. *Id.* at 200.

119. *ENCYCLOPEDIA OF AM. PRISONS* 118 (Marilyn D. McShane and Frank P. Williams III eds., Garland Publishing 1996) (“The low status of the guards was viewed as stress-producing. Often manipulated by the prisoners, officers felt themselves as much imprisoned as those they guarded.”).

120. Ron Holman, *Taking off the Uniform: Understanding Command Presence and How It can Affect Your Family*, available at <http://www.ccpoa.org/uniform.shtml>.

121. Thomas J. Aveni, *Shift Work and Officer Survival*, S&W Academy Newsletter (Summer 1999), available at http://www.theppsc.org/Staff_Views/Aveni/Shift-Survival.htm.

122. *ENCYCLOPEDIA*, *supra* note 119, at 129.

123. *Id.*; Recently, a blog entitled “Thoughts of a California Corrections Officer about Prisoners, Inmates, and their Keepers” featured a correctional officer who had expressed dismay at the high rate of suicide among officers. Cal. Progress Report, *Thoughts of a California Correctional Officer About Prisons, Inmates, and Their Keepers*, http://www.californiaproggressreport.com/2007/02/thoughts_of_a_c_1.html (Feb. 14, 2007).

124. See generally F.E. Cheek & M.D.S. Miller, *The Experience of Stress for Correctional*

Scholars have depicted guard/correctional work as alienated, cynical, burned out, stressed but unable to admit it, and frustrated beyond imagination.¹²⁵ So it is unsurprising that there are many obstacles to ensuring that officers maintain a balanced and healthy emotional disposition. As the training described above reveals, officers are given little training on how to maintain their own psychological and emotional welfare, even though some researchers have advocated making such training available to all officers.¹²⁶ Although the CDCR occasionally distributes flyers that encourage ways of coping with stress, beyond this there is not much support.¹²⁷ In this State, there is no mandatory counseling or routine psychological check-ups for correctional officers. Even though routine counseling might provide correctional officers with much needed psychological support, the fact is that few officers want to be associated with such services. In an environment where counseling and clinical support should be the norm, it is too often the exception. For officers, it typically may be a matter of pride or of not being perceived as mentally weak by prisoners or other staff; they seek to avoid being seen as soft or in need of help.¹²⁸

Correctional officers also have difficulty shaking off the effects of prison work while off the job. To learn more about life as a prison guard, one researcher actually went undercover and worked as a correctional officer at Sing Sing prison. Entitled *Newjack* (2001), this work paints a portrait of Ted Conover, an experienced journalist and recipient of a doctoral degree, who details his own behavior and how he treated both prisoners and his family.¹²⁹ After becoming a guard, his stress and aggression skyrocketed; he even began to hit his child.¹³⁰ Even when on vacation he found himself traumatized by dreams about the prison, recalling, "All I knew then was that even though my body was two thousand miles away, my mind was still trapped in Sing Sing."¹³¹ Although Conover's study was arguably as novel as it was unorthodox, other inquiry has documented similar effects of prison employment on officers:

Most officers recognized the changes that had taken place in themselves and spoke of those changes with sorrow and bitterness in the interviews. Many of their young marriages were in trouble or destroyed. Some officers were so burnt out that they could not go into

Officers: A Double-bind Theory of Correctional Stress, 11 J. OF CRIM. JUSTICE 105 (1983).

125. Philliber, *supra* note 115, at 9.

126. Jo Paton et al., Prisoner Officers Experiences of Identifying and Managing Mental Health Problems (2004).

127. See Appendix A.

128. LYNN ETTA ZIMMER, WOMEN GUARDING MEN 25 (1986) ("Because overt displays of fear by some members can be detrimental to the entire work group, subcultural norms and values stress the importance of overcoming fear through displays of masculinity and machismo.").

129. TED CONOVER, NEWJACK: GUARDING SING SING (Vintage 2001).

130. *Id.* at 244.

131. *Id.* at 115.

supermarkets or take their children to the zoo. Others were so drug dependant that they had to get drunk before going to work on the 7 a.m. shift. Some were so angry and frustrated that they punched holes in the walls of their homes and abused those whom they loved. The suffered severe headaches, hypertension, nightmares. Most of all, they were desperately unhappy and despaired that life could ever seem good again.¹³²

Similar conclusions are found in Lucien X. Lombardo's *Guards Imprisoned* (1990), an investigation into the guard lifestyle and its bipolar mix of chaos and boredom.¹³³ Faced with danger and a sense of powerlessness, it describes the guard as "a classic example of an alienated worker. To cope with these frustrations he resigns himself to the inevitability of forces beyond his control and finds alternatives to or strikes out against situations within his grasp."¹³⁴ More recently, prison guards at Guantanamo Bay have been reported to suffer psychological trauma as a result of the harsh environment, which is further testimony to the effects treatment of prisoners can have on their keepers.¹³⁵

From de Tocqueville's observations, nearly two centuries ago, little has changed about the dangerous nature of prison work and the effects of stress on prison personnel.¹³⁶ In addition to the stress that originates from inmates, service staff, other officers, visitors, and administrative superiors,¹³⁷ officers today bear the added brunt of managing unprecedented numbers of mentally ill inmates, which only heightens stress. Since mentally ill prisoners are more difficult to manage and more violent than the general prison population, their growing presence means more emotional strains for officers which typically including alcoholism, drug addiction, and domestic problems. Under the custody of such individuals, the question of inmate rehabilitation begins to look like a purely theoretical construct; far from being able to manage inmates and contribute to rehabilitation, officers sometimes cannot even manage themselves.

