Mental and physical toll of work on America's Correctional Officers

Posted by Colorado WINS on August 29, 2018

This is hardly news to Correctional Officers, but the occupational stress of working in prisons reduces life expectancy, increases heart disease, and manifests itself in higher rates of alcoholism and divorce rates.

Below you'll find links and excerpts of articles detailing the consequences of job stress in Correctional Officers.

"Reducing Staff and Inmate Stress," National Criminal Justice Reference Service, Oct. 1982

A recent study of the consequences of job stress in correctional officers revealed that the life expectancy of a correctional officer is 59 years, compared to 75 years for the national average. Stress, as manifested in many physical illnesses including hypertension, heart attacks, and ulcers, was found to be higher than that of a comparable sample of police officers. Moreover, alcoholism and divorce rates are higher for correctional officers than for the population in general.

As a result, correctional organizations spend enormous sums annually for sick leave, compensation, and liability claims. Stress among correctional officers and administrators is often caused by the conflicting goals of custody and rehabilitation, trial and error in management, and the correctional system's vulnerability to political and community groups.

In response to the problem, the New Jersey Department of Corrections has developed a number of correctional officer programs geared to reducing stress; families of officers participate in the programs. The nature of stress and burnout, their physical and social consequences, and positive and negative coping techniques are explored. Coping methods such as relaxation, desensitization, and self-image improvement are presented at these sessions. Correctional officers are taught to remain calm in the face of conflict, communicate their point of view, and consider possible solutions and consequences of a given situation. Similar sessions are offered for inmates. Twenty references are provided.

"Prison Officers Need Help, but They Won't Ask for It," Newsweek, May 2014

According to a study by professors Steven Stack and Olga Tsoudis of Wayne State University, the risk of suicide is 39 percent higher for [corrections officers] than in all

other professions combined. A 2009 study by the New Jersey Police Suicide Task Force found that corrections officers had double the suicide rate of police officers.

Other studies have found reduced life expectancy, which is linked to stress-related conditions such as high blood pressure, heart attacks and ulcers.

"You are in a constant state of fight or flight," says Brian Dawe, a former corrections officer in Massachusetts and co-founder of the American Correctional Officer Intelligence Network.

"Prison horrors haunt guards' private lives," Denver Post, March 2007

Prisoners fling bodily waste and attack without warning. Psychotic outbursts fill halls with howls. A man who upset the wrong clique ended up with a pencil driven though his ear.

Yet for correctional officers, getting mad isn't allowed.

Now these men and women, who face growing numbers of inmates in some of the nation's toughest federal and state prisons, say they're increasingly overwhelmed.

They harden themselves to survive inside prison, guards said in recent interviews. Then they find they can't snap out of it at the end of the day.

Some seethe to themselves. Others commit suicide. Depression, alcoholism, domestic violence and heart attacks are common. And entire communities suffer.

The hardships of correctional officers often go unseen by the public

Gerry Feld, Times columnist Published 5:00 p.m. CT June 9, 2018 | **Updated 3:40 p.m. CT Feb. 13, 2020**

It's almost incredulous that correctional officers are the least honored, least respected and least understood of all public service employees in the United States. According to the U.S Bureau of Prisons, there are roughly 410,950 COs working in federal, state and local facilities. These numbers do not include officers working in private, for-profit institutions.

> After every heinous crime we hear the public cry out, "Lock them up, throw away the key." What no one appears to comprehend is that the offender does not go into suspended animation in some far off diverse universe where they can never hurt another living soul. No, they exist in a correctional facility where they continue to act out; assaulting and possibly killing officers that, in my experience as a CO at the St. Cloud Correctional Facility for nearly 32 years, are commonly out-numbered in any given situation by a margin of 30 or 40 to one.
>
> People wrongly assume officers are armed with firearms or other offensive weapons, when in reality, they carry nothing more than small containers of chemical mace that may not affect every offender. Since 33.5 percent of all assaults in prisons are against staff,

according to corrections.com, Michael Morgan, a retired officer from the Oregon Department of Corrections accurately states in an article by The Guardian that every CO goes into battle mode when entering a prison, "We put on our armour. When you walk through the first gate, it clicks. And so does your back."

Shockingly, the website Corrections Today admits assault statistics have not been accurately recorded. They can report between 1999 and 2008, 113 officers were killed while 125,200 required emergency room treatment.

