Best Practices for Correctional Officers Managing Mentally Ill Offenders

Approved: Michael Klemp-North, PhD Date: May 5, 2011

Best Practices for Correctional Officers Managing Mentally Ill Offenders

A Seminar Paper

Presented to the Graduate Facility

University of Wisconsin-Platteville

In Partial Fulfillment of the Requirements for the Degree

Master of Science in Criminal Justice Offender and Victim Services

Richard L. Cloyd

May 2011

Acknowledgements

This capstone seminar paper represents my final contribution to my graduate program requirement for UW-Platteville distance learning. I began this journey September of 2007 and I distinctly remember receiving feedback from my professor for my very first assignment submission in Criminal Justice Systems. After reading the comments and seeing my grade I began to doubt whether I truly belonged in this graduate program. I began to wonder if I had bitten off more than I could chew and started to doubt my ability as a graduate student. I decided not to give up and I credit this professor for pushing me to be a better writer and much better student than I had ever thought possible. My experiences with the entire faculty via UW-Platteville distance learning have been top notch and I would easily recommend this program to anyone in my field especially due to the added flexibility of being online due to my often chaotic work schedule as a correctional officer. I will always appreciate the vast experiences of the classmates I have encountered through this program. I have learned from you all.

In particular I would like to take time to thank Dr. Fuller for the time you took out of your schedule to speak to me on the phone and answer my many questions about the graduate program and my capstone in particular. Dr. Bromley, your courses really stand out in my memory and I particularly remember an assignment where you asked us to engage in a public act of abnormality and write about our experiences. It was a pleasure to be part of your courses. Dr. Klemp-North, you assisted me greatly in guiding me through this capstone paper. You helped me stay organized through this process and helped me realize the importance of taking this paper one section at a time. Without this guidance I surely would have been lost and overwhelmed by the enormity of this undertaking.

I could write at great length about other people who have inspired and assisted me throughout my life and graduate career, so I will keep this simple.. Suffice it to say: to my Mom, Dad, Brother Shawn, Brother Brian and friends/people I hold dear: I love you all.

Abstract

Best Practices for Correctional Officers Managing Mentally Ill Offenders

Richard L. Cloyd

Under the Supervision of Dr. Michael Klemp-North

Due in part to the deinstitutionalization of many state mental hospitals and the poor organization of the mental health system, many mentally ill individuals have become absorbed in local jails and prison institutions across the United States. Mentally ill inmates face several hurdles associated with confinement and in some cases elements of incarceration can exacerbate symptoms of mental illness. A review of the research literature notes the increased need for better training of correctional officers in order to effectively manage mentally ill inmates and de-escalate volatile situations. This presents an enormous challenge particularly to correctional officers who, by and large, often lack the skills and training to understand the complexities associated with mental illness.

This paper will review best practices for correctional officers managing mentally ill offenders. The usage of crisis intervention teams (CIT) will be highlighted as an effective response model to crisis situations associated with mentally ill inmates. Recommendations will be set forth for the implementation of improved correctional officer training components related to mental health issues. Improved training and understanding of mental illness will contribute to safer prison environments for both staff and inmates.

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I. INTRODUCTION

A. Statement of the Problem

More and more people with mental illness are being absorbed into the criminal justice system due in part to punitive crime control policies and the deinstitutionalization of many state mental health hospitals across the United States over time (Heines, 2005). The American Psychiatric Association has found that as many as one in five inmates in state prisons and local jails may have a serious mental health disorder (Geiman, 2007). The mentally ill face significant challenges while incarcerated and in many cases some conditions of incarceration may exacerbate symptoms of mental illness (Rhodes, 2005). This is compounded by the fact that many prisons are overcrowded and chronically understaffed. Many line staff members of correctional institutions also lack sufficient training to understand many of the complexities associated with mental illness especially as it relates to suicidal inmates or noticing signs of major depression.

B. Purpose of the Study

The purpose of this inquiry is to provide a best practices template for line staff to utilize in order to gain a better understanding of mentally ill inmate populations. Analyzing prior case studies and secondary research data will allow this author to develop a template of best practices as it relates to training programs for correctional staff. This is an important topic because many correctional institutions are absorbing a greater number of the mentally ill. Correctional officers are also on the front lines every day and usually have more face to face interaction with inmates especially on work details and in housing units. Given this fact, it makes sense that officers should be expected to gain a better understanding of mental illness. With proper training and greater sensitivity to

mental illness, custody staff will be better suited to effectively manage inmates in a safer manner thereby lowering the inherent risks of the prison setting for both staff and inmates.

C. Implications of the Study

This research is significant because it will give prison administration a template to allow for better training of custody staff. As mentioned previously, correctional officers typically have more interaction with inmates and it certainly makes sense to educate officers about mental health issues among the inmate population. Having knowledgeable and professional staff will also have the added benefit of a safer prison environment for staff and inmates.

D. Methods of Approach

Information for this paper will be compiled from secondary sources. As an employee with the Federal Bureau of Prisons, this author will have access to other professionals (e.g., Psychological Services Department) in the field of corrections. Based in part on these interviews, this author will seek to develop a best practices template as it relates to training programs for custody staff. Other sources will be compiled from accredited journals, case studies, textbooks and various other electronic databases (e.g., NCJRS, EBSCOHost, Federal Bureau of Prisons website, etc).

