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The Interdependence of Caring, Safety, and Health in Correctional Settings: Analysis of a Survey of Security Staff in a Large County Jail System

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Abstract

The health of incarcerated populations is intertwined with the health of security staff, but the social mechanisms, and especially the specific interventions, that might mitigate these health harms are underexplored. We examine one possible mechanism of interrelated health harms: whether and how jail security staff are willing and able to care for mentally ill detainees. We hypothesize that the attitudes of security staff towards care affect the well-being of everyone in a jail setting—staff, as well as detainees. Analyzing 539 anonymous respondent surveys administered to a stratified cluster sample of security staff working in a large U.S. county jail system, we (1) describe the prevalence of a perceived *duty to care* and availability of *caring resources* among security staff and (2) analyze whether variations in a duty to care and caring resources predict outcomes associated with staff and detainee well-being. Across five maximum likelihood models estimated, both perceived duty to care and availability of caring resources are significantly associated with collaborative relationships with medical staff, increased perceptions of personal safety, decreased frequency of hostile encounters, and better self-reported health outcomes. Our models explain 20 percent of the variation in self-reported health outcomes ($R^2 = 0.20$), a meaningful effect of care on security personnel's well-being. Our findings suggest security staff have an often-overlooked duty to care akin to that experienced by healthcare staff. Among healthcare staff, dual loyalty trainings have successfully amplified caring duties relative to security duties; similar trainings for security staff might better leverage their caring duties to improve both staff and detainee well-being.

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The Interdependence of Care, Safety, and Health in Correctional Ecosystems:
Analysis of a Survey of Security Staff in a Large County Jail System

1. Introduction

The American Public Health Association (2019) maintains that the well-being of every person is inextricably tied to the well-being of every other person. Prisons and jails, long understood as amplifiers of disease and despair, dramatically illustrate this principle. A robust body of research documents the significantly detrimental (and racially disparate) medical and mental health consequences of incarceration (Bronson & Berzofsky, 2017; Dumont et al., 2013; Friedman et al., 2021; Maruschak et al., 2015; Rosen et al., 2023; Wildeman &Wang, 2017). Simultaneously, researchers have documented the occupational health hazards of working in prisons and jails (Cheek & Miller, 1983; Lerman et al., 2021; Obidoa et al., 2011). Indeed, recent work has recognized that the health of incarcerated populations is intertwined with the health of security staff (Ahalt et al., 2020; Cloud et al., 2021; Spinaris et al., 2012). While criminological scholarship has explored the relationship between ideological conflicts around the purposes of punishment and how these conflicts affect job satisfaction and institutional culture (e.g., Crewe et al., 2011; Lambert et al., 2019; Johnston & Ricciardelli, 2022), few studies have quantitatively evaluated whether the availability of specific, practical caring resources improves specific indicators of staff and detainee health and safety.

In this study, we examine one possible mechanism of interrelated health harms: whether and how jail security staff are willing and able to care for detainees, especially mentally ill detainees. We hypothesize that the attitudes of security staff towards care affect the well-being of everyone in a jail setting—staff and detainees. Analyzing 539 anonymous respondent surveys administered to a stratified cluster sample of security staff working in a large county jail system

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in the United States (U.S.), we describe the variability in perspectives on duties and resources for care among security staff. Finally, we consider how this variability relates to security staff's health and safety, and indirectly to detainees' health and safety, particularly regarding the frequency of hostile encounters between detainees and staff.

1.1 Jails are Hazardous Spaces to Live and Work

Jails, like prisons, are America's "new mental hospitals" (Torrey et al. 2010), and the criminal legal system has become a tool not just for managing but also for criminalizing mental illness (Harcourt, 2006). More than half of people incarcerated in state prisons and nearly two-thirds of people detained in jails report mental health diagnoses (Travis et al., 2014). Compared to non-detained populations, jail detainees are almost twice as likely to report chronic health conditions (from cancer and stroke to asthma and diabetes) (Maruschak et al., 2015), three times as likely to report psychological distress (Bronson & Berzofsky, 2017), and twelve times as likely to meet the criteria for drug dependence or abuse (Bronson et al., 2017). Indeed, large county jail systems in the U.S.—like those in New York City, Cook (Chicago), Harris (Houston), Maricopa (Phoenix), and Los Angeles counties—are epicenters of public health crises, especially tragic mental health care failures (Torrey et al. 2010; Venters, 2019).

Conditions in carceral facilities can lead to variable access to healthcare and may exacerbate existing mental health problems (Cloud et al., 2023; Friedman et al., 2021; Rosen et al., 2023; Yoon & Luck, 2016). Simply put, jails—which are notoriously chaotic, overcrowded, understaffed, and dangerous—harm detainee health (Venters, 2019). Jails harm the health of security staff, too. Security staff, like detainees, experience extraordinarily high levels of mental health disorders linked to their work, including post-traumatic stress, depression, and anxiety, as

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well as elevated levels of addiction, sleep disorders, suicide, ulcers, hypertension, and heart disease (Cheek & Miller, 1983; Lerman et al., 2021; Obidoa et al., 2011).

Not only do detainees and security staff experience physical and mental health problems at disproportionately high rates in jails as compared to the general population, but both also frequently feel unsafe in the jail setting, where violence and abuse—from self-harm to detainee-on-detainee assault to detainee-on-staff and staff-on-detainee assaults—can be rampant (Dholakia, 2023; Venters, 2019; Widra, 2020).