The Center for Mindfulness in Corrections states, “COs often compare starting their shift to entering a combat zone; making it quite common for them to shift into hyper-vigilance. With this state of hyper-arousal, the body is flooded with adrenaline, noradrenaline and cortisol - a primary cause of chronic stress related health risks."

According to The Guardian, COs suffer from PTSD at more than double the rate of police officers and the general public. Recent statistics found 34 percent of COs suffer from PTSD, compared to 14 percent of military veterans.

As stated in The Guardian article, PTSD can be considered taboo, as staff fear that the diagnosis can have negative repercussions on their careers. According to a study by a New Jersey police taskforce, the suicide rates of COs are twice as high as other law enforcement officers and the general public.

Additionally, COs have the highest mortality rate of any other occupation, including the highest rates of divorce, alcoholism and domestic assault, according to the American Addiction Center. **A Desert Waters report adds that on a national average many COs live only 18 months after they retire as their life expectancy age is 59 compared to 75 for the national average.**

Under-staffing is a major problem leading to prison assaults. Hiring and retaining qualified, capable officers is a problem all its own. In an article on U.S. News, Geoffrey Klopp, president of the Correctional Officers Association of Delaware said that raising salaries to a competitive level for COs could attract qualified applicants. That claim may certainly be accurate.

As South Carolina was among the lowest paying states in the nation, violence became an epidemic. In 2016 five murders occurred in their system, which rose to 12 in 2017, culminating with the bloody rampage in the Lee Correctional Facility in April, where seven offenders were killed.It was impossible for officers to control the situation as there were only 44 COs for 1,583 offenders. South Carolina has raised their pay $2,500 annually, and begun paying bonuses for overtime, staff retention and referrals.

According to the United States Bureau of Labor Statistics, California pays the highest salary at $71,630, Mississippi is the lowest at $29,040 and Minnesota pays $51,270.

One comment Morgan made is agreed upon by every CO who puts their lives on the line. “You believe all prison management should have fought an inmate at least once, before evaluating if you have used inappropriate force.” Regrettably, that scenario is completely accurate. All to often administrative staff are clueless to the dangers we COs are actually confronting on a daily basis.

This is the opinion of Gerry Feld, a lifelong Central Minnesota resident whose column is published the second Sunday of the month. He writes mostly about national issues from a conservative perspective.

AMA Journal of Ethics® June 2019, Volume 21, Number 6: E540-545 PERSONAL NARRATIVE Health Risks of Practicing Correctional Medicine Dionne Hart, MD

Abstract Correctional staff suffer high rates of posttraumatic stress disorder compared to military veterans, and the suicide rate among correctional officers is twice as high as that of both police officers and the general population and higher than that of all other professions combined. Correctional facilities’ physician employees are at risk of not only burnout but also other adverse mental health effects related to working in a correctional facility. Prison reform efforts should address the needs of both inmates and clinical staff.

Burdens of Working in Correctional Health Care How do you explain the experience of working in prison to members of the general public, whose interest in an offender ends when the flashing lights stop and the sirens are silenced? In some ways, the groupings in a prison are a visual flashback to the Civil Rights era—segregated by race, with Native Americans separated from whites, Hispanics, blacks, and Asians in dining halls, recreational units, and housing. In prisons, there are separate, self-sorted groups for various gang affiliations, white supremacists, sex offenders, and those with mental illnesses. According to the US Bureau of Justice Statistics, in 2016, there were 2162400 adults incarcerated in US prisons and jails.1 As CNN reported, “That means for every 100 000 people residing in the United States, approximately 655 of them were behind bars.”2 That the United States represents about 4.4% of the world’s population but houses 22% of the world’s prisoners is staggering.3

When you enter a correctional facility, you are searched and your belongings are scanned. By entering, you voluntarily disconnect from the world, as you leave behind your mobile phone and almost all contact with the community. Unlike visitors, correctional staff receive a stab-proof vest, mace, a radio, and keys to internal doors. Their nasal passages are the first to recognize pungent odors from body fluids, garbage, and musty old buildings. Drawing on my 16 years of personal experience, I seek here to raise awareness of the unique health risks to correctional workers.