E. Contributions to the Field

This seminar paper will serve as an educational tool and template for corrections officers to utilize when interacting with mentally ill inmates or responding to crisis situations. Many correctional officers are trained to be rigid when enforcing institution policy and security protocol. The hope for this inquiry is to help officers balance these safety concerns with a renewed sensitivity to mental health concerns among the inmate

population. Teaching officers to notice signs of emotional distress and depression will also have the added benefit of allowing officers to better communicate and alleviate potential volatile situations with mentally ill offenders.

F. Anticipated Outcomes

As mentioned previously, the recommendations set forth in this paper will provide a best practices template for prison line staff to utilize in order to better manage mentally ill inmate populations. A corrections officer who has a solid understanding of some of the issues associated with mental illness will be in a better position to communicate with the inmate population and notice signs of distress. Having this knowledge in hand, an officer can make appropriate referrals to psychological services and lower the risk of escalating potential volatile situations with mentally ill offenders. Having properly trained and knowledgeable staff also has the added benefit of contributing to safer prison conditions for both staff and inmates alike.

II. LITERATURE REVIEW

A. The Challenge of Defining Mental Illness in the Criminal Justice System

One of the greatest difficulties when discussing mental illness or psychological abnormality in the criminal justice system is the formation of a consistent valid definition. Many definitions of abnormality have been proposed over the years by a great number of scientific minds and clinicians, yet none of which is universally accepted. For example, the clinical definition of mental illness is usually much broader than a legal definition. A definitive definition of mental illness in a clinical sense is often less helpful than determining how a disorder should be classified or treated in the first place. Accordingly, there are two main international medical standards used in the classification of mental illness. The first of these is the World Health Organization's International Classification of Diseases (ICD-10). This medical standard was last revised in 1992 and is predominately used in Europe (Comer, 2007). The second international standard is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This being the case, most definitions of mental illness have certain features in common. For the purposes of this inquiry, this author will adopt the usage of the "four D's": deviance, distress, dysfunction and danger as it relates to mental illness in the criminal justice system (Comer, 2007). Before discussing these categories, it is worth noting that the aforementioned terms are just a guideline and it should become clear that these criteria can often be vague and subjective.

Behavior, thoughts and emotions are often deemed abnormal whenever they violate a society's idea about proper functioning (Comer, 2007). Society often establishes norms, which are implicit and explicit rules for proper conduct. Furthermore,

behavior that violates legal norms is considered to be criminal, while behavior, thoughts and emotions that impair psychological functioning is known as abnormal (Comer, 2007). These judgments of abnormality often vary from society to society and can change over time. For example, in Western society a woman's participation in the business world or the political sphere was considered strange and inappropriate a hundred years ago. In today's society women involved in the business world and politics is accepted and valued. This illustrates the fact that society's values can change over time, causing its views of what is psychologically abnormal to change as well (Comer, 2007). These norms are rooted in culture, which consists of its history, values, institutions, habits, skills, arts and technology (Comer, 2007). According to many clinical theorists, behavior, ideas or emotions usually have to cause distress before they are considered abnormal (Comer, 2007). Abnormal behavior can also tend to be dysfunctional if it interferes with daily functioning such as when a person is so upset, distracted or confused to the point that they cannot care for themselves or participate in normal social interactions (Comer, 2007). The last category for defining psychological abnormality is that of danger. This involves individuals whose behavior is consistently careless, hostile or confused may be placing themselves and others at risk. This being the case, not everyone who is struggling with depression, anxiety or even bizarre thinking patterns poses a significant danger to themselves or others (Comer, 2007).

As can be seen, it is generally society that selects the criteria for defining abnormality and at times it may be difficult to apply definitions to behavior consistently A society may also have difficulty distinguishing between an abnormality that would require intervention and an eccentricity. For the purposes of this inquiry, it presents an

enormous challenge to correctional officers to understand the maladaptive behaviors associated with mentally ill inmates because few of the aforementioned categories are as clear-cut as they would appear.

B. The Historical Development of Prisons in the United States and Its Impact on Mentally Ill Offenders

The historical development of prisons in the United States has seen several different stages over the years beginning with The Penitentiary Era in the early 1790s. This era of incarceration was heavily influenced by the Pennsylvania Quakers. The Pennsylvania system made use of solitary confinement and encouraged penance via personal Bible study as the primary mechanism for rehabilitation (Schmalleger, 2007). As prison populations increased it became evident that solitary confinement was not very cost effective. As such, one of the first prisons to abandon the Pennsylvania model was the New York State Prison at Auburn in 1825. The Auburn model required prisoners to be held in congregate fashion and featured group workshops. Corporal punishment such as whipping and hard labor were also enforced to maintain a rule of complete silence among the inmates under the Auburn model (Schmalleger, 2007).

The Reformatory Era beginning in 1876 saw the emergence of indeterminate sentencing as developed by two noteworthy correctional leaders of the mid-1880s such as Captain Alexander Maconochie. Maconochie developed a system of marks whereby prisoners could essentially earn enough credits to buy their freedom. Bad behavior removed marks from an inmate's ledger, while acceptable behavior added marks. This marks system made early release possible and was a precursor to later practice of parole (Schmalleger, 2007). Unfortunately, the reformatory style of prison was considered a bit

of a disappointment considering the fact that many inmates eventually returned to a life of crime upon release from prison (Schmalleger, 2007).