1.2 Caring Duties and Resources

Despite the overwhelming need for healthcare in carceral settings, providing this care is fraught. The physical conditions in jails, inadequate resources, and a *security* culture in conflict with a *caring* culture create significant barriers to care. The term "dual loyalty" highlights this security-care conflict, mainly as it exists for correctional healthcare staff. A growing literature documents the dual loyalty conflict that healthcare staff experience as they negotiate the imperative to care for incarcerated patients, on the one hand, and their perceived obligations to maintain institutional security, on the other (Ahalt et al., 2017; Barragan et al., 2022; Glowa-Kollisch, 2015; Magaletta et al., 2005; Pont et al., 2012). For instance, correctional officials may ask healthcare staff to assess whether a patient is mentally stable enough to spend time in solitary confinement or whether handcuffing procedures jeopardize an asthmatic patient's breathing. In some cases, healthcare staff compromise care in favor of security, clearing a patient for solitary confinement or conceding to handcuffing protocols under pressure. Acknowledging this conflict, training for correctional healthcare staff engages the concept of dual loyalty to bolster caring obligations and support staff in navigating the duty to care in a security setting (Blair & Reiter, 2015; Glowa-Kollisch, 2015; Venters, 2019).

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The idea of dual loyalty, however, is rarely applied to security staff. With a few notable exceptions (Kilmer et al., 2023; Reiter & Blair, 2018; Suarez, 2021), the dual loyalty literature only rarely asks how security staff navigate the tension between care and security. Kilmer et al. (2023) explicitly examine whether officers can both "implement dynamic security" and "contribute to therapeutic goals," acknowledging that the tension exists, at least in the context of Norway's national prison system, which is lauded for prioritizing rehabilitation. However, in American prisons and jails, where punishment is often prioritized (Phelps, 2011), the care-security tension for security staff is frequently ignored. Indeed, Reiter and Blair (2018) argue that even when security staff demonstrate expertise in distinguishing "dangerous" or "bad" detainees from "disturbed" or "mad" ones, healthcare staff often ignore or dismiss their insights.

On the other hand, Suarez (2021) describes how incarcerated pregnant women experience advocacy and compassion from security staff during and after their labor, with staff sometimes insisting on the provision of adequate healthcare or bending security rules to permit mother-child bonding. Findings suggest that security staff who perceive a duty to care might also face a dual loyalty dilemma, wherein pressures to care co-exist with pressures to secure in carceral settings. Just as dual loyalty training for correctional healthcare staff seeks to bolster and amplify healthcare staff's caring obligations, so might security staff's caring obligations be susceptible to bolstering and amplification.

Whether or not security staff experience a duty to care, they play vital roles in detainees' access to healthcare. First, security staff triage prisoners and detainees into or out of healthcare (Barragan et al., 2022; Ross et al., 2011; Rudes et al., 2020; Williams et al., 2009). Second, security staff pressures healthcare staff to assimilate security and care interests (Ross et al., 2011; Venters, 2019). Beyond being gatekeepers to care, however, security staff inevitably become

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caretakers themselves: making "decisions about medical clearance and administration of intake forms; monitoring incarcerated persons for substance withdrawal and suicide; [conducting] escorts and transports to jail and community medical visits; [administering] medication …; monitoring blood glucose and blood pressure; [and] responding to medical emergencies" (Rosen et al., 2023, p. 3; also see Suarez, 2021). Security staff oversee prison and jail populations more likely to have serious physical and mental health conditions (Williams et al., 2009), and healthcare staff are not always available to provide care.

Understanding that security staff routinely engage with the healthcare needs of detainees raises questions about whether and how security staff experience a duty to care for detainees and what resources they have to effectuate this duty to care. Indeed, the high prevalence of people with serious mental illness (SMI) incarcerated in jails, combined with the lack of political will to reduce this population in the near term, makes evaluating whether and when staff feels safe and competent to work with these clients urgent. Likewise, the high prevalence of detrimental health outcomes among security staff makes exploring mechanisms to improve their health and well-being similarly urgent. Engaging with Venters' work on dual loyalty (2019) and responding to [blinded] call to examine the interrelatedness of staff and detainee well-being (blinded), we first examine how security staff experience their duty to care and the associated caring resources available to them, and then explore how caring duties and resources relate to the well-being of security staff, and also detainees.

1.3 Security Culture

In the previous section, we drew on public health literature to highlight the tension between care and security, exploring how security staff, like correctional healthcare staff, experience dual loyalty conflicts. Criminologists, though, have long noted that people working in

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carceral settings experience a range of tensions in their work – especially ideological tensions around the purposes of punishment, such as the tension between rehabilitation and accountability (Johnston & Ricciardelli, 2022) or the tension between providing human services to individual people in prison, or punitive services on behalf of the state (Johnson & Price, 1981; Toch 1978; Tracy & Scott, 2006). Criminologists have connected ideological orientations toward rehabilitation and human services to overall positive institutional cultures (Damas, 2023; Toch, 1978), correctional officer job satisfaction (Lambert et al., 2019), and prisoner quality of life (Crewe et al., 2011). In sum, many of these studies over almost fifty years have engaged with the broad idea that "correctional" work in carceral facilities might simultaneously or alternatively be "care" work and that this alternative orientation has implications for various aspects of staff and incarcerated people's well-being (Toch 1978; Tracy & Scott, 2006).