Correctional Staff: Demographics and Health Risks Stereotypes abound not only about men and women who are criminally involved but also about men and women who work in these facilities. In the media, they're often depicted as corrupt, predatory, inept, and—most recently—as political pawns.4 This stereotype masks the vulnerabilities of correctional staff.

Similar to the inmate population, correctional staff are predominately white men, but there are a large minority of women. According to a recent Washington Post article, women correctional employees represent nearly 30% of staff employed in prisons, jails, juvenile facilities, and community-based facilities.5 However, women correctional staff often face verbal and sexual harassment and might experience retaliation.5

Correctional staff—like all law enforcement officers—face constant physical risks as well as lesser-known mental health risks. For example, 34% of correctional officers suffer from posttraumatic stress disorder compared to 14% of military veterans.6 And the suicide rate of correctional officers is twice as high as that of police officers and the general population.7,8 In fact, the suicide risk for correctional officers is 39% higher than that of the general working-age population and all other professions put together.8-10 Correctional staff also have higher rates of depression and substance use.11 Given these statistics, it is perhaps unsurprising that the average life expectancy of a correctional officer is 59 years compared to the national average of 75 years.12 (SEE SITES BELOW)

Modeling Tolerance The causes of health risks associated with correctional work are multifactorial, and every worker's story is unique. My story began more than a decade ago when I accepted a position at a prison hospital; I was young, healthy, and invested in performing my duties. Inmates were mostly appreciative. It was uncommon for a staff member or inmate to be assaulted, threatened, or harassed. That changed. Occasionally, I would overhear black men shouting the n-word across the compound as a term of endearment to each other as they joked. I wondered why they chose to normalize a word characterized by such deep-seated pain for so many. I would hear inmates use so much profanity and slang in one sentence that it was difficult to understand even the simplest message. I would caution inmates that a judge sentenced them to prison, but the prison culture doesn't have to live in them. Each day, I tried to model tolerance. I never withheld a greeting to an inmate covered in a swastika or confederate flag tattoos, nor considered giving special favors to someone who shared my ethnicity. I treated everyone the same. Occasionally, I would hear other staff members refer to me as an "inmate lover" when they thought I was out of hearing range, but I did not internalize their judgment. The physician workforce in the United States is only 4% black or African American, 13 so I was well aware of my privilege to provide health care to one of the most underserved populations in the country, and I was determined to fulfill my professional duties without compromising my values.

The Challenge of Remaining Neutral I cannot pinpoint the moment or the turning point when the prison environment began to take its toll, but it has. I recall the first time I was verbally harassed—a white inmate called me the n-word so many times in one minute that I thought he was going for a world record. He rejected my professional expertise because of the color of my skin. He expressed his preference and concluded that I was an unqualified "affirmative action hire" and that he would not permit me the opportunity to assist him. The inmate was mentally ill, so I told myself when he begins to recover and his frontal lobe function improves, he will not use such language. I informed him that often when people are ill, they feel vulnerable and seek to gain control by making derogatory comments to others, particularly those in charge of their care. I reassured him that, regardless of his derogatory

comments, I would not abandon him and that he would receive the best care possible. I endured more episodes with inmates who expressed their biases, preferences, and feelings by spewing hatred, particularly when acutely mentally ill.

But soon I encountered a different type of inmate, one who used offensive language in daily intercourse solely out of disdain for my ethnicity. I began to use write-ups when I encountered this kind of insolence, hoping write-ups would help deter these behaviors. However, my reports were repeatedly ignored, dismissed ("You work in a prison"), or discarded, so I taught myself a new skill. Each time I heard the n-word, I internally replaced it with a calming word. My new means of coping solved one problem, but it also generated more questions.

Does Concordance Matter? In a liberty-restricted setting, such as a correctional facility, how much freedom should an incarcerated person have to choose a racially concordant clinician? Since 1976, prisoners have had a constitutional right to health care.14 Does this right mean they should be allowed to choose caregivers based on racial or any other preference? In prison settings, clinician shortages limit the feasibility of honoring preferences. In addition, honoring an incarcerated patient's preference for a clinician of a specific gender or race can unjustly undermine a nonracially concordant clinician's authority or elevate a racially concordant clinician's authority, perhaps for the wrong reasons.