The Industrial Era beginning in 1890 saw the advent of a model intended to capitalize on the labor of inmates. With rising inmate populations and prison costs, prison administrators saw great potential in the profitability of inmate labor. Many of the prisons of this era smelted steel, manufactured cabinets, molded tires and a variety of other goods for the open market (Schmalleger, 2007). Prisons in the South tended to concentrated on farm labor and other public-works projects. The Industrial Era came to a halt in 1935 due in part to a variety of factors including the Great Depression, organized labor union complaints and federal legislation known as the Ashurst-Sumners Act that restricted interstate commerce of prison-made goods (Schmalleger, 2007). The end of free-market prison industries ushered in the Punitive Era of corrections, which began in 1935. This era was categorized by the belief inmates owed a debt to society that could only be repaid through a rigorous period of confinement (Schmalleger, 2007). During this period maximum security institutions such as the federal penitentiary on Alcatraz Island flourished and an inmate's routine was that of monotony and routine.

In 1945 the mood changed in the United States as industries were on the rise and America's position of world leadership was unrivaled. Due in part to the post World War II economic boom, politicians and the public developed a new interest in the medical model of corrections (Schmalleger, 2007). This therapeutic model applied a diagnostic perspective of medical science to treating offenders. This became known as the Treatment Era of corrections and therapy often took any number of forms such as behavior therapy, drug therapy, neurosurgery, sensory deprivation and aversion therapy

(Schmalleger, 2007). Most of these models assumed that inmates simply needed to mature psychologically and should assume responsibility over their lives. Programs were developed around individual treatment and group therapy approaches. This treatment era was not without its share of criticism from academics and legal scholars who often pointed to a lack of evidence in support of the medical model's effectiveness especially regarding controversial psychosurgery such as lobotomy procedures (Schmalleger, 2007).

The treatment era's belief of behavioral change can be credited for the movement away from institutionalized corrections towards opportunities for reformation in the local communities. This became known as the Community-Based Era starting in 1967 and is also commonly referred to as deinstitutionalization, diversion or decarceration. The community-based model is based on the premise that rehabilitation does not exist in isolation from civilian society and that inmates must eventually return on day (Schmalleger, 2007). Proponents of this model also point to many of the dehumanizing aspects of incarceration especially as it relates to mentally ill inmates and claim that prisons already victimizes offenders who have already been negatively labeled by society. This decarceration movement used several programs to keep offenders in contact with the community and include halfway houses, work-release programs and other open institutions (Schmalleger, 2007). This community based format has also led to innovations in the use of prison volunteers for vocational opportunities and religious services as well as the extension of certain inmate privileges including weekend passes and other extended visits by family members and friends. For instance, in 1968 the California Correctional Institute at Tehachapi initiated conjugal visits in which certain

inmates were allowed to live with family members for three days per month in apartments on institution grounds (Schmalleger, 2007).

Beginning in the early 1980s, a major shift in public attitude associated with high recidivism rates coupled with dramatic media accounts of crime led many conservative politicians to push legislatures to curtail many aspects of educational and work release programs for inmates. The start of the 1980s has become known as the Warehousing Era in corrections and is based on the desire to prevent recurrent crime. This change in correctional philosophy can also be attributed to changes in individual sentencing decisions of judges, since many judges began to view rehabilitative programs as failures (Schmalleger, 2007). As a result, many judges adopted a just deserts model when making sentencing decisions. Recidivism rates were often quoted in support of this warehousing initiative. For instance, one such study found that nearly 70% of young adults paroled from 22 states in 1978 were rearrested for serious crimes one or more times within six years of their release (Schmalleger, 2007). The continued attack on the treatment model and public outcry of rising crime rates gave rise to a nothing-works doctrine that was popularized by Robert Martinson (Martinson, 1974). This new philosophy also contributed to new sentencing laws such as mandatory minimum sentencing, truth in sentencing provisions and "three strikes and you're out" laws (Schmalleger, 2007). As a result of this new mentality and changing sentencing laws, the prison population across the United States grew significantly during the warehousing era. For example, between 1980 and 2005, the federal and state prison populations more than quadrupled from 329,000 inmates to over 1.5 million (Schmalleger, 2007). This surge in inmate population can also be attributed to changes in sentencing laws that targeted drug

offenses associated with the War on Drugs and other zero tolerance mindset in enforcing the law.

As early as 1900, many mentally ill members of society were treated through various state-operated mental health facilities across the United States. Due to a confluence of events, resources and support for the mentally ill within the community has waned most notably during the Warehousing Era of American corrections (Schmalleger, 2007). This has resulted in the growing number of mentally ill being absorbed into the criminal justice system at present time. As an example of this trend, former President Ronald Reagan systematically closed down mental health hospitals as Governor of California during the 1970s. Soon after as President, Reagan sought to cut aid for federally funded mental health programs (Schmalleger, 2007). One of the challenges that prisons face today is that many of these institutions are not adequately funded and staffed to respond to the complex needs of the mentally ill population. As such, mentally ill inmates face several challenges while incarcerated and are at an increased risk of victimization. Punitive crime control policies along with changes in sentencing laws has contributed to the rising number of the mentally ill being absorbed into the criminal justice system at present time.

C. Current Challenges Faced by Mentally Ill Inmates

A popular stereotype in the media and Hollywood revolves around the notion that mentally ill individuals are inherently evil or violent. Very often this misconception leads to the belief that these offenders will refuse treatment or simply do not deserve it. In actuality, few of these mentally ill inmates have committed violent offenses. For the most part, these individuals are arrested mainly for misdemeanor offenses including

loitering, stealing, trespassing and disturbing the peace, public drunkenness or vagrancy. Very often these individuals repeatedly make the rounds from jail to the streets as the cycle continues.