We bring a concrete and practical operationalization of "care" work to this literature, drawing on a conception of care—as providing specific health-related resources to incarcerated people—developed in the dual loyalty literature. Rather than focus on general ideological orientations and conflicts, we focus on specific examples of caring resources, like treatment programs and training programs, and specific perspectives on the effectiveness of these programs and the associated obligations to provide care. To our knowledge, ours is the first study to operationalize "care" work in this concrete way and then use multivariate probability methods to link the measure of care work to the health and safety of security personnel, as well as incarcerated people. In doing so, we bring robust empirical analyses to test the hypothesis, developed in qualitative studies in criminology over decades (Toch, 1978; Johnson & Price, 1981; Johnston & Ricciardelli, 2022) that engaging in care work might improve the overall well-being of security staff and incarcerated people. In addition to bringing a robust quantitative

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analysis to this literature, we also bring a focus on a large U.S. jail to a literature that is increasingly international, mainly focused on prisons in Canada (e.g., Johnston & Ricciardelli, 2022), the United Kingdom (e.g., Crewe, Liebling & Hulley, 2011), and Scandinavia (e.g., Damsa, 2023). In sum, we not only describe the prevalence of the care-security role conflict in carceral work, but we measure its effect on carceral culture, describing and measuring the social mechanisms linking security personnel's health to the health of those incarcerated.

Methods

2.1 Sample Design and Data Collection

The study sample represents civilian and sworn law enforcement officers, at or below the rank of sergeant, responsible for the direct supervision and care of people incarcerated in a large urban jail system in the U.S. We received permission to analyze the data in 2023, following the initial administration of the survey in 2019. Carceral systems in the U.S. are notoriously resistant to sharing data; delays of 3-5 years in fully accessing data are standard (see Lovell et al., 2020; Mitchell & Aronson, 2023).

The sample was selected using a stratified cluster sample design. The sampling units were combinations of work assignments (up to 20 assignments per institution) and shifts (3), stratified by jail facility (8). We oversampled one facility due to a low initial response rate to ensure the ability to describe employees' experiences accurately by facility.

The research team distributed 912 self-administered surveys and a sealing envelope to employees as they began their work shifts. To maintain anonymity, the team collected the sealed envelopes two hours later or at the end of the night shift. The team gave a raffle ticket to those who returned an envelope for $50 and $100 prizes. The trade unions that represented the employees donated and administered the prizes. The participants returned 569 surveys. Thirty

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questionnaires were excluded from the analyses because data on all variables included in the current study were missing. The resulting response rate was 59.1%, which compares favorably to the response rates (below 50% and as low as 29%) obtained in comparable studies conducted in the U.S. (Taxman et al., 2007).

We developed the survey instrument following the tailored design method (Dillman et al., 2014) using new and previously validated measures drawn from law enforcement and health research. We pretested the survey with a group of security staff and incorporated familiar language to strengthen the content validity of the measures. For example, security staff used the term "inmate" to refer to an incarcerated person. However, we use "detainee" and "person in jail" to discuss our findings and align with our professional norms regarding the use of humanizing language (Tran et al., 2018).

2.2 Dependent Variables

We examined five dependent variables to understand the interrelationship between care, safety, and health. Table 1 summarizes the descriptive statistics and scale reliability coefficients for the measures of interest.

Insert Table 1

1) We measured *cooperation with healthcare professionals* with an index combining responses to two statements about the quality of the working relationship with medical and mental health staff (alpha = .82). Participants indicated their level of agreement with the statements on a six-point Likert scale ranging from "strongly disagree" to "strongly agree."

2) *Hostile encounters,* a latent concept, was measured with a summative scale based on a modified version of the police-citizen hostility index (Regoli et al., 1990). Participants

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were asked how frequently they experienced seven encounters, including five items from the police-citizen hostility index (disobey orders, antagonize, curse, obstruct your work, and threaten) and two added items (ignore and ask for a favor). Although asking for a favor may seem innocuous, it is often prohibited by policy within correctional settings in the U.S. Even minor breaches of professional boundaries may be viewed as a source of manipulation and corruption (*see e.g.,* Cooke et al., 2019). The frequency of encounters was measured on a five-point scale that included "daily," "4 to 6 times a week," "2 to 3 times a week," "once a week," and "less than once per week." A confirmatory factor analysis conducted with the Stata *sem* command found that the seven items loaded on one factor (StataCorp, 2023). The fit statistics indicated a good fit (RMSEA = .034; CFI = .997; TLI = .994; SRMR = .017), and the scale demonstrated high internal validity (alpha = .89).

3) *Fear* of seriously mentally ill detainees was measured with a single item asking respondents to report how safe they feel working with people with SMI. Responses were recorded on a six-point Likert scale.

4) *Stress* was measured by asking participants how much stress they experienced in the last year on a four-point scale, including "almost no stress," "relatively little stress," "a moderate amount of stress," and "a lot of stress."

5) Self-rated *health* was recorded on a four-point scale ranging from "poor" to "excellent." This simple question is widely used to measure general health and is valid and reliable for use with populations without cognitive impairment (Bombak, 2013).

2.3 Independent Variables

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We examine two potential influences on security personnel's safety and well-being: respondents' perception of a duty to care and the availability of resources to care for individuals with mental illnesses. A duty to care was measured with an existing scale, and we developed four measures of caring resources to understand security staff experiences managing and providing care to persons with mental illness.