CONCLUSION

The aggregate impact of the mentally ill population on prisoners and correctional officers cannot be overstated. In general, scholars, the government, and the media all characterize California's prison system as

132. KELSEY KAUFFMAN, PRISON OFFICERS AND THEIR WORLD 212 (1988).

133. Lombardo, *supra* note 116, at 140.

134. *Id.*

135. James Randerson, *Guantanamo Guards Suffer Psychological Trauma*, THE GUARDIAN (Feb. 25 2008), available at <http://www.guardian.co.uk/science/2008/feb/25/guantanamo.guards>.

136. *Id.* at 129.

137. See generally Richard Tewksbury, *Prison Staff and Work Stress: The Role of Organizational and Emotional Influences*, 30 AM. J. OF CRIM. JUST. 247-256 (2006).

deeply flawed or completely broken.¹³⁸ Consequences of this crisis will certainly arise in the coming decades as tens of thousands of psychologically damaged inmates return to society without proper acclimation.¹³⁹ Virtually all researchers writing in the area of inmate psychology acknowledge that prisoners are adversely affected by SHUs.¹⁴⁰ What is not as evident, however, is whether any credible data suggests that SHUs produce any widespread beneficial effects.¹⁴¹ Independent of these considerations, there is “little doubt about not only [their] capacity to inflict widespread psychological pain but also [their] potential to significantly undermine already tenuous chances for subsequent adjustment.”¹⁴²

From the purview of contemporary criminal justice, these issues, as they relate to mental illness, should be of utmost concern. Due to the sparse training in the area of mental illness, management of inmates is made all the more difficult.¹⁴³ Thus, the system’s substantive instrument of punishment, the penitentiary, is defective in ways that pose challenges to its rehabilitative purpose. Moreover, history has shown at the idea of rehabilitation has not always been welcomed by inmates, and at times prisoners have rejected the system’s notion of rehabilitation;¹⁴⁴ rather than submit to whatever is done to them in the name of rehabilitation, they have altogether rejected treatment.¹⁴⁵ This author has heard anecdotal evidence from numerous prisoners who claim that the rehabilitation relationship is backward—that the criminal system needs rehabilitation, not they.¹⁴⁶ From the point of view of these prisoners, there is no question of “rehabilitation” because there is no problem. The problems, instead, come from corrupt policing tactics, court room biases, racial profiling, unfair sentencing laws, parole technicalities, and incompetent prison administrations. For these inmates, a wholesale emphasis on rehabilitation allows the state to ignore the systemic inequalities of the criminal justice system and lays the full burden of crime on the prisoner—a gross oversimplification. These critiques of rehabilitation policy, however, are only peripheral to the core question of how to acquire success in a criminal justice

138. See e.g., ANGELA DAVIS, ARE PRISONS OBSOLETE? (Open Media 2003).

139. Abramsky, *supra* note 2, at 144; see also Kupers, *supra* note 30, at xxvi-xxvii (“[I]t is especially foolish, costly, and dangerous to warehouse [inmates] in overcrowded prisons, deny them adequate psychiatric attention, and leave them to become the victims and perpetrators of violence.”).

140. Haney, *supra* note 38, at 534.

141. *Id.*

142. *Id.* at 568.

143. Bonnie J. Sultan, *The Insanity of Incarceration and the Maddening Reentry Process: A Call for Change and Justice for Males with Mental Illness in the United States*, 13 GEO. J. POVERTY L. & POL’Y 357, 371 (2006).

144. DAVID GARLAND, *THE CULTURE OF CONTROL: CRIME AND SOCIAL ORDER IN CONTEMPORARY SOCIETY* 55 (The University of Chicago Press 2001).

145. *Id.*

146. The author has researched in Lancaster State Prison and has taught courses at San Quentin State Prison.

system that has been described as failing its mentally ill prisoners “at every step.”¹⁴⁷

This is not to say that there is not a need for rehabilitation. Research has already pointed out that California provides fewer rehabilitation programming that comparable states.¹⁴⁸ What scant services that are provided must counteract the huge problems of drug addiction, lack of education, and lack of job skills. Although California has pledged an additional 10,000 beds for medically and mentally ill prisoners,¹⁴⁹ due to recent financial woes it is unlikely that the state can make good on this promise and uncertain what effect fulfilling the promise would have on conditions behind bars.