Another problem faced by mentally ill offenders in prison that is worth noting is sexual abuse. The actual extent of prison sexual abuse is difficult to predict with any accuracy due to under reporting or fear of violent reprisals among inmates. As a result, any available statistics must be accepted as conservative measures of sexual assault since discovery and documentation of these incidents are compromised by the nature of the prison subculture, inmate codes and staff attitudes or indifference (Dumond, 2000). The problem is further complicated by complex social-psychological circumstances associated with the correctional setting. Coerced sex may take several different forms on a continuum ranging from trading sex for protection or to other extreme scenarios (Dumond, 2000). In addition to experiencing physical harm, sexual abuse victims are also exposed to a myriad of other risk factors including exposure to a sexually transmitted disease, post traumatic stress disorder, depression and suicidal ideation (Dumond, 2000). Certain groups of inmates may also be at an increased risk of sexual victimization. These individuals include: young or inexperienced, physically small or weak, inmates suffering from mental illness or mental disability, inmates convicted of sex offenses and inmates known to be homosexual or overtly effeminate (Dumond, 2000).

Many correctional institutions struggle to supervise offenders with mental illness. Prison line staff members often lack the training necessary to recognize and acknowledge the complexities associated with mental illness. Compounding the issue is the fact that many corrections institutions are chronically understaffed and overcrowded. Institution

codes associated with the subculture of prison encourage predatory behavior and exploitation of vulnerable inmates. Inmates suffering from a mental illness also run a high risk of being physically and sexually abused by other inmates who sense their vulnerability. Conversely, some inmates with serious mental health concerns pose an enormous threat to the safety of other inmates and corrections staff should they choose to violently act out in frustration or confusion. As a result of this violence, mentally ill inmates frequently spend a significant amount of time in protective custody known commonly within the Bureau of Prisons as special housing units or segregation. These segregated units are often associated with solitary confinement for as long as 23 hours a day. These living conditions can sometimes serve to exacerbate symptoms of mental illness. The sensory deprivation and lack of social contact can sometimes contribute to increased rage and disorientation of mentally ill inmates (Rhodes, 2005). Due to these problems, it should come as no surprise that suicide is the leading cause of death among prison and jail inmates (Harvard Mental Health Letter, 2003).

Part of the prison experience is to reinforce social norms and expectations. Unfortunately, many mentally ill inmates are unable to abide by some of these rules associated with the prison regimen due to illogical thinking patterns often associated with delusions and hallucinations. To compound the problem, inmates with cognitive problems often have difficulty understanding some of the basic rules and expectations associated with the prison routine. As an example, an inmate with cognitive problems might have great difficulty showing up on time for their work detail assignments and fulfilling basic inmate expectations in prison such as following the proper inmate dress

code. These inmates with cognitive problems usually have the tendency to receive more incident reports from staff and often spend more time in special housing units as a result.

D. Direct and Indirect Costs of Incarcerating the Mentally Ill

Mentally ill inmates contribute to the overcrowding of United States prisons and local jails. In fact, recent federal statistics indicate that the number of mentally ill offenders in United States prisons and jails has quadrupled as of midyear 2005. Bureau of Justice Statistics also indicate that over half of all prison and state inmates now report mental health problems, including symptoms of major depression, mania and psychotic disorders (Glaze & James, 2006). In 1998, the Bureau of Justice Statistics reported an estimated 283,000 prison and jail inmates who suffered from mental health problems. As of 2006, this number is now estimated to be 1.26 million (Glaze & James, 2006). Confinement of the mentally ill also comes at a price to the US economy. Many of these costs can be either direct or indirect. Direct costs relate to the involvement with the criminal justice system through arrest and incarceration. Indirect costs relate to the dehumanizing aspects of incarceration. The prevailing social meaning of mental illness is closely aligned with the punitive and moral paradigm (Pustilnik, 2005). Under this model, mental illness is seen as a failure of personal responsibility. This ideology forms the basis of American culture where everyone is presumed to be responsible for their actions. This is also evident in the fact that American society tends to criminalize behavior and demand legal action for those who break the law. Under this model, every action is perpetuated by a motivated offender (Blomberg and Cohen, 2003).

Conversely, the subordinate model often overlooked by lawmakers is the medical and therapeutic approach, which seeks to address the underlying cause of mental illness

via treatment and rehabilitation. An effective criminal justice system enacts formal social control to deter the general population from participating in crime. The United States criminal justice system spends a substantial amount of taxpayer money on prison expansion and a variety of other formal social control mechanisms. In classical economic terms, incarceration expenditures can be considered net positive if the value produced through public safety and deterrence exceeds that of the cost (Pustilnik, 2005). As is the case with mentally ill individuals, many are arrested and incarcerated for non-violent offenses. The paradox of the criminal justice system is that mentally ill offenders have been absorbed into a prison system designed to punish intentional lawbreaking (Pustilnik, 2005).

Quantifying the total direct and indirect costs cannot be calculated based on current data alone, though the costs associated with incarceration are immense. Indirect costs relate to a pure social loss. Access to treatment for mentally ill can ameliorate pain and suffering while promoting general well-being. A conservative estimate indicates that state prisons spend roughly $4.75 billion dollars a year alone just to incarcerate nonviolent mentally ill offenders (Pustilnik, 2005). Mentally ill inmates on average serve twelve months longer than inmates convicted of equivalent offenses (Pustilnik, 2005).

As this literature review has indicated, the mentally ill have increasingly become absorbed into correctional institutions across the United States due in part to homelessness and the poor organization of the mental health system. Symptoms of mental illness also tend to worsen given the sensory deprivation of isolated segregated housing units and rules of conduct governing the prison environment. Mentally ill inmates also face other day to day challenges associated with depression, sexual assault,

physical violence and suicidal ideation just to name a few. Given the many challenges that mentally ill inmates face, it should be no surprise that correctional officers face a major hurdle in supervising this inmate population. Prison institutions in general were never meant to bear the responsibility of the welfare of the majority of the mentally ill in the United States. With improved officer training opportunities, these institutions can become safer environments for both staff and inmates.