While Americans express a value for cultural and ethnic diversity, we often shy away from discussing racial discordance in patient-clinician relationships. Yet one study of 9 white therapists found that they initiated discussions of race with black patients within the first 2 sessions to help build a therapeutic patient-clinician relationship.15 While racial concordance has been associated with improved health care experiences among minority patients,16 surveyed patients' self-reports suggest that it does not improve outcomes,16 so it would be hard to argue that denying a patient's concordance request constitutes a violation of a prisoner's right. In fact, prisoners in the United States do not have a constitutional right to health care beyond the walls of their facilities and do not have a right to request a specific course of treatment. 17

Setting aside racial concordance, what is to be done about patient bias? An educated, outspoken woman of color is perceived by some prisoners and staff members as equally or more threatening than a prisoner. Perhaps more important are negative attitudes of patients toward clinicians; efforts to address patient bias toward clinicians like me should focus on helping clinicians build therapeutic alliance with patients. As always, it is the responsibility of all clinicians to practice medicine consistent with the American Medical Association Code of Medical Ethics. A physician should be dedicated to providing competent medical care with compassion and respect for human dignity and rights.18

Policy and Practice While separated from the community by obvious barriers, correctional facilities remain a reflection of American culture, including its ethical values. In a setting so clearly influenced by race and ethnicity, correctional physicians have a unique opportunity to lead the profession. Each time we are faced with patient bias, we can practice virtues of neutrality and tolerance, bedrocks of treating any high-risk population. This does not mean we should be required to do so without support from the organizations and the public we serve. Correctional physicians have the opportunity to increase the level of public awareness of the negative impacts of perceived and actual racial discrimination and race-based health disparities—and the positive impacts of intentional increased diversity in the workplace—on both patients and clinicians. And, given the number of women employed in correctional facilities, including in health care, we would be wise to promote efforts such as those of TIME'S UP Healthcare, whose mission

is “to unify national efforts to bring equity, inclusion and safety to the healthcare industry” in all settings.19 What I’ve written here is a brief introduction to the challenges correctional staff face and a plea for federal, state, and organizational policy to address more effectively the needs of incarcerated patients and to improve the working environment of correctional workers.

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Mass. sheriffs respond to corrections officer suicides

Agencies across the state are developing a suicide-prevention policy after at least 16 COs died by suicide in the past decade

Sep 24, 2019

By Marie Szaniszlo
Boston Herald

BOSTON — Sheriffs departments across Massachusetts are working to develop a suicide-prevention policy after a state commission found that at least 16 corrections officers had taken their own lives in the past decade.

The special commission created by the state Legislature to study the prevention of suicide among 3,800 Bay State correction officers found that life expectancy for prison guards nationwide has hit an alarming low.

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“There is an epidemic here in Massachusetts,” said former Worcester County Sheriff Guy Glodis, a spokesman for the Massachusetts Correction Officers Federated Union.

“Our officers are 24/7 on the front lines of Massachusetts’ most dangerous criminals, and unfortunately, a lot of our members take that stress home with them. They don’t just leave that anguish behind them when they punch out,” the former state senator, who once worked as a jail guard, added.

The report cites a 2017 study by the University of California at Berkeley that found that correction officers are exposed to violence at rates comparable to military veterans. The

American Jail Association, which has studied the physical toll on correction officers, found their life expectancy is as low as 59 years old.

As a result of the report, sheriffs across the state are expected to work together to develop a sample policy that would make peer support teams, employee assistance programs and critical incident teams available to correction officers, said Essex County Sheriff Kevin F. Coppinger, a commission member.

“For years, talking about your emotions was considered a sign of weakness,” Coppinger said. “But things are getting better because the occupation and society are more willing to recognize the problem. We want to find these issues early. The message we like to stress is you’re not alone.”

The Massachusetts Department of Correction’s Employee Assistance Service Unit offers a two-day workshop that teaches officers to recognize when someone is at risk of suicide and works with that person to create a safety plan.

The unit also has a Question, Persuade, Refer program to teach DOC employees to recognize officers who may be in distress. The program presents scenarios to correction officers that they may encounter and tells them how to best navigate those situations. It also encourages counseling and therapy, physical health, medication compliance, friends and a sponsor as parts of a “wall of resistance” to suicide.