Due to the many problems outlined in this article, the CDCR faces an uphill battle to fulfill the goals its title implies. Without a change in the CDCR’s “culture of failure,”¹⁵⁰ there will be little opportunity for meaningful rehabilitation, especially as it relates to the training of new officers and measures to secure their psychological well-being and that of prisoners. The mental health crisis has been brewing for more than three decades and cannot be fixed overnight with a name change that, more than anything, resembles a public relations tactic than a substantive change. Although some researchers believe that the line officer is in the best position to assist in the rehabilitative potential of inmates,¹⁵¹ California has not welcomed this suggestion. Due to the high levels of stress that officers already face, some may not be in an effective position to help rehabilitate inmates.

Until the mental health crisis is brought under control there will likely be little chance for the CDCR to implement a meaningful rehabilitation strategy. As it currently stands, the California Expert Panel has reported that nearly half of all prisoners released in 2006 sat idle—not participating in a work or other rehabilitation program—for their entire stay in prison.¹⁵² These dismal figures show that there is already a tremendous shortage of rehabilitation programs. When considered alongside California’s budgetary woes and inability to comply with the orders of its court-ordered special master, the flaws and incompetency of CDCR’s current system are evident. Under the current penal philosophy and practices, the realization of rehabilitation begins to look like a distant, almost theoretical notion; without serious attempts to contain the mental health crisis the idea of rehabilitation will remain just that—an idea.

147. Ball, *supra* note 29, at 5.

148. Petersilia, *supra* note 14, at 39.

149. Office of the Governor, Gov. Schwarzenegger Unveils Comprehensive Prison Reform Proposal (2006), <http://gov.ca.gov/index.php?/print-version/press-release/4972/>.

150. Ball, *supra* note 29, at 35.

151. WILLIAM C. COLLINS, CORRECTIONAL LAW FOR THE CORRECTIONAL OFFICER 1 (American Correctional Association 2003).

152. CAL. DEP’T OF CORR. & REHAB, *California Expert Panel on Adult Offender Recidivism Reduction Programming: A Roadmap for Effective Offender Programming in California: Report to the California State Legislature* (2008), <http://www.cdcr.ca.gov/news/ExpertPanel.html>.

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Without a genuine attempt to treat the mental hell behind bars, the CDCR may as well change its “R” from “Rehabilitation” to “Recidivism,” to reflect more accurately its achievements.

Appendix A

YOUR HEALTH



Tips for Staying Healthy from The Office of Employee Wellness

Work-Life balance: Ways to restore harmony and reduce stress

Finding work-life balance in today's frenetically-paced world is no simple task. Spend more time at work than at home and you miss out on a rewarding personal life. Then again, if you're facing challenges in your personal life such as caring for an aging parent or coping with marital or financial problems, concentrating on your job can be difficult.

Whether the problem is too much focus on work or too little, when your work life and your personal life feel out of balance, stress – and its harmful effects – is the result.

It isn't easy to juggle the demands of career and personal life. For most people, it's an ongoing challenge to reduce stress and maintain harmony in key areas of their life. Here are some ideas to help you find the balance that's best for you:

- **Keep a log** – Track everything you do for one week. Include work-related and non-work related activities. Decide what's necessary and satisfies you the most. Cut or delegate activities you don't enjoy, don't have time for or do only out of guilt.

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- **Manage your time** – Organize household tasks efficiently. Doing one or two loads of laundry every day rather than saving it all for your day off, and running errands in batches rather than going back and forth several times are good places to begin. A weekly family calendar of important dates and a daily list of to-dos will help you avoid deadline panic.
- **Rethink your cleaning standards** – An unmade bed or sink of dirty dishes won't impact the quality of your life. Do what needs to be done and let the rest go.
- **Nurture yourself** – Set aside time each day for an activity that you enjoy, such as walking, working out or listening to music. Unwind after a hectic workday.
- **Set aside one night each week for recreation** – Take the phone off the hook, power down the computer and turn off the TV. Discover activities you can do with your partner, family or friends. Making time for activities you enjoy will rejuvenate you.
- **Protect your day off** – Try to schedule some of your routine chores on workdays so that your days off are more relaxing.
- **Get enough sleep** – There's nothing as stressful and potentially dangerous as working when you're sleep-deprived.
- **Bolster your support system** – Give yourself the gift of a trusted friend or co-worker to talk with during times of stress or hardship. Ensure you have trusted friends or relatives who can assist you when you need to work overtime or travel for your job.

Balance doesn't mean doing everything. Examine your priorities and set boundaries. Be firm in what you can and cannot do. Only you can restore harmony to your lifestyle.

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For more information please visit the Office of Employee Wellness website <http://intranet/HR/OEW/default.asp>

Questions or ideas for future topics may be directed to Michelle Brooks at michelle.brooks@cdcr.ca.gov

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