E. The Crisis Intervention Team (CIT Program)

The Crisis Intervention Team (CIT) Program exemplifies effective strategies for crisis workers to respond to mentally ill populations. The CIT model is a nationally recognized pre-booking diversion program used by police officers to avoid unnecessary incarceration or institutionalization of people with mental illness (Cattabriga, Deprez, Kinner, Louie & Lump, 2007). In 1988, the Memphis Police Department formed a partnership with the Memphis Chapter of the National Alliance on Mental Illness (NAMI), mental health providers and local universities in developing a training curriculum for police officers to develop a safe and humane approach when dealing with mentally ill individuals (Memphis Police Department, 2011). This collaboration was the genesis behind the Memphis Police Department's Crisis Intervention Team.

The CIT program was developed in part because of budget constraints, economic concerns and other social factors associated with the large number of homeless people suffering from mental illness who often come in contact with the general public. These same homeless individuals would have formerly been hospitalized as inpatients, but have been left to wander the streets due to the deinstitutionalization of state mental health facilities across the United States (Gilliland & James, 2005). The problems experienced

by the homeless are often exacerbated by drug or other alcohol use and contribute to mentally ill people being subjected to highly dangerous situations. Coming into contact with this segment of the population also poses an increased likelihood that police officers could become seriously injured or even killed, which is why improved officer training was necessary to deescalate these volatile situations.

F. Case Study of NAMI Maine's 2005-2007 Expansion Program

Prison institutions also have their own challenges associated with mentally ill inmates and the principles of the CIT Program can also be applied to correctional officer training. To address the needs of mentally ill inmates, the National Alliance on Mental Illiness (NAMI) in Maine developed an expansion Crisis Intervention Team training program for law enforcement and correctional officer teams to identify mental-health based problems and appropriately intervene in psychiatric emergencies. This pilot program was notable because correctional officers had been traditionally excluded from CIT training in the past (Cattabrigga, Deprez, Kinner, Louie & Lumb, 2007). The structure of the 40-hour training sessions consisted of several guest speakers on the topics of background information related to mental illness, community resources, inmate perspectives, legal issues, medication side effects and substance abuse. Role playing was considered to be an essential component of the training and was used to teach de-escalation techniques among officers (Cattabriga et al., 2007). Another training component consisted of family members of people with mental illness recounting their stories so that officers could gain a better understanding of the impact mental illness can have on families. Although the content of training program was highly structured, the Memphis model allows for flexibility in selecting applicable issues that are relevant to

specific prison environments. After the training was completed, NAMI conducted follow- up site visits to provide ongoing support as officers began to implement their new skills in the workplace. The CIT expansion training curriculum addressed mental health issues in a systematic and comprehensive way by training officers in the following topics:

1. Understanding and recognizing psychiatric signs and symptoms
2. Training officers to use de-escalation skills to calm and reassure people with psychiatric disorders
3. Linking officers and mental health service providers within the institution who can respond quickly to calls for assistance
4. Building on each officer's experience and comfort level in working with individuals with mental illness
5. Training officers in suicide prevention
6. Alcohol and drug behavior in dual-diagnosed individuals
7. Psychotropic medications and their side effects
8. Inmate rights and legal aspects of crisis intervention (Cattabriga et al., 2007).

An evaluation of the pilot program was conducted by the Center for Health Policy, Planning, and Research (CHPPR) at the University of New England. Correctional and police officers from seven county jails in Maine were included in this expansion CIT training between 2005 and 2007. The findings of this evaluation indicate that the introduction of the expansion CIT program to seven correctional facilities in Maine was effective. Before attending the CIT training, the Maine correctional officers generally did not feel adequately prepared to intervene in mental health crisis interventions. This

problem is exacerbated due to chronic understaffing in many of the aforementioned facilities. Additionally, officers who volunteered for the training also self reported a higher degree of comfort in de-escalating crisis situations and increased confidence in their own ability to recognize maladaptive behaviors caused by mental illness (Cattabriga et al., 2007). Officers also reported increased preparedness in encountering people threatening suicide. The opportunity for correctional officers to gain knowledge about mental illness alongside members of outside law enforcement was another notable beneficial component of the training that provided important networking opportunities for both groups and increased understanding about the role each plays in dealing with people with mental illness (Cattabrigga et al., 2007). One noted drawback related to some of the correctional facilities in Maine was the high turnover rated associated with correctional officer positions, which makes it a challenge for administrators to sustain CIT training without dedicated funds and support from key stakeholders.

The CIT expansion training program for law enforcement and correctional officers was meant to bridge a major gap in officer training regarding mentally ill inmates. To illustrate this point, the Institution Human Resources Director Bruce Kann at the Prairie du Chien Correctional Institution indicated that suicide prevention is the only training provided across the Wisconsin Department of Corrections and that these officers receive nothing else regarding mental health training. The burden for all other mental health crisis events among the inmate population rests with social workers and psychologists within the institutions (Bruce Kann, personal communication, March 14, 2011). While this isn't necessarily indicative that all correctional institutions across the

United States are ill equipped to manage mentally ill inmates, it still points to a growing challenge to develop strategies to appropriately respond to this inmate population.