Boosting correction officer ranks has the effect of reducing the stresses that can accompany overtime, a spokesman for the Massachusetts Executive Office of Public Safety and Security said in a statement. So the Department of Correction has hired more than 400 new officers in the past year.

A New Vision for Correctional Officers

by Sunny Schwartz and Leslie Levitas

Sunny Schwartz is the author of the book *Dreams From The Monster Factory: A Tale of Prison, Redemption and One Woman’s Fight to Restore Justice To All* and has worked in the San Francisco Sheriff’s Department for thirty-one years. Leslie Levitas, M.A., has worked for the San Francisco Sheriff’s Department since 1996. She has coauthored articles on a variety of topics related to criminal justice and social justice. Her writing and photograpy were included in the recent anthology *Razor Wire Women: Prisoners, Activists, Scholars, and Artists* (SUNY Series in Women, Crime, and Criminology).

Incarceration has been failing for decades as a means for promoting public safety. More often than not, the finger is pointed at the unreformed inmate as the source of that failure. What about those who work in prisons and jails? What responsibility do they bear for promoting real change that reduces crime and restores communities? What difference could they make if they were trained in the basic principles of human relations, business management, and motivational change, not to mention restorative justice?

In this article we share our experience, as longtime developers of restorative practices in a San Francisco County Jail, of the deputized staff who have assisted in bringing about a new vision. We honor the courage of those mavericks,and acknowledge the desire of many more to be a part of that vision. We recognize how a profession that is unavoidably brutal can, with the right institutional leadership, encouragement, and training, take steps toward becoming the noble vocation that many correctional officers long for it to be.

We have known decent, smart, and compassionate people who have worked as deputies or correctional officers. If that surprises you, you may be prejudiced. But you would not be alone, because the nature of the prison system encourages each of us to take sides and dehumanize everyone on the other side. The most inspiring people behind the clanging doors of jail and prison are those individuals—whether wearing prisoners 'fatigues, law enforcement uniforms, or civilian clothes—who resist that temptation and, in doing so, help to build humanity where it is in short supply.

How Prisons Fail Correctional Officers

Let's be clear, there is nothing ennobling about our current prison system. The traditional way of incarcerating and releasing people is a "crime after crime." Most members of the general public now know what industry insiders have known for forty years. In the typical jail or prison, men or women sleep in their bunks, play dominoes and cards, watch The Jerry Springer Show on TV, and scheme. About two thirds of those released are rearrested within three years. The corrections system has failed the victims of crime and our communities' needs and expectations. It has failed the people inside, and their families. What many of us do not yet realize is that the system has also failed the professionals who run it.

For sure, deputy sheriffs (or "deputies") who work in county jails and prison custody staff (commonly referred to as correctional or corrections officers, COs, or sworn staff) have careers that appear attractive and are lucrative. They are paid to attend a mandatory four-to-six-month pre-employment training/academy. They begin their careers free of student loan debt. Many undergrads would envy that, along with the starting base salary between $45,000 and $65,000, an extensive benefit plan and defined-benefit pension that provides for retirement at age fifty-five with 85 percent of salary for life.

But the content of the standard training does not adequately prepare them for the realities they face on the job or the highly stressful and inhumane things they are asked to do. Occupational stress is a pervasive problem within all correctional jurisdictions. Deputies and corrections officers face the daily challenges of effectively managing the inmate population as well as their own stress levels.

A correctional officer's life expectancy is heartbreaking. On a national level, according to the Correctional Peace Officers Foundation project statistics published in 2004, there were thirty-nine deaths in the line of duty in the four years preceding the report. The suicide rate for corrections has been recorded as 39 percent higher than that of other professions (Archives of Suicide Research, 1997). The Society of Actuaries reported in 1994 that Corrections Officers had the second highest mortality rate of all occupations. The Metropolitan Life Actuary Statistics reported in 1998 that the average life expectancy of a corrections officer is fifty-eight.

Our goal for the sworn staff is not just to reduce this stress level by developing more collaborative and humane ways to manage prisons. It is to give them a positive role in creating better communities in the low-income locales from which most inmates come, and from which many of sworn staff also come. We envisage a future in which restorative justice spreads nationally and prisons are drastically reduced in number, but in which the sworn staff are partners in this vital approach, utilizing their experience in holding people accountable, in combination with restorative practices, thereby gaining the respect of all segments of the community.