1) A professional *duty to care* was measured with the benevolence subscale from the procedural justice literature and modified for use with a jail population (alpha = .66) (Trinkner et al., 2016). The summative scale consists of the average response to three items assessing support for a caring role: "It is important to show inmates that you care about their problems;" "Custody personnel have a responsibility to try to help inmates with their problems;" and "Helping inmates cope with their problems and adjust to jail is one of my major concerns while I am on the job." Responses were recorded on a six-point Likert scale ranging from "strongly agree" to "strongly disagree."
2) Respondents were asked to estimate the *prevalence of SMI* by gauging the percentage of people with "a serious mental illness" incarcerated in the facility where they worked. A serious mental illness is defined as a disorder that results in serious functional impairment (National Institute of Mental Health, 2023). In the jail system studied, individuals classified with mild functional impairment due to a mental illness are housed in the general population. In contrast, individuals with higher levels of impairment (from moderate impairment to severely debilitating symptoms) are placed in housing units with mental health supervision.
3) Respondents rated the *quality of programs* available to treat SMI on a four-point scale ranging from "poor" to "excellent."

4) We asked participants how well training *prepared* them to work with seriously mentally ill detainees on a five-point scale ranging from "not well at all" to "extremely well." All employees participated in a required 32-hour training program modeled after crisis intervention training (Dupont & Cochran, 2000), focused on identifying symptoms of mental illness, communicating with individuals suffering from SMI, and de-escalating mental health crises.

5) S*elf-efficacy* managing people with mental illness was measured with a summative scale consisting of average responses to three items assessing the respondents' confidence in identifying symptoms of mental illness, recognizing when someone is having a mental health crisis, and de-escalating a crisis. Response options were recorded on a five-point scale ranging from "not at all confident" to "extremely confident." The scale demonstrated good internal reliability (alpha = .87).

Finally, we controlled for gender (1=male, 0 = female), race (1=White, non-Hispanic, 0= other race, and ethnicity), age, level of education, years of work experience, whether the respondent was a sergeant (i.e., a supervisor) (1=yes, 0 = no), and whether the respondent was a non-sworn officer, who was hired and trained to work exclusively in the custody division of the jail, or a sworn officer, who was hired and trained as a law enforcement officer, with the option to work either in the custody division of the jail or on patrol in the community (1=non-sworn, 0 = sworn).

2.4 Method of Analysis

The data were analyzed in Stata version 18 with *svyset* to account for the sample design and survey weights (StataCorp, 2023). In addition, we conducted a series of nested, full information maximum likelihood (FIML) estimation models to account for missing data. Across the 17 variables we included in the analyses, the proportion of missing data ranged from 1% to

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18%. An examination of the pattern of missingness suggested that some participants were uncomfortable sharing information about their rank or demographic characteristics. Little's MCAR test found that the data were missing completely at random (chi-square = 673.6, p = .36). FIML is regarded as a state-of-the-art missing data technique that improves power and accuracy and is easier to replicate than multiple imputation methods (Graham, 2009).

2.5 Qualitative Responses

Of the 569 returned surveys, 130 included handwritten, narrative responses, adding specific examples and qualitative depth to the numeric responses. We transcribed and labeled the responses according to the survey topics addressed and sorted responses into topical sub-groups. Since these responses were completely open-ended, they ranged from a few words to a few sentences and covered 20 different survey topics, from the "use of cameras in prison" to "frustrations with external oversight agencies" to "general stress," "feeling unsafe," and "relationships with medical." We reviewed relevant coded sub-categories of narrative responses for qualitative examples of our quantitative findings, paying particular attention to topics like "feeling unsafe" and "relationships with medical"; where available, we include relevant narrative responses to contextualize and elaborate on the quantitative findings. The fact that nearly one-quarter (23%) of respondents took the time to volunteer comments on a 15-page-long survey suggests that respondents engaged carefully and thoughtfully with the survey.

Results

3.1 Perceptions of a Duty to Care and Availability of Caring Resources

As noted above, jails are America's "new mental hospitals" in that they contain vastly more people with serious mental illness than psychiatric hospitals do. Security staff understand this problem intimately. When asked to estimate the prevalence of SMI, security staff reported

that between one-third and almost two-thirds of the people incarcerated in the facility where they work experience SMI. We compared perceptions to officially diagnosed rates of serious and any mental illness in four facilities for which these data were available. Figure 1 shows that staff perceptions follow the overall patterns of officially reported rates of mental illness by facility. However, security staff perceive higher levels of SMI than are officially reported. Although subjective, security staff's assessment of the prevalence of SMI may be correct. Research shows that correctional staff understand deeply the physical and emotional challenges imprisoned people face (Reiter & Blair, 2018; Toch & Adams, 1987), and may be more, not less, accurate than official records (Williams et al., 2009). Security staff are uniquely positioned to understand the level of functional impairment detainees experience as they go about their daily routines.

Insert Figure 1

While security staff recognized that a substantial proportion of detainees suffer from SMI, they were skeptical about the quality of available treatment programs to meet this need. Sixty-two percent of respondents thought that the quality of programs to treat mental illness was only poor (19%) or fair (44%), as opposed to good (32%) or excellent (6%).