G. Competing Work Cultures of Correctional Officers and Clinical Staff

One of the challenges in implementing a training curriculum like the expansion CIT program especially in a correctional environment is the competing work cultures of custodial and clinical staff. Although they must work together cooperatively, correctional officers and clinical staff each have unique professional cultures and missions that must be appreciated. For instance, the primary mission of correctional officers is to serve society by confining inmates, whereas clinicians and other healthcare staff must serve the inmate by providing individualized treatment (Appelbaum, Hickey & Packer, 2001). The correctional work culture typically involves regimentation and universally applied rules to all inmates. The disparity in ideologies between these two work cultures can sometimes lead to conflict between these groups. For instance, some correctional staff might view clinicians as naïve, gullible or too coddling of inmates. Some officers might perceive mental illness as a character flaw or resent the fact inmates have access to free mental health services (Appelbaum et al., 2001). Additionally, some officers may also perceive treatment as protecting inmates from the consequences of their actions. By that same token, some clinicians can view correctional staff as excessively harsh and punitive. Furthermore, many health care providers may view antisocial behavior of inmates as an indication for treatment, not punishment (Appelbaum et al, 2001).

These differences highlight a major disconnect regarding competing work cultures of custodial line staff versus clinicians in which officers frequently develop a

public safety mindset and act immediately rather than taking a person-centered approach that benefits the inmate in crisis situations. The differences between correctional officers and clinical staff members illustrate a deeply ingrained custody work culture that rewards officers who are hyper vigilant and unbending when it comes to enforcing inmate accountability. An officer who takes time to empathize and listen to an inmate vent frustrations might be perceived as naïve or too accommodating to inmates in the eyes of hard liner senior correctional officers. When faced with a mental crisis event many officers lack the creativity and flexibility to respond appropriately to mentally ill inmates and instead resort to issuing conduct incident reports in the hopes that it will curtail rule infractions in the future. The wide gap between correctional officers and clinical staff needs to be bridged to foster collaboration and ultimately safer working environments for both staff and inmates. This requires deep reflection and reassessing what it truly means to be an effective correctional officer.

H. Summary of Literature Review

This literature review has demonstrated the unique challenges associated with managing mentally ill offenders in prison settings. Correctional institutions in general were never specifically designed to accommodate the mentally ill segment of the population, yet at present time many prisons have become modern day insane asylums at least to a certain extent. This presents a growing challenge for prison administrators and especially correctional line staff who must work in close proximity to mentally ill inmates. Crisis Intervention Team training was highlighted in this section as an effective program in helping correctional officers utilize de-escalation techniques and other skill sets when encountering mentally ill inmates in crisis situations. The next section will

cover crisis intervention models and the underlying theory behind how CIT training programs can be effective.

III. THEORETICAL FRAMEWORK: CRISIS INTERVENTION MODELS

In this section, theory will be applied to highlight crisis intervention and its application to mentally ill inmates in correctional environments. For the purposes of this inquiry, the discussion of the theory will be limited due to the fact that a standard theoretical framework is not readily apparent in traditional criminological fields. As a result, this author sought out other human service fields to determine how professionals typically respond to the needs of mentally ill clients in crisis situations.

Due to the inherent dangers of working in a prison environment, this author stresses the importance of having both clinical mental health staff and correctional officers trained in crisis intervention strategies. Having custody staff trained in basic crisis intervention concepts is doubly important considering the fact that these are the individuals who are often on the front lines and generally have more face to face interaction with inmates especially during evening or overnight hours when clinical staff is likely away from the institution. In regard to theories of crisis intervention, there is no single crisis intervention model that encompasses every view of human crisis. For the purposes of this paper, three basic crisis intervention models introduced by Leitner (1974) and Bellkin (1984) include the equilibrium model, the cognitive model and the psychosocial transition model (Gilliland & James, 2005). These three models lay the groundwork for several types of crisis intervention strategies and methodologies.

A. The Equilibrium Model

The equilibrium model is based on the notion that people in a crisis are in a state of psychological or emotional disequilibrium. When a person is experiencing disequilibrium it means that their usual coping mechanisms to deal with problems have

failed. Therefore, the goal of the equilibrium model is to help individuals regain a state of pre-crisis equilibrium (Gilliland & James, 2005). This model seems most appropriate for early intervention when the individual is out of control, confused or disoriented. It should also be noted that the main focus during this stage is to stabilize the individual. As an example, if a correctional officer were to encounter an inmate threatening suicide with a sharp instrument it would make little sense to attempt to delve into the underlying factors contributing to suicidal ideation until the inmate can be stabilized to the point of agreeing to relinquish the weapon.

B. The Cognitive Model

The cognitive model of crisis intervention is based on the idea that crises are rooted in faulty thinking patterns. The goal of this model is to help people gain control over their crisis by changing their views about the crisis events or contributing situations (Gilliland & James, 2005). Very often the messages that people in a crisis send themselves can be negative and twisted when contrasted with what is actually happening in reality. This can be especially true of mentally ill inmates who can often have dilemmas that push their internal perception towards negative self-talk resulting in a self-fulfilling prophecy or a feeling that a situation is hopeless. At this point it becomes the goal of the crisis worker to help the individual rewire their thought process to a positive feedback loop by rehearsing new self-statements until the old negative cognitions become expunged (Gilliland & James, 2005). It is worth noting that the cognitive model is generally most appropriate after the individual has been stabilized to a pre-crisis condition.