In contrast, security staff felt confident and prepared in their ability to manage mentally ill detainees. More than half of security staff said they were "very" or "extremely" confident in their abilities to identify the symptoms of mental illness (59%), recognize a mental health crisis (58%), and de-escalate a crisis (57%). Close to two-thirds of security staff reported training had prepared them extremely well (6%), very well (18%), or moderately well (34%) to work with individual detainees with SMI.

Security staff expressed mixed views, however, when asked about their role in providing care. Over half of respondents agreed, at least somewhat, that "it is important to show inmates

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that you care about their problems" (58%) and that they have "a responsibility to help inmates with their problems" (57%). However, only about one-third of respondents agreed that "helping inmates cope with their problems and adjust to jail is one of my major concerns" (38%). Most responses clustered in the murky, or non-committal, middle, with participants only "somewhat" agreeing or disagreeing with statements about a duty to care and few participants expressing strong feelings one way or another.

3.2 Perceptions of Working Relationships, Safety, and Well-Being

When asked whether they had "a good working relationship" with mental health professionals, security staff expressed tepid agreement: 31% disagreed, and 34% only somewhat agreed. Respondents reported a lower level of cooperation with medical staff. Forty-five percent of study participants disagreed that they had "a good working relationship with medical staff," and 31% only somewhat agreed with this statement. As one respondent described, security staff relations with healthcare professionals were frequently tense: "Department of mental health does not take the input of deputy personnel when it comes to inmates. To medical and psychological staff, they are always right, and we (deputy and custody personnel) are always wrong."

Survey results also help quantify the routine difficulty security staff experience working closely with persons in jail. We evaluated the self-reported frequency of seven encounters with hostile valence between security staff and detainees. The most frequent encounters staff perceived as hostile were being disobeyed, ignored, cursed at, and asked for a favor. More than half of respondents reported daily experiences of at least one hostile encounter. Three out of five security staff experienced more aggressive hostility—antagonizing, obstructing, and threatening—weekly. In addition to frequent hostile encounters, half of the security staff indicated *fear* of detainees, disagreeing with the statement that they felt "safe working with

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mentally ill inmates." Another respondent, in a narrative response at the end of the survey, explicitly connected the frayed relations between security and healthcare professionals to these feelings of hostility and fear: "In the custody environment, there seems to be a disconnect amongst custody personnel, mental health clinicians, and medical personnel. This sometimes creates an unsafe and unpleasant work environment due to conflicting orders and interests."

Finally, respondents reported high stress levels but good to fair self-rated health. Eighty-three percent of security staff said they experienced "moderate" (51%) to "a lot" (32%) of stress in the previous year, and another 13% reported experiencing a "great deal" of stress. However, most respondents indicated their overall health was "good" (54%), and approximately 15% indicated "excellent." Still, close to one-third rated their health as "fair" (26%) or "poor" (6%).

3.3. The Association Between Care, Working Relationships, Safety, and Well-Being

We estimated a series of nested, full-information maximum likelihood models to explore the association between perceptions of the duty to care and availability of caring resources, on the one hand, and cooperation with healthcare professionals, safety (including hostile encounters and fear), and well-being (including stress and overall health), on the other hand. Across all five models, we found that favorable perceptions of the duty to care and the availability of caring resources are directly and indirectly related to the safety and well-being of security staff. The results are reported in Table 2.

Insert Table 2

The model predicting cooperation with medical professionals explained 17% of the variance in the dependent variable (R^2 = .17). Other things being equal, security staff who endorsed a duty to care (b=.20; p <.000), those who had more confidence in the quality of mental health programs (b=.23; p <.000), and those who felt better prepared (b=.12; p =.005) to work

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with people diagnosed with SMI were significantly more likely to report a cooperative working relationship with healthcare professionals. However, self-efficacy in managing mentally ill detainees and the perceived prevalence of SMI were unrelated to cooperation. Non-sworn officers were also significantly more likely to have cooperative relationships with medical professionals than sworn law enforcement officers.

The model predicting hostile encounters explained 19% of the variance in the dependent variable ($R^2 = .19$). Significantly, confidence in the quality of mental health programs ($b=-.12$, $p = .039$), feeling prepared by training ($b=-.10$, $p=.019$), and cooperation with medical professionals ($b=-.14$, $p =.002$) were associated with fewer hostile encounters with detainees. However, those with higher levels of self-efficacy ($b =.24$, $p < .000$) and those who estimated higher prevalences of serious mental illness ($b=.004$, $p < .000$) reported significantly higher frequencies of hostile encounters. Demographic characteristics also influenced hostile encounters: men and non-white employees were more likely to have hostile encounters, but those with more years of work experience and in more senior positions (sergeants) were less likely to have hostile encounters.

The third model predicted 7% of the variance in fear of seriously mentally ill detainees ($R^2 = .07$). Staff who felt better prepared to work with detainees with SMI were less fearful ($b= -.16$, $p = .016$) and more frequent hostile encounters were associated with higher levels of fear ($b=.10$, $p = .037$). A duty to care was also associated with less fear about working with incarcerated people with SMI but did not reach statistical significance at the .05 level ($b=-.12$, $p = .08$).

Thirteen percent of the variance in stress was accounted for by the fourth model ($R^2 = .13$). Security staff who reported higher levels of fear of detainees with SMI ($b= .07$, $p =.012$)

and those who had more frequent hostile encounters (b= .15, p < .000) were significantly more likely to report higher levels of stress. Poor perceptions of the quality of programs to treat mental illness were negatively associated with stress but did not reach statistical significance at the .05 level (b= -.07, p=.07). Similarly, perceived self-efficacy managing detainees with SMI approached statistical significance and was associated with higher levels of stress (b=.09, p = .06). Interestingly, controlling for the other variables in the model, the perceived prevalence of SMI was unrelated to feelings of stress (b = .001, p = .681).

Finally, the model predicting self-reported health explained 20% of the variance in the dependent variable (R^2=20). Staff who reported higher levels of stress rated their health more poorly (b=-.31, p <.000). Even controlling for stress and other variables in the model, the quality of mental health programs for detainees (b=.08, p =.039), high perceptions of self-efficacy (b=.11, p = .015), and cooperative relationships with medical professionals (b= .06, p=.03) were all significantly associated with better self-rated health. Fear of detainees with SMI approached statistical significance and was negatively related to self-rated health (b=-.04, p = .066).

Discussion

This study analyzed the results from 539 survey respondents employed as security staff in a large county jail system in the U.S. The study described perceptions of a duty to care and the availability of caring resources, including reported experiences managing mental illness. It examined how these experiences affected perceptions of working relationships with medical staff and detainees and personal well-being. First, we found that security staff accurately assessed the prevalence of SMI in their institutions. We found, second, that most security staff were confident in their abilities to identify symptoms of mental illness, recognize and de-escalate a crisis, and felt at least moderately well-prepared to do all this by the training they had received. However,

security staff generally were skeptical about the quality of programs to treat the rampant mental illness they perceived; almost two-thirds reported that available mental health treatment programs were poor or, at best, fair. Security staff were also skeptical about their caring roles. Barely over a third identified “helping inmates cope” as a priority, and most were ambivalent about their relationships with healthcare professionals. Moreover, they experienced frequent hostile encounters with detainees and experienced high stress levels, even though many reported having fair to good health.

Maximum likelihood models supported our hypothesis that challenges managing mental illness and caring for detainees strain working relationships between security and health professionals, contribute to hostility and fear, and erode the well-being of security staff. Feelings of ambiguity about a caring role (i.e., reported perceptions of a limited duty to care), as well as perceptions of limited resources for care, training, and efficacy, were significantly related to negative outcomes in staff interactions and for staff well-being, including less-collaborative relationships with healthcare professionals, elevated levels of hostility experienced by security staff in encounters with incarcerated people, and higher stress levels and worse health among security staff. In fact, our models explained 20 percent of the variation in self-reported health, suggesting the substantial impact of the variables we measured on the well-being of security staff.

Two of our dependent variables were especially interesting across our models. First, perceptions of self-efficacy played a counter-intuitive role in our models: it was significantly associated with more frequent hostile encounters and higher stress levels but better self-rated health. We hypothesize that this could be due to officers over-estimating their ability to manage SMI or due to a greater willingness to engage with detainees, creating more opportunities for

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hostile and stressful encounters. This finding deserves further exploration in future models. Second, cooperation with healthcare professionals played a particularly significant role in our models: perceptions of high-quality working relationships with healthcare staff were strongly associated with fewer hostile encounters with detainees and better self-rated health. This suggests that investing in improving cooperativeness between security staff and healthcare professionals would be of high value for the safety and health of security staff.

In sum, we found that security staff experience a tension between care and security, akin to the dual loyalty challenges healthcare professionals face. An inability to provide adequate care and ambivalence about their role in delivering this care appear to exacerbate relational challenges between security and healthcare staff and between security staff and detainees. Likewise, lower-quality relationships between security and healthcare staff were associated with more hostile encounters and lower self-rated health. Weak commitment to a duty to care, inadequate availability of caring resources, and even low-quality relationships with healthcare staff have negative health consequences for security staff. But the inverse relationships point towards valuable policy interventions: a strong orientation towards caring for jail detainees and the perceived efficacy of training for handling people with mental illnesses were significantly related to positive outcomes among staff, including more cooperative relationships with healthcare professionals, less frequent experiences of hostility with detainees, lower stress levels, and better self-reported health. In other words, increasing resources to provide adequate care and reducing ambivalence about providing this care might improve both relationships (between security and medical professionals and between security staff and detainees) and health outcomes for security staff.

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Acknowledging that security staff face dual loyalty dilemmas akin to those of healthcare professionals—experiencing a duty to care alongside their duty to secure—opens the possibility that security staff, like healthcare professionals, might benefit from more training to support the idea that health and security can co-exist. Of course, this presumes that ambivalence about providing care is modifiable and that jails can increase the availability of caring resources. Advocates of dual loyalty training for healthcare professionals argue that the ambivalence of dual loyalty can be addressed with well-designed training (Pont et al. 2012; Venters 2019). Specifically, dual loyalty training for healthcare professionals seeks to mitigate the idea that health and security are necessarily in opposition and instead facilitate health and security co-existence (Glowa-Kollisch et al., 2015; Liebling, 2011). Likewise, cultivating the idea of a therapeutic alliance, not just between healthcare professionals and detainees, but between security staff and detainees, could be fruitful (Id.). The Correctional Change Initiative (CCI) provides a preliminary model for developing this kind of training intervention: created by the National Institute of Corrections in the early 2000s to "address negative prison culture," CCI involved a 3-day training to support the development of workplace improvement plans and was associated with a decrease in overall misconduct among incarcerated people, as well as a decrease (not statistically significant) in violent incidents (Byrne et al., 2008).