C. The Psychosocial Transition Model

The psychosocial transition model is based on the premise that people are products of genetics as well as their social environments. Due to the fact that people are constantly changing and their social influence is always evolving, crisis may be related to both internal and external difficulties (Gilliland & James, 2005). The goal under this model is to collaborate with individuals in assessing the internal and external difficulties contributing to the crisis and helping them choose alternatives to their behaviors and attitudes. The psychosocial transition model is unique because it does not assume crisis as an internal struggle that resides totally within the individual. Specifically, it goes one step further by analyzing external systems such as peers, family, occupation, religion, setting and various other dimensions that may promote or hinder psychological well being (Gilliland & James, 2005). Regarding mentally ill inmates, it bears mentioning that the prison setting itself especially as it relates to single cell segregation units can often exacerbate symptoms of mental illness and contribute to these crisis situations in the first place. As was the case with the cognitive model, the psychosocial transition model seems most appropriate only after the individual has stabilized. The aforementioned models of crisis intervention describe techniques that can be taught to anyone with a willingness to learn. This proves especially important in a prison setting due to the fact that correctional officers are often in close proximity to a diverse contingent of inmates who often experience a multitude of unique challenges and crisis situations often stemming from a mental illness.

D. Characteristics of Effective Crisis Workers

Effective crisis workers also share a number of characteristics. Such a worker may have life experiences to draw upon in the event of a crisis. The life experiences that

crisis workers have can serve as a reservoir of strength and emotional maturity in times of emergencies (Gilliland & James, 2005). These experiences combined with training enable crisis workers to be firm, fair and consistent in their encounters with others. Crisis workers should also maintain their poise and resiliency especially as it relates to a prison setting since very often correctional officers can be confronted with shocking and threatening inmates who are out of control. Additionally, crisis workers often do not have the luxury of time to reflect and mull over options in a crisis situation so fast mental reflexes to deal with constantly emerging issues is essential. Practicing relaxation techniques is just one way the interventionist can keep calm in such highly charged crisis situations (Gilliland & James, 2005). Creativity and flexibility are some other important attributes to crisis workers facing perplexing crisis situations and can be practiced in training workshops with peers through role playing scenarios. Multicultural competency is also crucial, which is why crisis workers should remain vigilant in exploring their own unintentional cultural or racial assumptions about the people they serve (Gilliland & James, 2005). Finally, crisis workers must also have the potential and desire to grown and change. This entails staying up to date in current practices and training as well as learning from past miscues in crisis situations. One possible way to ensure this growth is for correctional institutions to develop debriefing groups or after action panels for those involved in crisis situations. Involving correctional officers in this process will also have the added benefit of creating solidarity and collaboration between custodial and clinical staff. The aforementioned characteristics of effective crisis workers is just a brief list of positive attributes and by no means represents all possible avenues of success in crisis intervention.

E. Summary of Theoretical Framework

This section has explored crisis intervention theory and its application to mentally ill inmates in a correctional setting. Within the literature review Crisis Intervention Team programs were discussed as a viable training curriculum for correctional officers managing mentally ill offenders. The NAMI expansion training program mentioned previously in particular seems to incorporate the key principles associated with the aforementioned crisis intervention models. Moving forward this author will discuss recommendations associated with the implementation of Crisis Intervention Team training programs in more correctional institutions along with fostering better working relationships between custodial and clinical staff.

IV. RECOMMENDATIONS

A. Improved Training of Correctional Officers via the Recommendations of the NAMI CIT Expansion Training Program

Within the literature review, CIT programs were highlighted as viable training options for law enforcement and correctional officers in particular. Specifically, the NAMI expansion CIT training to jails in seven Maine counties showed that the CIT model can be effectively used with correctional officers managing mentally ill inmates. This has implications for the implementation of similar CIT programs in correctional institutions across the United States. CIT training helps fill a major gap in correctional officer training and ensures that crisis situations are handled appropriately. Additionally, inmate and officer injuries were found to be kept to a minimum in the NAMI study when the incident is resolved through verbal de-escalation rather than force (Cattabrigga et al., 2007). Officer surveys also demonstrated a high level of satisfaction with the CIT program and that these officers felt more comfortable with their de-escalation skills after the training. Furthermore, correctional officers also felt more comfortable with their knowledge of mental illness and substance abuse issues (Cattabrigga et al., 2007). Recommendations set forth by NAMI Maine's CIT program as it is further implemented in the future consist of the following:

1. Continue to train new correctional officers to replace officers lost to turn-over or retirement.
2. Offer annual refresher courses in CIT to those who have previously been trained so that their skills can be maintained and expanded.

3. Integrate both law enforcement and corrections officers in CIT training so that both groups can benefit from common interaction.
4. Work with state and federal agencies to make CIT training a permanent component of corrections training with sustained funding and commitment from community stakeholders
5. On-site follow up to determine how well the officers have retained information from the training (Cattabrigga et al, 2007).

One limitation noted in the evaluation of the CIT expansion training program is the fact that staff burnout and turnover is prevalent in the field of corrections. Corrections can be a dangerous and often stressful occupation for officers. This is compounded by the fact that many officers receive mandatory overtime due in part to chronic understaffing of many institutions. The challenges of shift work and not having consistent days off to spend time with their families can take a heavy toll on many officers as many decide to resign within the first year of employment. This presents a challenge in the implementation of CIT training programs since it could potentially become time consuming and expensive to train correctional officers who might decide to resign soon after. One way to alleviate this dilemma is to carefully screen the officers who volunteer for CIT training. For instance, officers who apply for the program should have good records as officers, pass personality tests for mental stability and ultimately be interviewed to receive such training (Gilliland & James, 2005). Having highly motivated individuals who are committed to improving their skill sets as correctional officers is one way to combat problems associated with staff turnover.