Deploying a survey of hundreds of staff in a large U.S. jail system, we operationalized and measured attitudes towards and experiences with "care" work, particularly focusing on resources for helping people with serious mental illnesses. Our analyses bring dual loyalty frameworks from public health literature into conversation with criminological literature examining ideological orientations to "care" work in carceral facilities. Even though we found overall low rates of support for care work, cooperativeness with healthcare professionals, and

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efficacy of available resources for mental health care among our respondents, our multivariate probability models revealed receptiveness to care and access to caring resources to be associated with multiple positive effects on cooperation with healthcare staff, frequency of hostile encounters, and staff health. The findings suggest that even preliminary interventions, like dual loyalty training for security staff, cultivating therapeutic alliances, or piloting workplace improvement training programs like CCI, might have significant impacts on staff and even incarcerated people's well-being.

4.1 Limitations

This study has three primary limitations. First, while the survey had a relatively high response rate and hundreds of respondents sufficient to power our analyses, it was confined to a single, albeit large, urban, and diverse county jail system. Replicating this survey in other large, urban county jail systems could be valuable for understanding how staff experiences vary across jurisdictions and jail contexts. Likewise, facility-level variation within large carceral complexes deserves further analysis in future work. Although adjusting for the sampling design accounted for some clustering by facility, we cannot rule out contextual effects that may condition the interrelationships between care and caring resources we observe. Second, the measures we examined here were part of an extensive survey covering many aspects of work experience in the county jail system, so we could not ask multiple or detailed questions about experiences working with detainees with SMI. Future work could benefit from more detailed questions focusing on the concepts analyzed here. Relatedly, the idea of security staff experiencing dual loyalty conflicts akin to those of healthcare professionals arose inductively from our analyses of the survey results. Additional longitudinal, experimental, and qualitative research directly exploring security staff's experience of dual loyalty would be valuable for better understanding predictors

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of this conflict and points of intervention for amelioration. For instance, questions and vignettes exploring how security staff navigate specific cases of conflict between care and security could be included in future surveys and interviews. Finally, the care resources we ask about in this survey are meager, entailing basic familiarity with SMI, access to one 32-hour training, and general perceptions of interactions with healthcare professionals. However, staff perception of even these minimal care resources had a powerful impact on relationships and well-being. The findings indicate that more attention is needed to understand what care resources are most impactful – and how those resources can be expanded.

4.2 Conclusions and Implications

While our analysis focused on how perceptions of a duty to care and the availability of caring resources predicted security staff's relationships with healthcare professionals and detainees, as well as their own health, our results indirectly suggest that perceptions of a duty to care and the availability of caring resources might also predict detainee well-being. For instance, if security staff who report a strong duty to care have fewer hostile interactions with detainees and cooperate more with healthcare professionals, then detainees might also be safer because of decreases in hostile interactions and healthier because of more access to healthcare professionals. Of course, more research is needed to explore this potential relationship further. To the extent security staff and detainee well-being are interrelated, however, interventions that improve one might improve the other.

As the American Public Health Association's (2019) Code of Ethics reminds us, "[T]he health of every individual is linked to the health of every other individual … and to the integrity and functioning of environmental ecosystems." Our findings suggest this is especially true in the highly surveilled, disproportionately unhealthy, and frequently hostile context of jail systems.

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Rather than choosing between the health and safety of security staff or the health and safety of incarcerated people, we need interventions to improve the well-being of both. Indeed, millions of people annually experience incarceration, along with the detrimental health outcomes of living and working in epicenters of social and medical crises. An estimated 1.8 million people were in prison or jail in the United States in 2023; more than five times as many people (9 million) cycle through jail in any given year (Assistant Secretary for Planning and Evaluation); and another 363,250 people work in prisons and jails (U.S. Bureau of Labor Statistics, 2022). Understanding staff perspectives and correlations between staff perspectives and outcomes for incarcerated people is an essential first step to reducing harm for all involved.

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Table 1. Measures and Descriptive Statistics

Variable	n	M	Std. Err.	Min.	Max.	alpha
Dependent						
Cooperation with Health Staff	488	3.33	.05	1	6	.82
Hostile Encounters	530	3.65	.04	1	5	.89
Fear of Mentally Ill Detainees	489	3.67	.06	1	6	
Stress	508	3.11	.03	1	4	
Health	508	2.77	.03	1	4	
Independent						
Duty to Care	518	3.37	.05	1	6	.66
Caring Resources						
Estimated Prevalence of SMI	503	43.18	1.08	0	100	
MI Program Quality	496	2.23	.04	1	4	
Self-Efficacy with MI Detainees	502	3.59	.03	1	5	.87
Prepared	504	2.72	.05	1	5	

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Table 2. Full Information Maximum Likelihood Models