One additional way to ensure the success of CIT programs in correctional environments is to solidify support from key community stakeholders. The original CIT program in Memphis, Tennessee was successful due to the intricate network alliance of community stakeholders. This included the Memphis city government, police department, community mental health centers, public hospitals, local universities and several other private practice psychologists (Gilliland & James, 2005). This alliance was formed because both the Memphis police and mental health community came to the realization that the problems associated with mental illness were too severe for either of them to handle alone (Gilliland & James, 2005). Having a network alliance in a correctional environment is also possible with the collaboration among community volunteer groups, local universities, community relations board members, mental health experts and various internal departments within the institution all working towards a common goal of improved training for correctional officers.

B. Cooperation Between Corrections Officers and Clinical Staff

In addition to a CIT training component, the literature review also noted the competing work cultures between clinicians and correctional officers. The elements behind successful collaboration between these two groups can be broken down into categories of shared core values and respect, ongoing communication, cooperation, orientation and training (Appelbaum et al., 2001). Correctional officers can maximize their contribution to multidisciplinary mental health care in prisons when they have a solid understanding of mental illness and remain steadfast in noticing signs and symptoms of mental illness (Appelbaum et al., 2001). Corrections officers must also have a willingness to refer cases to mental health staff. By that same token mental health

staff should also approach correctional officers with a fundamental respect for the important and often difficult job they perform.

Orientation and training is another area where the division between clinicians and correctional officers can be narrowed. This can be accomplished by exposing clinicians to matters of institution security. By that same token, correctional officers can also be exposed to clinical styles of managing mentally ill inmates. For example, in Massachusetts all new clinicians attend a mandatory weeklong Department of Corrections orientation conducted primarily by correctional officers. This training introduces mental health staff to the prison setting and seeks to emphasize safety, security and the importance of following established protocol in the institution. The training also allows clinicians to gain a glimpse inside the mindset of correctional officers, particularly as it relates to maintaining a structured and orderly environment (Appelbaum et al., 2001). Through this training clinicians realize that without established security protocols, meaningful clinical work is impossible. In turn, these collaborative training sessions also give correctional officers an opportunity to learn about mental illness and suicide prevention. These sessions cover recognition of mental illness, suicidal risk factors, denial of parole, high-risk times and places and procedures for referring mentally ill inmates to clinicians (Appelbaum et al., 2001).

Correctional officers can play a vital role in the delivery of mental health services in jails and prisons. Clinicians and officers may have different work mentalities, yet this does not mean they have completely different goals when it comes to managing mentally ill inmates. When correctional officers can appropriately share information with

clinicians and assist in the management of mentally ill offenders, it contributes both to the quality of treatment of inmates and overall safety of the correctional environment.

V. CONCLUSION

This paper has illustrated the many challenges that mentally ill inmates face in the prison setting. These problems include increased risk of suicide, sexual assault, post traumatic stress disorder and depression just to name a few. The sensory deprivation of segregated housing units is also problematic and further exacerbates symptoms of mental illness such as hallucinations and increased rage. To combat the myriad of complicated issues surrounding this inmate population, correctional officers are provided with very limited training and minimal resources to understand mental illness and develop effective responses to crisis situations. The need for improved training opportunities for correctional officers is very clear. The literature review has revealed that the utilization of crisis intervention teams (CIT) can be very effective in preparing officers in their encounters with mentally ill inmates and crisis situations. As a basic template, this author promotes a 40-hour training curriculum as was used in the NAMI Maine expansion CIT training program. As was mentioned previously, the structure of the 40-hour training sessions consisted of several guest speakers on the topics of background information related to mental illness, suicide prevention, community resources, inmate perspectives, legal issues, medication side effects and substance abuse. Annual refresher training of correctional staff can be a way for officers to retain much of this information. Another recommendation associated with the CIT training involves role playing. Role playing proved effective because it allowed officers an opportunity to practice de-escalation techniques and creatively participate in scenarios that might involve mentally ill inmates. Before any of this training can occur, prison institutions need to first develop a strong network alliance of committed stakeholders. One of the noted drawbacks of

implementing CIT training in prison settings revolves around the fact that staff turnover in corrections is particularly high, which means that it can become time consuming and likely expensive to train many officers who may decide to resign soon after. As a recommendation, this author promotes careful screening of applicants for CIT programs so that only motivated officers are selected for training.

Finally, one last essential step in this process is bridging the wide gap between correctional officers and clinicians within the institution. This relates to the fact that correctional officers and clinicians often have competing work cultures when it comes to dealing with inmates. This author also supports the implementation of sensitivity training so that both of these work groups can understand and value the role of one another. As was noted earlier, this can be accomplished by exposing clinicians to basic corrections orientation training so that they can understand matters of institution security protocols. The hope of this paper was to contribute a best practices template for correctional officers to be better prepared to deal with mentally ill inmates and crisis situations.

The recommendations set forth in this paper are not meant to be an exhaustive list of all of the possible effective strategies in dealing with mentally ill inmates. Instead, it is the hope of this author that these recommendations will serve as a starting point for the implementation of CIT training programs for correctional officers in more prison facilities across the country. In a perfect world, mental health systems across the country would be better organized and equipped to help the mentally ill and keep them out of prisons in the first place. Reforming the way the criminal justice system and society as a whole responds to mental illness could be a topic of an entirely different paper. The reality of the situation is that prisons will never be the best place to house the mentally ill

since incarceration by its very definition will always have an adverse effect on mentally ill inmates to varying degrees. Even though this may seem like a bleak forecast, this should not be an excuse to give up on mentally ill inmates.

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