	Cooperation		Hostile Encounters		Fear		Stress		Health	
	b	**se**	**b**	**se**	**b**	**se**	**b**	**se**	**b**	**se**
Duty to Care	.200***	.049	-.011	.043	-.123	.070	-.024	.033	-.014	.033
MI Program Quality	.228***	.061	-.121*	.059	-.085	.084	-.075	.042	.079*	.039
Prepared	.124**	.043	-.110*	.04	-.162*	.067	-.022	.035	.044	.031
Self-Efficacy	.096	.066	.243**	.069	-.023	.094	.089	.047	.113**	.046
SMI Prevalence	-.001	.002	.004*	.002	-.001	.003	.001	.001	-.001	.001
Age	.075	.062	-.105	.070	-.002	.093	.040	.047	.001	.047
Male	.075	.129	.357**	.143	-.073	.177	.050	.100	.056	.092
White, non-Hispanic	-.080	.112	-.379**	.171	.175	.160	.063	.081	.089	.080
Level of Education	.0003	.042	.005	.044	-.027	.060	.022	.033	.061*	.029
Years of Experience	-.003	.010	-.029**	.011	.018	.015	-.008	.009	-.019*	.008
Sergeant	.083	.204	-.423*	.218	.169	.248	.203	.120	-.048	.157
Non-Sworn Officer	.520***	.107	-.173	.131	-.110	.160	.151	.091	.097	.076
Cooperation			-.137**	.047	-.085	.067	-.050	.034	.064*	.030
Hostile Encounters					.102*	.049	.148***	.030	-.025	.026
Fear							.068**	.027	-.044	.023
Stress									-.305***	.044
		R^2		R^2		R^2		R^2		R^2
Model Statistics		.17		.19		.07		.13		.20

Note: *p≤.05; ** p≤.01; *** p≤.001

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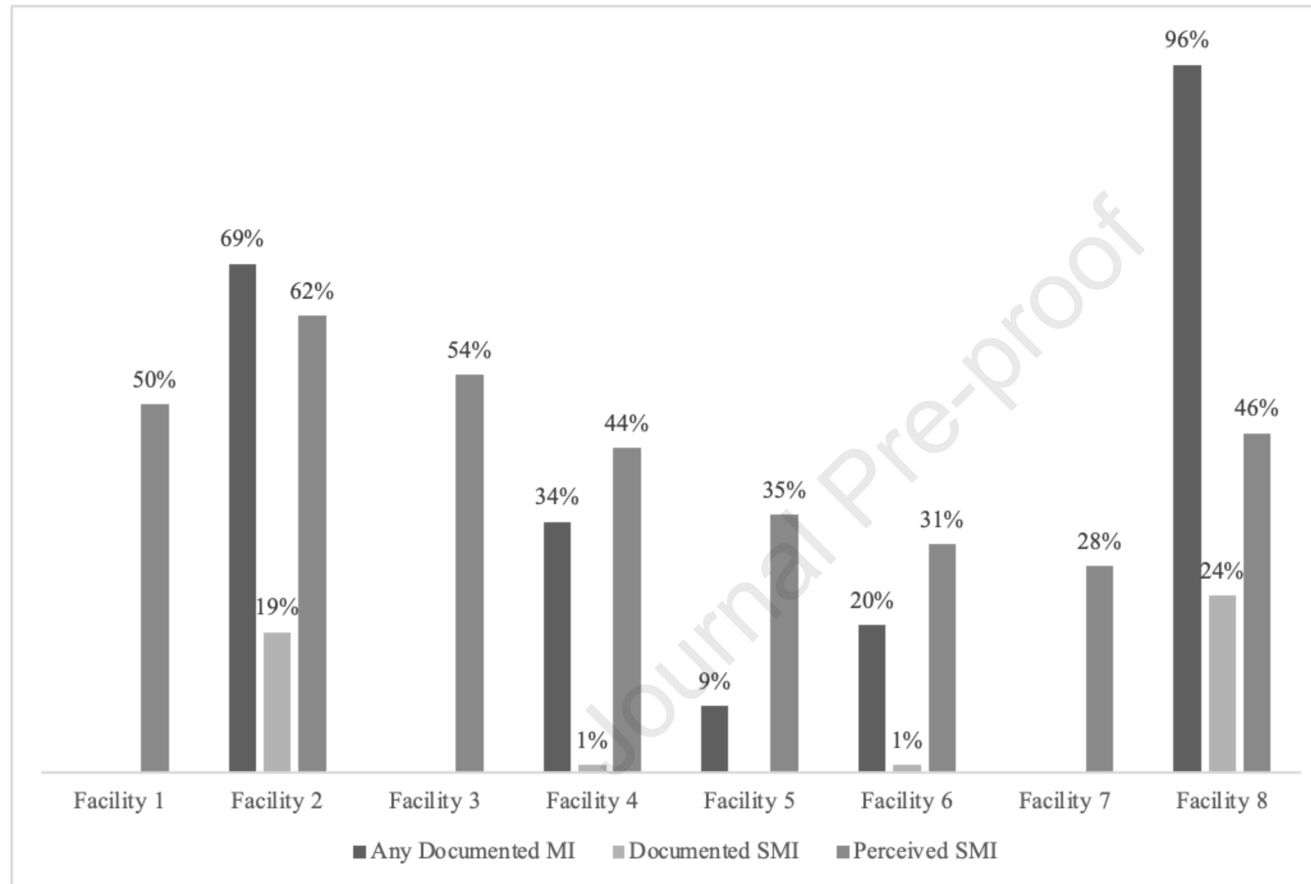
Figure 1. Official and Estimated Prevalence of Serious Mental Illness by Facility



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Highlights

- Security staff, like medical staff, experience "dual loyalty" conflicts in jails.
- Jail security staff with access to more caring resources are healthier and safer.
- Health and safety of jail security staff is closely related to that of detainees.
- More access to caring resources can improve overall staff and detainee well-being.

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